

MISSOURI BEHAVIORAL HEALTH SYSTEM ASSET MAPPING PROJECT

JULY 2021



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EXECUTIVE SUMMARY

Ideal community behavioral health systems (i.e., systems to treat mental health conditions and substance use disorders) are organized at the community level to meet the overlapping and intersecting needs of the whole population. Missouri organizes its behavioral health system primarily at the state level, with a focus on specific subpopulations that are priority targets for interventions by Department of Mental Health (DMH) contractors. Other state departments have a similar approach within their respective domains of responsibility.

Missouri has important state-level collaborations that reinforce state-level direction and development, such as the certified community behavioral health organization (CCBHO) collaboration between DMH, MO HealthNet, and the Missouri Behavioral Health Council (formerly Missouri Coalition for Community Behavioral Healthcare); the Missouri Trauma Initiative; and the Justice Reinvestment Initiative. However, Missouri has no consistent approach for empowering community-level accountability and responsibility for health and behavioral health services. As a result, Missourians, including those with so-called “good insurance,” experience major gaps in behavioral health services. These gaps lead to inefficiencies and inequities across the state, with varying effects in each community.

Missouri also fails to reap the full benefit of lessons learned by people who access (or try to access) behavioral health services. The number of peer support specialists is growing and there are a few peer-run organizations across the state, but it is rare to find people who self-identify as people with lived experience actively engaged in developing policy and services related to behavioral health.

Despite numerous local efforts to collaborate, and the involvement of many amazing and hard-working individuals and creative grant-funded programs and projects, communities constantly struggle to achieve sustainable progress to address intersectional community needs and disparities beyond what the state-level system naturally addresses.

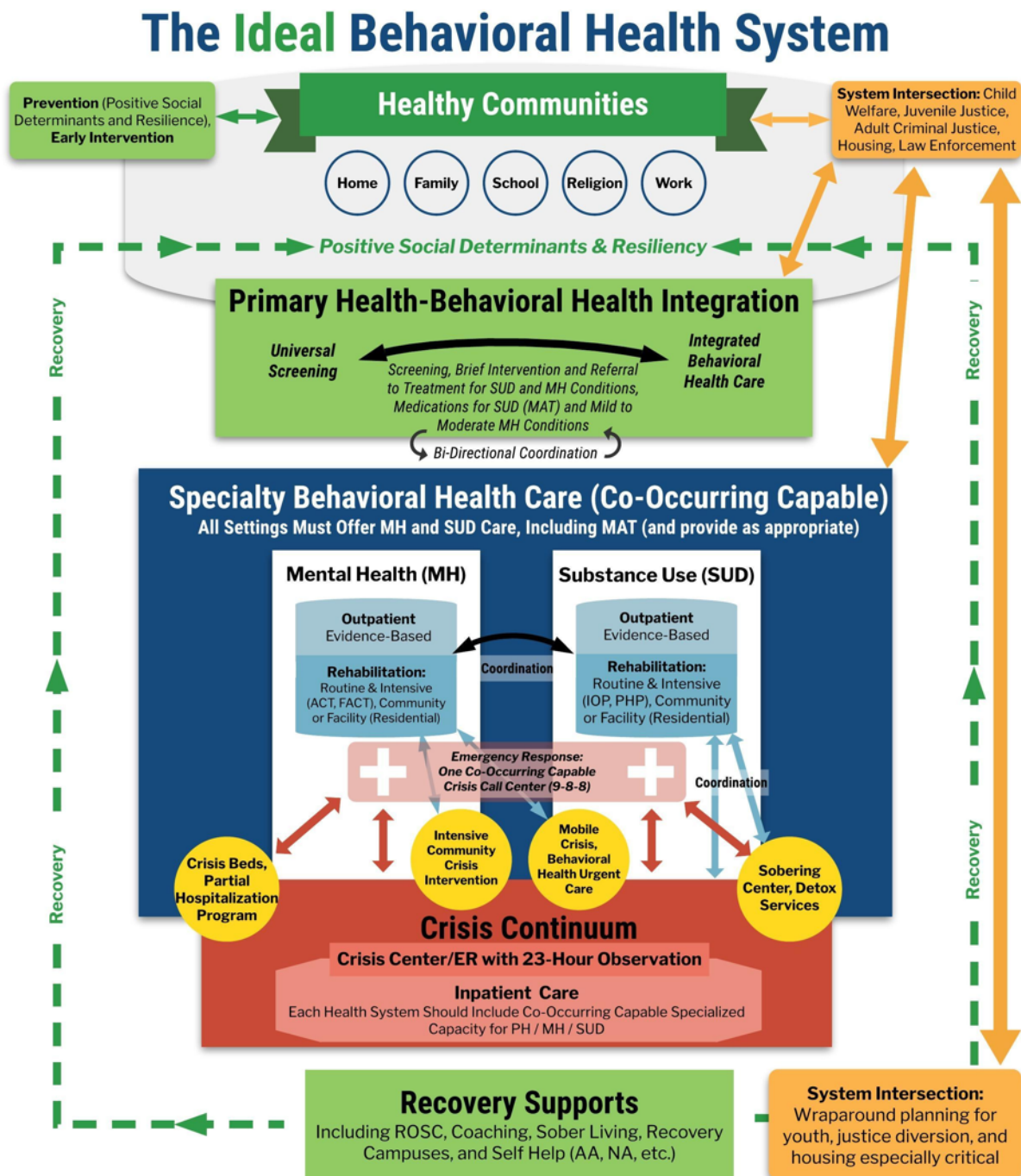
Changing this will not be easy or quick, but change is necessary for sustainable progress. As changemakers, foundations can be important collaborators and drivers of strategic progress.

FINDINGS

This report builds on preliminary findings and hypotheses generated in an earlier phase of the Behavioral Health Asset Mapping project, with additional information gathered through in-depth interviews with community-level leaders and stakeholders and focus groups of youth, adults, and families with lived experience from June 2020 to March 2021. During these regional assessments, we gathered information on all elements of the ideal behavioral health system (see Figure 1). Based on strategic prioritization work with Missouri Foundation for Health, Health Forward, and the project's advisory group, we prioritized three areas for detailed discussion:

1. Empowered Local Collaborations,
2. Primary Health/Behavioral Health Integration, and
3. Community Behavioral Health Crisis Systems.

Figure 1. Ideal Behavioral Health System



EMPOWERED LOCAL COLLABORATIONS FINDINGS

What did we look for? Behavioral health (mental health and substance use) needs overlap with all aspects of health and human services. Ideal community behavioral health systems require collaboration at the local level to bring together multiple funders, service providers, and subsystems (criminal justice, housing, child protection, health) to work together to meet community needs. The systems of prevention, intervention, and recovery support at the community level—whether for adults, for children, or for both—should be accountable to the voice of the local community, be responsive to the diversity of that community, and be inclusive of the empowered voice of people with lived experience.

What did we find?

- In Missouri, state systems are designed more centrally, not only within each department, but even within subdomains of service (e.g., in the Department of Mental Health: mental health versus substance use disorder versus intellectual/developmental disabilities, adult versus child). This leads to strong standardization of innovation, but less community oversight, less empowerment of community voice, and less opportunity for coordination of multiple types of resources locally.
- We learned that in every community that we assessed, there are a wealth of collaborations coming together to address community needs, with different levels of function and capacity. We identify some of these collaborations in the report. However, there is significant opportunity for all these collaborations to be stronger and more successful, working in partnership with state agencies to coordinate public and private, state and local resources to better meet community needs.
- There are significant opportunities in Missouri to build on current capacity in each region to develop routine mechanisms by which empowered community collaborations (that include local agency leaders representing multiple systems and the empowered voice of people served) can work in partnership with state agencies to design locally accountable service systems.

PRIMARY HEALTH/BEHAVIORAL HEALTH INTEGRATION FINDINGS

What did we look for? Population health innovations recognize that health and behavioral health are interlinked. Developing healthy communities requires addressing health and behavioral health together throughout the delivery system and leveraging medical spending to support behavioral health capacity in routine primary care, pediatric care, and specialty care, as well as in specialized efforts to address complex populations who are using high levels of resources without achieving healthy outcomes. Addressing racial and geographic disparities, as well as social determinants of health, is a critical feature throughout all services. Therefore, in an ideal behavioral health system, the goal is that all services address co-occurring needs and that all resources are leveraged to support appropriately matched integrated service delivery.

What did we find?

- Missouri's Health Home program is coordinated by MO HealthNet, DMH, the Missouri Behavioral Health Council, and Missouri Primary Care Association and includes implementation of behavioral healthcare homes in Community Mental Health Centers (CMHCs) and dissemination of the Primary Care Health Home initiative in Federally Qualified Health Centers (FQHCs). It is recognized as a national model for bringing the benefits of health home service development to safety net providers statewide.
- At the community level, although every CMHC/CCBHO and FQHC has developed some level of integrated services, the health home population is only a small percentage of the total population served in most settings. There are some amazing success stories (see Community-Level Assets) where individual providers or provider collaborations have developed a more comprehensive integrated service continuum. These are examples of where further development is possible.
- Hospital systems may play a very important role in the provision of behavioral health services, but they are not routinely included in state-level behavioral health system design. Nonetheless, some large hospital systems (two of which are highlighted in the report) are making enormous strides toward developing integrated continua of care throughout their health services. Other large hospital systems are beginning to create strategic innovations to address populations with complex needs. All the health systems we interviewed expressed awareness of the need to develop population health capacity, even if they were only in early planning stages. All the health systems we interviewed indicated that they need more education, consultation, and technical assistance to make progress.
- School-based health and behavioral health systems are an emerging best practice in which the school population is a focus of development for a "healthy community." This can be accomplished through developing trauma-informed schools, emphasizing social and emotional learning, integrating behavioral health and health into "healthy schools" campuses, and connecting children and families with higher levels of need to specialty behavioral health services and other resources both within and outside of the school system. We found that several Missouri communities are making great strides in developing these school system initiatives, supported by the Department of Elementary and Secondary Education leadership on trauma-informed schools statewide (Missouri Trauma Initiative) and the Show Me School-Based Health Alliance of Missouri, with strong leadership at the local level exercised by school superintendents and others.
- There is tremendous opportunity to enhance capacity, resources, and outcomes for adults and children with complex health, behavioral health, and human service needs by starting with organizations that have developed more capacity for integration, and building on statewide consultation, technical assistance, and learning communities to advance population health. Population health partnerships between health/behavioral health systems and providers, school systems pursuing "healthy schools" initiatives, and community agencies addressing trauma and social determinants of health are an emerging opportunity for community system impact.

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEMS FINDINGS

What did we look for? The essential elements of an ideal community behavioral health crisis system are outlined in the [Roadmap to the Ideal Crisis System](#) by the Group for the Advancement of Psychiatry. Nationally, there is enormous energy dedicated to preparing crisis systems to respond to the implementation of the federally mandated 988 mental health crisis line by 2022. Extensive new federal and state resources are becoming available to plan and implement the elements of this system. There is a need for communities to collaborate to design and implement community behavioral health crisis systems and a need to bring together multiple private and public funds (including commercial insurance) to design a full continuum of care.

What did we find?

- In Missouri, the state-supported behavioral health crisis system has some excellent elements that are universally distributed. These include 24-hour National Suicide Prevention Lifeline-certified call centers, limited mobile crisis services, emergency room enhancement services for adults, and community mental health liaisons with law enforcement. Statewide implementation of CCBHOs has created capacity for walk-in response and open access in almost all communities. However, in spite of this capacity, there are strikingly significant gaps in the crisis system statewide and locally. The presence of these gaps was confirmed during the community assessments. Further, many of the focus group participants commented that peer warm lines were defunded and dismantled (during the timeframe of this project), which is adding to the pressure on the crisis system.
- Several communities, however, have initiated collaborative efforts to create new crisis services to fill those gaps. These include crisis centers, crisis stabilization units, behavioral health urgent care centers, and sobering centers. There is a great need as well for expansion of certified peer support specialists in crisis services as well as greater expansion of crisis response to individuals with serious opioid use disorder. These local innovations are now being considered for further dissemination with new state budget resources; however, much more needs to be done. Medicaid and private insurance rarely pay for many of the necessary elements of a crisis system. Existing service continua are not at scale and many service gaps remain.
- There are significant opportunities in Missouri to engage existing (or develop new) regional/local collaborations to be strong and effective partners with the state in bringing multiple types of public, private, state, and local resources to the table to design and continuously improve the behavioral health crisis continuum. The examples highlighted in this report are demonstrations of what some communities have done. These efforts form a foundation for the development of further capacity, so that every Missourian with behavioral health needs can receive the right response in the right place, every time.

INTRODUCTION

In fall 2019, Missouri Foundation for Health in St. Louis and Health Forward Foundation in Kansas City launched this project—the first ever statewide system and service asset mapping of Missouri’s behavioral health system. The purposes of this statewide initiative were (1) to gain a comprehensive understanding of how multiple systems and stakeholders intersect with and influence Missouri’s efforts to help individuals and families with behavioral health challenges, and (2) to identify opportunities for collaboration and investments to improve service capacity and outcomes for individuals, families, and communities across the state. The team of consulting firms contracted to perform the Behavioral Health System Asset Mapping project is led by ZiaPartners, Inc. and includes:

- Kenneth Minkoff, MD, ZiaPartners, Inc.
- Chris Cline, MD, MBA, ZiaPartners, Inc.
- Samuel Shore, LMSW, TriWest Group
- Cassie Morgan, LCSW, TriWest Group
- Lynda Frost, JD, PhD, Lynfro Consulting
- Joe Parks, MD, National Council for Mental Wellbeing (formerly National Council for Behavioral Health)
- Joe Powell, LCDC, Association of Persons Affected by Addiction

The Behavioral Health System Asset Mapping project had two phases. Phase One involved gathering information from fall 2019 to spring 2020 to produce a high-level overview of the state’s behavioral health system in relation to the elements of the ideal behavioral health system (see Figure 1), with a focus on assets and improvement opportunities.

Phase Two of the Behavioral Health System Asset Mapping project involved in-depth assessments of regional and local systems in six main areas of the state (central Missouri, the Greater St. Louis area, Kansas City, northern Missouri, southeast Missouri, and southwest Missouri) covering ten distinct communities listed below.

- | | |
|------------------|--|
| ■ Cape Girardeau | ■ Kansas City/Jackson County |
| ■ Columbia | ■ Kennett |
| ■ Hannibal | ■ Moberly/Randolph County |
| ■ Jefferson City | ■ Springfield |
| ■ Joplin | ■ St. Louis (seven counties in the region) |

Throughout the course of the project, we also engaged an advisory group comprised of experts and partners in the behavioral health field to provide input and guidance. Project advisory group members include:

- Nora Bock, Director, Division of Behavioral Health, Department of Mental Health
- Jama Dodson, Executive Director, St. Louis Mental Health Board
- Sarah Earll, Executive Director, St. Louis Empowerment Center
- Bruce Eddy, Executive Director, Jackson County Community Mental Health Fund

- Angela Herman-Nestor, Quality and Performance Improvement Manager, Missouri Primary Care Association
- Jason Klaus, State Coordinator, Missouri CIT Council
- Brent McGinty, President/Chief Executive Officer, Missouri Behavioral Health Council
- Mark Miller, Vice President, Behavioral Health Services, Swope Health
- Lauren Moyer, Vice President, Clinical Innovation, Compass Health Network
- Wendy Orson, Chief Executive Officer, Behavioral Health Network
- Joe Pierle, Chief Executive Officer, Missouri Primary Care Association
- Gena Terlizzi, Executive Director, NAMI Missouri
- Brian Williams, Executive Director, Randolph County Caring Community
- Karl Wilson, Retired Clinical Psychologist; Board Member, Mental Health America of Eastern Missouri
- Laine Young-Walker, Associate Dean, Department of Psychiatry, University of Missouri

The advisory group has helped us to identify, recruit, and engage key stakeholders and people with lived experience; identified and contributed key sources of information and data; provided input to guide the project; and served as a reference group for emerging findings and recommendations.

In November 2020, we met with the advisory group, Missouri Foundation for Health, and Health Forward, to identify priority areas for action based on the emerging findings and themes. The three priority areas identified for additional action included:

1. Empowered Local Collaborations,
2. Primary Health/Behavioral Health Integration, and
3. Community Behavioral Health Crisis Systems.

We developed strategic frameworks with specific action steps for each of the priority areas, with input and feedback from the advisory group members between December 2020 and March 2021. In this report, we summarize the state and regional findings centered around these three priority areas and highlight relevant community-level assets.

METHODOLOGY

Throughout the course of this project, we have gathered both qualitative data (through stakeholder interviews, focus groups/listening sessions, and reviews of reports and materials from various agencies and projects) and quantitative data (from analysis of population demographics and estimates of need as well as analysis of data relevant to service provision and outcomes, when available). Below, we describe the processes for the stakeholder interviews and the focus groups with people with lived experience of recovery and we also describe our overall focus on strengths and assets.

INTERVIEWS

In collaboration with Missouri Foundation for Health, Health Forward, and the project advisory group, we identified stakeholders across Missouri with knowledge of the behavioral health system and other systems that intersect with behavioral health in their respective communities. The goal of the interviews was to learn about what is working well in the different regions, about what unique and creative solutions communities have developed, and about areas where communities could use more help and support to better meet behavioral health needs.

The project team developed interview questions based around:

- Service capacities, strengths, and gaps;
- Local system intersections and collaborations; and
- Progress toward each element of an ideal behavioral health system

Please see Appendix A. Regional Interview Guide for more information on the structure and diversity of questions asked of stakeholders depending on their areas of expertise. Because of the COVID-19 pandemic, we conducted interviews virtually by Zoom or teleconference. Between June 2020 and April 2021, we interviewed over 330 stakeholders across Missouri, representing each of the ten communities of focus.

FOCUS GROUPS WITH PEOPLE WITH LIVED EXPERIENCE OF RECOVERY

Because of the COVID-19 pandemic, in-person gatherings were not feasible, and the team pivoted to design and facilitate a series of online listening sessions. The process began with several meetings of a design team composed of project consultants and local partners with deep expertise around peer support and people with lived experience of recovery in Missouri. The design team served to identify promising contacts for potential local hosts and to help vet and revise the language and design of the meetings to be consistent with local culture and norms. The design team also requested that we call the listening sessions “focus groups,” as that language would be familiar to participants and would feel more impactful rather than implying just listening and doing nothing with the information. Please see Appendix B. Template for Regional Focus Groups for People with Lived Experience of Recovery, which resulted from the design team meetings.

The consultant team used the contacts to confirm local hosts for each of the 10 focus communities. The local hosts provided feedback on the meeting template to customize the approach to the local community, recruited participants for the focus group, assisted with notetaking (for the larger focus groups with multiple breakout rooms), and gathered contact information to ensure each participant received a stipend to honor their time (a \$20 physical or electronic gift card to Walmart). The majority of focus groups were entirely via Zoom, although some met in person with an online facilitator or with an in-person facilitator who was coached by the consultant team.

Ultimately, there were 20 focus groups across the state with a total of 144 participants. The groups ranged in size from one to 17 participants. All participants identified as people with lived experience, although the nature of their experiences varied widely. Most were adults in recovery related to mental health or substance use (or both), with the groups divided roughly equally between the two experiential sets. There were also groups of parents of children and youth with mental health challenges and a group of young adults who recently aged out of foster care. The majority of participants identified as White, although some groups were primarily African American. Few Latinx or Asian Americans participated. Many participants were currently or recently unhoused. Several had been or were currently under the supervision of the criminal justice system. Some also identified as veterans. Participants expressed appreciation that their perspectives were sought out, and some also expressed concern that this information *must* translate into action, not just another report.

FOCUS ON ASSETS

We made a consistent effort to illustrate strengths, assets, and progress while also indicating where more progress remains to be made. Our goal was to recognize the significant efforts that have been made to provide and improve behavioral health services despite the multiplicity of challenges that all states face, as well as specific challenges within Missouri, while acknowledging improvement opportunities that might be more effectively identified and addressed collaboratively—both at the state level and the regional or community level—as a result of this project.

EMPOWERED LOCAL COLLABORATIONS

WHY IS IT IMPORTANT?

Behavioral health issues (i.e., mental health conditions and substance use disorders) overlap and intersect with social, economic, and environmental factors across different life stages and levels of risk. Community systems that effectively address behavioral health and social determinants of health require intersystem collaborations to maximize impact in the community.

WHAT IS IMPORTANT?

Within the framework of the ideal community behavioral health system, the purpose of the overarching behavioral health collaboration is to work across boundaries to ensure that the system (the interactive network of funders, service providers, and other community resources) continuously improves to meet the behavioral health needs of the community.

This requires much more than a collaboration for general advocacy and education, for resource sharing, or for case conferencing. It is more than a collaboration to implement one program, or to make a single improvement in policy and practice. **Rather, such a collaboration must be designed to achieve continuous improvement for the community system and to oversee the implementation of multiple strategic and focused changes over time.**

Having formal local structures (e.g., county behavioral health departments, community services boards, regional behavioral health entities) with expectations of partnership with the state and with delegated authority to manage resources at the local level facilitates success. In the absence of such structures, as is the case in Missouri, each community must work harder to develop and maintain an effective and continuing collaboration to manage its behavioral health system.

Consequently, the following elements are critical for the design of effective regional health and behavioral health system collaborations:

Figure 2. Elements of Effective Behavioral Health System Collaborations



- **Knowledgeable and Engaged Leadership:** The structure of the collaboration and the participants in the collaboration have the authority to make necessary decisions that affect the system. Formalizing the collaboration and engaging those who have formal authority in the community can be essential.
- **Inclusive of Empowered Voices:** The collaboration promotes equity by including representatives of the relevant systems and organizations that are addressing relevant issues, as well as the empowered voices of diverse community/neighborhood members and of people with lived experience of recovery.
- **Sustainable:** The collaboration has base resources that allow for continuity of implementation over time rather than a short-term project focus.
- **Population-Focused:** The collaboration works to improve behavioral-health-related experience and outcomes for a defined population or community, not just for individuals served in a single program.
- **Adequately Resourced:** The collaboration has sufficient staff and data analytic resources for effective management of multiple improvement activities over time.
- **Data-Driven:** The collaboration gathers and shares data to guide improvement and outcomes.
- **Strategic Collective Impact Orientation:** The collaboration knows how to use the tools of collective or community impact to make change through a strategic data-driven improvement process that may have multiple simultaneous or sequential areas of focus. Each focus area should have the following [components of community change](#) (per the Center for Community Health and Development at the University of Kansas):
 - Clear mission and objectives,
 - Leadership and facilitation,
 - Action planning,
 - Resources,
 - Feedback with data,
 - Technical assistance as needed, and
 - Measurable and achievable timeframes and outcomes.

WHAT ARE THE STATE-LEVEL FINDINGS IN MISSOURI?

Statewide, Missouri is effective within each state department or division, and often effective in collaboration with state provider associations, at creating consistent practices in contracted services. Generally, successful interdepartmental collaborations, such as the Missouri Trauma Initiative, occur at the state level.

"There's a gap in communication among hospitals and mental health organizations. They shouldn't be rivals. We're seeing more collaboration now, but we have a long way to go."
- Person with lived experience of recovery

However, unlike many other states, Missouri has little routine expectation or framework for empowered behavioral health collaboration at the regional or local level.

State-Level Gaps

- There is no consistent county or regional intermediary structure for behavioral health coordination or planning between systems or agencies. Further, there is no routine process by which state leadership can partner with single-county or regional behavioral health collaborations to ensure that state-funded services are accountable to meeting the needs of diverse populations.
- There is a perception among people with lived experience of recovery that services are poorly coordinated and that there is a lack of collaboration among various service providers. People with lived experience felt that their voices were largely excluded from service design, advocacy, and policy development, including at the community level.
- There are few, if any, performance expectations governing regional or local collaboration between Department of Mental Health divisions (i.e., mental health, substance use disorder, and intellectual/developmental disabilities) or requirements for county leaders, health systems, behavioral health providers (including CCBHOs), or other health and human service partners to develop formal, empowered, population-focused, and sustainable regional collaborations.
- There is also a legacy state-level structure for assigning geographic responsibility for public mental health services to Community Mental Health Centers that usually does not align with the geographic mapping of other types of services and systems (e.g., substance use disorder services, Federally Qualified Health Centers, Children's Division, circuit courts, etc.), especially across more rural regions. This makes inter-system collaborations more challenging and requires more intentional efforts to help them succeed.

Consequently, each community is on its own when it comes to developing and sustaining effective collaborations. This is a significant improvement opportunity.

WHAT DID WE FIND IN THE REGIONAL ASSESSMENTS?

In spite of the challenges described above, every region and community we assessed has developed some level of regional/local behavioral health and/or health system collaboration with some of the elements of effectiveness. Many communities have multiple collaborations. Some collaborations are overarching efforts to address health and/or behavioral health for the whole region or community. Others are more narrowly focused on a particular population (such as children and youth) or a particular service area (such as crisis services). All could benefit from an increased strategic focus on improving ongoing capacity, sustainability, reach,

and inclusion. In the next section, we highlight one of the collaboration assets found in each of the Missouri communities we assessed. Even though many communities have multiple successful collaborations, we are unable to highlight them all because of space limitations.

COMMUNITY-LEVEL ASSETS

CAPE GIRARDEAU: CRISIS SYSTEM PLANNING COLLABORATION



Purpose and Scope: The multi-county Crisis Intervention Team (CIT) council and other partners have been coming together to plan for improvements in community crisis response, including establishing a crisis center.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is an example of a regional rural collaboration with a focus on improving behavioral health crisis services.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Adequately Resourced:** The collaboration has obtained project-specific funding resources from Missouri Foundation for Health.
- **Sustainable:** Built on the foundation of the CIT Council, the collaboration has continuity in the community.
- **Knowledgeable and Engaged Leadership:** Leaders include the crisis director of Community Counseling Center and a local CIT officer who is the Missouri CIT coordinator.
- **Inclusive of Empowered Voices:** Multiple representatives from various community providers, law enforcement agencies, and other stakeholders participate in this collaboration.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

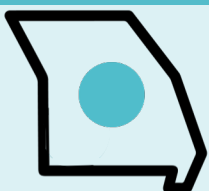
- They developed a collaboration to improve services.
- They have continually improved connection to CIT services.
- They researched models for development of a crisis center and identified recommendations.
- They obtained technical assistance to engage in regional sequential intercept mapping with a focus on intercept zero (crisis diversion).
- They gathered support for expansion of local inpatient beds by Universal Health Services.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- The collaboration has a strong need for formal authority to create sustainable system change.

- Participation of leadership from major health and behavioral health systems and providers, as well as from county government, law enforcement, justice system, and local mental health funds would be beneficial.
- Empowered participation of people with lived experience as well as affected community members who represent underserved populations would also strengthen this collaboration.
- Sustainable infrastructure with local support is needed rather than grant reliance.
- To manage and measure system improvement and change, the collaboration needs the continuing ability to gather system-level population data.
- Recognition by the state (e.g., the Department of Mental Health) as a formal collaborative entity for designing the crisis continuum would empower mechanisms for accountability of services to local needs and priorities.

COLUMBIA: BOONE COUNTY CRIMINAL JUSTICE/BEHAVIORAL HEALTH COLLABORATION: "JAIL OVERCROWDING COMMITTEE"



Purpose and Scope: This collaboration focuses on improving outcomes and reducing unnecessary jail utilization for individuals with behavioral health needs who are involved with, or at risk of involvement with, the justice system.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is the strongest example in Missouri of a county behavioral health/criminal justice collaboration that has committed to the national Stepping Up initiative (sponsored by the National Association of Counties), performed sequential intercept mapping, and demonstrated progress.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** This formal collaboration functions under the auspices of one of the county commissioners with high levels of participation from all levels of Boone County's health and human services leadership, from the justice system, and from the behavioral health system, including housing and recovery supports.
- **Strategic Collective Impact Orientation:** The collaboration has utilized the sequential intercept mapping process to identify improvement opportunities.
- **Sustainable:** Oversight by the circuit court administrator ensures continued operationalization of objectives.
- **Data-Driven:** They use shared data to measure progress.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They completed the sequential intercept mapping process in 2015 and again in 2019.
- They have developed diversion initiatives at multiple intercept points.

- The National Association of Counties has recognized them as an implementation leader.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- There is opportunity for increased intersection with other behavioral health collaborations in the county and the region.
- The State could formally recognize the collaboration as an intermediary for justice reinvestment planning and coordination.
- They need increased capacity for coordination with other counties within the same circuit served by a different Administrative Agent (e.g., Calloway County, served by Arthur Center), as well as with counties in different circuits in the region that are served by the same Administrative Agent (e.g., Burrell Behavioral Health).
- It would be beneficial to include justice-involved individuals with lived experience of recovery from both mental illness and addiction in the collaborative.

NOTE: There are multiple effective and overlapping collaborations in Boone County. These include, but are not limited to, Boone Impact Group, Boone Schools-Mental Health Coalition, Functional Zero Taskforce, Show Me Boone Mental Health Committee, and Cradle to Career Alliance. There is not, however, one entity which is formally empowered and recognized both at the state and local level to oversee coordination, performance, and accountability of behavioral health services for the community.

HANNIBAL: HANNIBAL ALLIANCE FOR YOUTH SUCCESS



Purpose and Scope: Hannibal Alliance for Youth Success is a community organization under the auspices of Douglass Community Services that supports the well-being of children through community collaboration.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is an example of how an informal collaboration to improve outcomes for youth in a small community can be strengthened by support from a community nonprofit and a local funder.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** This asset has engaged the participation of community members, schools, and other agencies and support from Douglass Community Services, a respected nonprofit human services agency that functions as a neutral convener.
- **Adequately Resourced:** In addition to infrastructure support from Douglass Community Services, they received funding from the United Way of the Mark Twain Area to implement a trauma-informed schools program as a prevention initiative.

- **Strategic Collective Impact Orientation:** They are a data-driven, trauma-informed initiative, with an internal organizational committee that keeps them organized to meet deliverables.

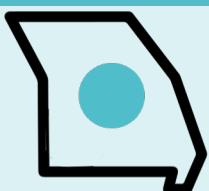
WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They implemented a mentoring program in schools.
- They have offered trauma-informed training and other preventive educational interventions.
- They have provided a collaborative forum for discussions between Children's Division, juvenile justice services, schools, and providers regarding children at risk.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- It would be beneficial to engage empowered and collaborative participation from major behavioral health provider organizations as leaders and partners.
- It would also be beneficial to engage empowered and collaborative participation from people with lived experience of receiving services, including certified family partners.
- There is a need for a clear mission and for increased resources to establish a Children's System of Care for Hannibal.
- More formal engagement with the leadership of other system and service partners (Children's Division, Hannibal Regional Medical Center) is needed to address system change opportunities in Hannibal and surrounding area.

JEFFERSON CITY: MENTAL HEALTH SUBCOMMITTEE OF THE FIVE-COUNTY COMMUNITY HEALTH NEEDS IMPROVEMENT COLLABORATION



Purpose and Scope: The Cole County Health Department, with United Way, assisted with convening the two major health systems (Capital Area and SSM/Mercy), plus the community health center and four other county health departments (Osage, Miller, Calloway, Moniteau) to perform a five-county regional community health needs assessment in 2018. The assessment identified mental health as a significant gap and led to the Mental Health Subcommittee of the Community Health Needs Assessment. This collaboration has included Compass Central Region, Preferred, New Horizons, Community Health Center of Central Missouri, Council for Drug Free Youth, and the hospitals.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is an example of how a five-county collaboration to perform a community health needs assessment can lead to initiation of a regional behavioral health collaboration under the auspices of multiple county health departments and health systems.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** Five county health departments are working together with key provider leaders.
- **Strategic, Data-Driven Collective Impact Orientation:** The subcommittee was developed to address gaps identified in the regional collaborative community health needs assessment.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They are the initial starting place for regional behavioral health collaboration and are recognized as an important foundation for meaningful regional change by participants.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- Resources and infrastructure support are needed to revitalize the Mental Health Subcommittee (which has not met since the beginning of the pandemic) and to identify priorities for action.
- There is opportunity to focus on potential issues of immediate shared concern related to crisis system planning, opioid overdose prevention, and intervention.

JOPLIN: ONE JOPLIN

Purpose and Scope: One Joplin is a movement of people representing 76 organizations (and growing) who have committed to work together “to create a collaborative environment in which Joplin can flourish.” One Joplin has four areas of focus—health (and behavioral health), human services, poverty, and literacy—around which organizations partner to tackle big issues and collaborate with neighborhood connectors who have a desire to create change in their neighborhoods.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is an example of a locally funded, grassroots community collaboration that addresses health and behavioral health objectives within its work streams.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** One Joplin has broad participation from leaders of key community organizations, including health systems, departments of health, Ozark Center, and other behavioral health providers.
- **Adequately Resourced:** Local and state foundations, including United Way of Southwest Missouri, Joplin Area Community Foundation, and the Joplin Chamber of Commerce Foundation, contribute base funding.

- **Sustainable:** They have provided their staff with training and continuing technical support in change management.
- **Strategic Collective Impact Orientation:** Driven to be an umbrella for continuing community collaboration on a variety of issues, One Joplin uses a “synergy” model of program change, which involves teams organized to address each of the focus areas with specific objectives.
- **Inclusive of Empowered Voices:** They have formally engaged neighborhood councils in collaboration with agency partners.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They have successfully fostered a sustainable community partnership with a growing level of trust.
- They implemented the Complete Streets project for increased community exercise.
- They have organized a policy advocacy project for improved housing.
- They have supported prevention activities regarding suicide and substance use disorders.
- They established a recovery resource center.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- Sustainable staff resources are needed to support more robust collective impact activities.
- Capacity should be developed to shift from short-term project focus to ongoing change management.
- A formal health and behavioral health leadership team would have more capability for system design.
- With increased capacity, there is opportunity to extend from Joplin to be a hub for regional system improvement.

KANSAS CITY: KANSAS CITY RECOVERY COALITION: RECOVERY-ORIENTED SYSTEM OF CARE



Purpose and Scope: The Kansas City Recovery Coalition is a network for substance abuse treatment and recovery support providers. It is a 501(3)(c) nonprofit organization made up of programs and professionals who work with individuals and their family members to overcome substance use disorders. The coalition includes faith-based providers, community substance abuse and mental health treatment centers, local medical centers, prevention providers, and other community-based organizations. These partners, along with other community organizations and city, county, state, and federal government agencies, support a Recovery-Oriented System of Care to deliver services to thousands of people every year.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is one of the strongest recovery coalitions in the state, illustrating the potential for engaging and empowering recovery support providers and the voices of people with lived experience to develop regional collaborations.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** Kansas City Recovery Coalition is affiliated with Dismas House, the founder and coordinator of the Missouri Coalition of Recovery Support Providers.
- **Adequately Resourced:** The Department of Mental Health provides resources for recovery support that help support the coalition's activities.
- **Inclusive of Empowered Voices:** They have engaged participation from all types of provider organizations addressing substance use disorders, from treatment services within large mental health centers, to small faith-based providers, to recovery support providers and recovery residences.
- **Strategic Collective Impact Orientation:** The members work together to allocate recovery support resources for clients and connect clients to services.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- Connection among treatment providers, recovery support providers, and recovery residences has created a better continuum for clients.
- They have established a system for equitable allocation of recovery support vouchers.
- Collectively, the members are strong advocates for the importance and funding of recovery supports for substance use disorders.
- They have fostered a connection between the provider continuum and local funders, such as Jackson County Community Backed Anti-Crime Tax (COMBAT).
- They have provided training and technical assistance to help members with operational needs and to attain certification (e.g., National Alliance for Recovery Residences certification).

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- The coalition is very effective with resource coordination, technical assistance, and advocacy, but they need further capacity to engage in system improvement.
- Developing a sustainable, well-resourced, and empowered behavioral health coalition that includes both substance use disorder and mental health provider leadership along with recovery supports providers representing the Kansas City Recovery Coalition and people with lived experience of recovery could potentially result in an empowered collaboration for designing, coordinating, and improving the whole behavioral health continuum.

NOTE: There are multiple other intersecting and overlapping collaborations in Kansas City (Jackson County). These include, but are not limited to, Violence-Free KC Committee (Aim 4

Peace), Jackson County Community Backed Anti-Crime Tax (COMBAT), KC Common Good, KC Metropolitan Health Commission, Greater KC Mental Health Coalition, Safe Families Coalition, and the Behavioral Health Funders group, as well as numerous local coalitions and collaborations that address issues for specific municipalities.

KENNETT: BOOTHEEL NETWORK FOR HEALTH IMPROVEMENT



Purpose and Scope: The Bootheel Network for Health Improvement is a multicounty rural health network, with collaboration between the six county health departments in the Bootheel, whose mission is to enhance efficiency, expand access, coordinate and improve the quality of essential healthcare services, and strengthen the rural healthcare system as a whole. The current major focus of the network is on infant mortality, not on behavioral health.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This collaboration illustrates how small, rural county health departments can work together to create a formal network for addressing health improvements in the region.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Population-Focused with Knowledgeable and Engaged Leadership:** There is collaboration between six county health departments with a broad mission to identify regional health improvement.
- **Inclusive of Empowered Voices:** Each county has its own action team, some of which are organized by the county's health department and some by other agencies.
- **Strategic Collective Impact Orientation:** They have partnered with Bootheel Regional Consortium and Bootheel Babies and Families to focus on infant mortality.
- **Sustainable and Adequately Resourced:** Technical assistance is provided by Network for Strong Communities.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They have developed sustainable regional infrastructure through long-term grant funding.
- They have focused on dissemination of safe sleep initiatives to reduce infant mortality.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- There is a need for a formal and empowered partnership with health and behavioral health service provider leaders in the region.
- Support for a focus on regional behavioral health planning and implementation, initially in relation to the impact of behavioral health issues on pregnant women, mothers, and children, would be beneficial.

- Increased infrastructure for collaborative implementation and data collection regarding behavioral health is necessary.

MOBERLY: RANDOLPH COUNTY CARING COMMUNITY PARTNERSHIP



Purpose and Scope: The Randolph County Caring Community Partnership has evolved to create linkages between providers and services to better serve individuals with health, behavioral health, and social needs in Randolph and surrounding counties.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This illustrates how a grassroots Caring Community Partnership can provide a starting place for building health and behavioral health collaborations in rural counties.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** Their leadership has been consistent for almost 20 years.
- **Inclusive of Empowered Voices:** They have engaged participation from many providers and partners, including some in leadership roles.
- **Sustainable:** They have developed some level of sustainable resources from the Family and Communities Trust, plus numerous grant-funded projects (e.g., Rural Mental Health Network, Rural Community Opioid Response Project, and Accountable Communities for Health).
- **Data-Driven, Strategic Collective Impact Orientation:** They share data to measure progress for grants.

WHAT HAVE THEY DONE?

- They have implemented a shared client information system (i.e., CCMO) to get people to the right resource.
- They mobilized community health workers to act as liaisons between clients and services.
- Service to individual clients has been improved by strengthened partnerships.
- They have developed some ability to collaborate to target health improvement

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- With formal authority, the partnership could create sustainable system change.
- There is a strong need for participation of leadership from major health and behavioral health systems and providers, as well as from county government, law enforcement, justice system, and so on.
- All state and local provider agencies, as well as community health workers and the voice of people with lived experience, are also needed as empowered participants.
- There is need to establish their formal geographic and population scope.

- Sustainable infrastructure with local support, rather than grant reliance, is needed.
- The partnership would benefit from continued ability to gather system-level population data to manage and measure system improvement and change.
- The Department of Mental Health could recognize them as a local partner with authority and capacity for ensuring accountable performance by state-contracted providers.

SPRINGFIELD: HEALTHY LIVING ALLIANCE



Purpose and Scope: The Healthy Living Alliance coordinates and leads health and behavioral health improvement efforts for the population in Greene County.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is one of the strongest examples in Missouri of an empowered regional health and behavioral health collaboration, bringing together local funding resources, the Greene County Department of Health, and executives from key partners, including the business community.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** Chief executive officers of health systems and behavioral health services, the president of Missouri State University, leadership of community foundations, Department of Health, and law enforcement officials (e.g., Springfield chief of police) are all active participants.
- **Sustainable and Adequately Resourced:** The Healthy Living Alliance is supported by local foundations and administratively supported by staff of Greene County Department of Health. It is a continuing structure, rather than one organized for just one project or problem.
- **Data-Driven, Strategic Collective Impact Orientation:** The Healthy Living Alliance performed a comprehensive assessment and had the authority to drive a collaborative improvement plan based on the results.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They completed a shared review of a community health needs assessment.
- They conducted a community mental health and substance abuse assessment.
- They have utilized data sharing to establish a baseline of need.
- The administration has prioritized the need for a crisis center.
- Leadership has developed a shared plan and obtained delegated resources for mental health crisis services from the county's approved public safety tax levy to expand the jail.
- They have fostered a continuing collaboration to improve and expand crisis system.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- Empowered voices of community members and empowered voices of people with lived experience should be formally included in the organization.
- Leadership needs to consider the potential for developing into a regional multi-county alliance.
- There is a need for state agencies to recognize the importance of promoting state-local partnerships and of developing mechanisms for accountability for funds and performance.
- Strategic next steps (e.g., sequential intercept mapping) should be identified.

"When we offer resources to people who feel vulnerable, we need to be sure those agencies actually offer those services. Sometimes they don't and the ball is dropped. We need better partnerships in the mental health community."
- Person with lived experience of recovery

ST. CHARLES: COMMUNITY AND CHILDREN'S RESOURCE BOARD OF ST. CHARLES COUNTY



Purpose and Scope: The Community and Children's Resource Board operates on a partnership model with local nonprofit agencies to improve access to and provide mental health and substance use treatment services for children in St. Charles County.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is one of the strongest examples in Missouri of how a children's services board can move from simply allocating funding to creating an effective, data-driven collaboration to address population needs and gaps, specifically for children and families.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Inclusive of Empowered Voices:** Established by county ordinance, this empowered structure is led by a volunteer board of directors.
- **Adequately Resourced:** They are a funding conduit for the Children's Services Fund tax levy, which provides resources for infrastructure.
- **Population-Focused with a Strategic Collective Impact Orientation:** The Community and Children's Resource Board utilizes data in collaboration with providers to track outcomes and make investment decisions with a system focus rather than a program focus. They also established a partnership with providers around shared values, using the framework of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's System of Care model.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- Efficient funding and high-quality services contribute to St. Charles County consistently ranking in the top five counties for overall child well-being in Missouri, as determined by Missouri Kids Count. According to the Community and Children's Resource Board website, "Partner agencies in the 45 programs funded in whole or in part set high standards for outcomes and in 2019 they met or succeeded in over 92% of those clinical outcomes." Since the onset of localized funding, St. Charles County accomplished the following community outcomes while experiencing a 13.4% increase in youth population:
 - Violent deaths to teenagers are down 19%,
 - Infant mortality is down 20%,
 - Out-of-school suspensions are down 44%,
 - High school dropouts are down 46%,
 - Teenage pregnancy is down 56%,
 - Juvenile-status offenders are down 74%,
 - Juvenile delinquency offenders are down 76%, and
 - In-school suspensions are down 84%.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- Rather than program-specific funding, they would benefit from increased flexibility to utilize funding for system change and capacity building.
- Technical assistance is needed to initiate more integrated attention to substance use interventions in existing service models and to develop a more systematic response to youth in crisis.
- State agencies should formally recognize that the organization has the capacity to oversee system coordination of child and family services in the county.

ST. LOUIS: BEHAVIORAL HEALTH NETWORK OF GREATER ST. LOUIS

Purpose and Scope: Behavioral Health Network of Greater St. Louis is a collaborative effort of providers, advocacy organizations, government leaders, and community members dedicated to developing an accessible and coordinated system of behavioral healthcare throughout the eastern region of Missouri (St. Louis City, St. Louis, Franklin, Jefferson, Lincoln, St. Charles, and Warren Counties).

WHY ARE WE HIGHLIGHTING THIS ASSET?

Behavioral Health Network is the largest formal regional collaboration in Missouri that specifically addresses behavioral health system development in a large metropolitan area.

WHY DOES IT WORK? (WHAT ELEMENTS OF COLLABORATION ALLOWED THEM TO GET TRACTION?)

- **Knowledgeable and Engaged Leadership:** Established by the St. Louis Regional Health Commission, the board and committees are made up of formal delegates of major health and behavioral health providers in the region, along with county agencies, law enforcement, recovery supports organizations, and human services providers.
- **Sustainable and Adequately Resourced:** Funding for numerous projects by state and local funders as well as by foundations has created a resource base for operations.
- **Strategic Collective Impact Orientation:** Organized strategic planning processes have supported major innovations.
- **Data-Driven:** Capacity for data sharing and evaluation has promoted measurement of progress and evolution of accountability.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES OF THE COLLABORATION?)

- They have continued to develop trust and collaboration between partners in the face of significant competitive challenges.
- Leadership has established credibility among outside funders.
- They have engaged in strategic planning for improved response to high-need populations in the region. Examples of projects and programs include Project BEACN, Hospital to Housing program, Behavioral Health Urgent Care at SSM DePaul, a sobering center, the Hospital-Community Linkages inpatient project, the youth Emergency Room Enhancement project, Bridges to Care and Recovery, and Engaging Patients in Care Coordination.

WHAT COULD FURTHER STRENGTHEN THIS COLLABORATION?

- **Authority and oversight:** Behavioral Health Network is a collaborative network launched by the Regional Health Commission but without the same level of formal authority.
- Increased empowerment and inclusion of neighborhood voice and voice of people with lived experience is needed within the organization.
- The Department of Mental Health should formally recognize Behavioral Health Network as a funding, coordination, planning, implementation, and accountability partner for the region.
- There is a strong need for increased base resources to continue infrastructure development, including data analysis, rather than relying on resources “borrowed” from project grant funding.
- It would be beneficial to develop the capacity to allocate resources based on performance and population outcomes.
- Leadership should cultivate and strengthen partnerships with multiple funders and payers, including managed care organizations and Medicare Advantage.
- Capacity is needed to support both regional projects and county-level (and even neighborhood-level) collaborations within one broad framework of regional behavioral health system planning and implementation.

NOTE: There are multiple other collaborations within the St. Louis region. These include, but are not limited to, Integrated Health Network; the St. Louis City Health Department Substance Use Disorder Task Force; Children's System of Care (CSOC) collaborations in St. Louis, St. Charles, and Jefferson counties; and United Way's Community Information Exchange.

STRATEGIC FRAMEWORK: EMPOWERED LOCAL COLLABORATIONS

The project advisory group identified and ranked strategic behavioral health priorities for Missouri. This led to the development of a strategic framework focused on empowered local collaborations.

- [See Appendix C. Strategic Framework: Empowered Local Collaborations for an example of our strategic framework with potential strategic actions and opportunities.](#)

PRIMARY HEALTH/BEHAVIORAL HEALTH INTEGRATION

WHY IS IT IMPORTANT?

Individuals with significant physical health issues frequently have co-occurring mental health, substance use, and/or trauma issues, and vice versa. Evidence increasingly demonstrates that integrating behavioral health interventions into primary and specialty health settings promotes better access to behavioral healthcare as well as better health and behavioral health outcomes. It is also a more efficient use of specialty behavioral health resources. Similarly, integration of medical services and care coordination into behavioral health settings facilitates more effective access to healthcare, better health outcomes, and reduced costs. With the framework of population health improvement—moving from a “sickness” system to a system that promotes health and well-being through high-quality evidence-based prevention and treatment interventions—large health systems and public and private healthcare payers are increasingly recognizing the importance of integrating interventions for health, behavioral health, and social determinants of health (including experiences of trauma and the traumatic effects of racial and ethnic disparities) for individuals as well as community populations.

According to best practices, population health improvement not only provides integrated care but also organizes the provision of care across the whole population, with stratification of resource allocations based on identified health risks and intensity of needs. Investment by health systems and health insurers in integrating behavioral healthcare into primary and specialty medical care can result in better utilization of health system resources through both better outcomes and medical cost savings. This is a more cost-effective approach to expanding capacity to meet the behavioral health needs of the population, rather than simply putting increased pressure on limited resources for behavioral health specialty care.

WHAT IS IMPORTANT?

In an ideal community behavioral health system, all primary care settings would be trauma-informed, and routinely identify and treat common mental health and substance use disorder conditions, including providing medication-assisted treatment for opioid use disorder and providing integrated primary health/behavioral healthcare coordination to high-need populations. Behavioral health integration would be similarly routine in specialty settings, such as obstetrics and gynecology, pediatrics, and oncology. In specialty behavioral health settings, there would be routine identification, care coordination, and intervention for assisting individuals and families with managing physical health conditions and disabilities. Such interventions would be financially sustainable across healthcare payers for all populations. Specialty behavioral health and primary health providers would routinely work collaboratively to ensure that the whole community can receive integrated care in the setting where they are most naturally engaged.

In addition to primary health/behavioral health integration (PHBHI) at the provider level, health and hospital systems would embed PHBHI throughout all their services (including

affiliated outpatient practices) and participate in making investments in population health improvement in partnership with community behavioral health and human service providers. Such investments would be ideally supported by payment methodologies that create financial incentives for yielding health and wellness outcomes and for reducing unnecessary utilization.

WHAT ARE THE STATE-LEVEL FINDINGS IN MISSOURI?

Several of Missouri's statewide initiatives to improve PHBHI and population health management are recognized as national models. Similarly, there are strong state-level efforts to encourage building PHBHI health capacity at the provider level. Examples of state-level supports for improving PHBHI include Department of Mental Health (DMH)-coordinated training for behavioral health consultants, the Missouri Child Psychiatry Access Project for child psychiatry consultation, and University of Missouri's social work internship program for learning behavioral health consultant skills.

Missouri's Health Home program partnered with MO HealthNet, DMH, Missouri Behavioral Health Council, and Missouri Primary Care Association to effect dissemination of the Primary Care Health Home initiative in Federally Qualified Health Centers (FQHCs). [According to the Missouri Primary Care Health Homes: Progress Report](#), hospitalizations decreased by 75% and emergency department visits decreased by 82% among health home members over the first 6 years of health home service implementation.

Implementation of behavioral healthcare homes in Community Mental Health Centers (CMHCs)/Certified Community Behavioral Health Organizations (CCBHOs) within the CMHC Healthcare Home initiative has led to successful and sustainable statewide uptake and is associated with improved outcomes and reduced costs for the targeted "high-spend" individuals. As a result of the CMHC Healthcare Home initiative, there has been an average cost savings of \$289 per member per month; a 28% reduction in hospitalizations; a 41% reduction in emergency room visits; and clinical improvements in cholesterol, blood pressure, HbA1c, and weight (Missouri Department of Mental Health, 2018). Every FQHC and CMHC site can identify the number of individuals who were receiving Health Home-level care. In addition, DMH's 3700 outreach program directs resources to mental health and substance use disorder providers to engage identified individuals with complex needs.

Missouri Primary Care Association has provided consistent training and support to its member organizations around trauma-informed care (in collaboration with Alive and Well Communities) and is investing in additional support regarding PHBHI. All FQHCs that we interviewed were interested in expanding their capacity to deliver truly integrated services. Despite the unavailability of state opioid response funding for FQHCs, most FQHCs have consistently implemented medication-assisted treatment for opioid use disorder.

Nonetheless, consistent with findings in other domains, these central efforts are inconsistently implemented at the community level. Further, the mechanisms at the community level to ensure that health payers, health systems, FQHCs, and behavioral health providers routinely collaborate for PHBHI implementation and population health improvement in their shared geographies are inconsistent.

State-Level Gaps

- The CMHC Healthcare Home initiative has had good penetration (50–75%) for adults in comprehensive psychiatric rehabilitation services, but not for others who may need integrated health and behavioral health services. The Primary Care Health Homes generally reach less than 10% of the FQHC population.
- The potential value of integrating behavioral health services within the medical service lines and affiliated practices of large health systems is often under-recognized. A few large health systems have made significant progress with integration, but most hospital systems need additional assistance.
- Implementation of behavioral health integration in FQHCs is inconsistent, and only a few (e.g., Jordan Valley Community Health Center and Community Health Center of Central Missouri) have developed the capacity to bill payers to support full sustainability of embedded behavioral health consultants. Most health centers report that they need consultation and technical assistance for broader implementation of integrated care and sustainability.
- It is important to challenge the assumption that administrative integration or shared ownership of health and behavioral health service lines results in a PHBHI continuum. Although there are many “combined” organizations, this does not mean that integrated services are present in all or most sites.
- Integrated screening and intervention services have not been scaled up to meet the needs suggested by the estimated prevalence of behavioral health conditions in the Missouri population.
- The number and distribution of child psychiatrists is too low and concentrated in urban centers to fully address the behavioral health needs of children across the state. The Missouri Child Psychiatry Access Project is being implemented to expand access but there are many barriers to adoption to overcome.
- Peer support specialists and family support specialists are almost never used outside of specialty behavioral health settings, despite their potential for addressing stigma and helping individuals and families navigate service settings.
- People with lived experience of recovery identified barriers to accessing services, such as lack of transportation; socioeconomic, racial, and ethnic disparities; lack of insurance or means to pay for services; unexpected co-pays; and sometimes long wait-times to see providers.

There are additional barriers to routinely integrating primary health and behavioral healthcare services in Missouri. Although eight of the CMHCs that participated in our assessment are co-owned and/or co-located with FQHCs or health systems, the routine integration of primary healthcare coordination with CMHC services for the whole population served is rare, even within the settings where there is administrative integration.

- BJC is a component of the Barnes Jewish Health System but does not have routine integration of Barnes Jewish primary care into BJC behavioral health or vice versa.
- Compass includes both FQHC and CMHC services at multiple locations, but whereas some sites are well-linked and coordinated (e.g., St. Charles in the former Crider location), many other sites offer one service without the other, and some locations do not coincide in the service area. (Compass is the Administrative Agent in Cole County, but does not provide FQHC services there; Compass provides FQHC services in Boone and Randolph Counties, but is not the Administrative Agent there).
- Comtre health and behavioral health services are co-located and well-coordinated in Arnold.
- Hopewell Center is owned by People's Health Center but does not have more than basic integration of health and behavioral health in its multiple health locations.
- Ozark Center is embedded in the Freeman Health System, but penetration of integrated PHBHI services is still an area for improvement in that health system.
- Preferred Family Healthcare has excellent integration (in the face of complex allocation of geographic responsibilities for Clarity FQHC, Preferred Family Healthcare CCBHO, and Comprehensive Substance Treatment and Rehabilitation [CSTAR] in the Hannibal region), but Preferred Family Healthcare services in other locations may be more loosely connected between health and behavioral health.
- Swope (an FQHC) and Truman (a hospital system) both operate CMHCs in Kansas City, but neither has integration of health into all their behavioral health sites, and both operate health services that may have only limited integration of behavioral health.
- Conversely, there are strong partnerships for PHBHI between providers who are not administratively integrated, such as Family Care Health Center's satellite site at Places for People, Compass' relationship for behavioral health services with Community Health Center of Central Missouri, and Burrell's relationship with the CoxHealth system. In short, administrative integration is not directly connected to the provision of PHBHI; that has to be assessed in each location in relation to the experience of the population served. Further, co-location of behavioral health services and health services does not necessarily reflect the extent to which those services are integrated (i.e., working as a team to meet the needs of patients with complex challenges) versus simply referring back and forth in parallel service delivery in the same site.

Locally, despite evidence of creative partnerships described above, there are inconsistent expectations for CCBHOs and local health centers to coordinate or collaborate rather than to establish parallel or even competitive services. Similarly, the geographic catchment areas for Administrative Agents, CSTAR providers, and FQHCs often do not overlap and/or are inconsistent—with different partners serving different counties or even neighborhoods within

a county—which contributes substantially to this challenge. There are numerous funding disjunctions. For example, for medication-assisted treatment, FQHCs and health systems do not have access to Opioid State Targeted Response funds, whereas behavioral health providers do not have access to 340B medication pricing.

For health and hospital systems, there is a similar range of commitment and investment to population health. Even though there is no clear statewide system for supporting all hospitals to improve PHBHI and population health management, there are a few large health systems (e.g., Children’s Mercy in Kansas City, Mercy Health system in St. Louis, CoxHealth in Springfield) that have invested in significant innovations. Other large health systems (e.g., Barnes Jewish Hospital, St. Louis Children’s Hospital, and SSM Health Saint Louis University Hospital in St. Louis; MU Healthcare in Columbia; and St. Luke’s in Kansas City) have begun to identify behavioral health and population health as significant strategic priorities and are starting to make investments “outside their walls” to contribute to better outcomes and reduced costs. Yet, there needs to be much more capacity to analyze data, partner with payers, and demonstrate value.

“Having [one entity] do everything—my child’s doctor, two counselors, the family support specialist—everybody is on the same page and stays connected. It makes a huge difference.”
– Parent of child with lived experience

Alive and Well Communities is launching a new effort in collaboration with Missouri Hospital Association to provide trauma-informed care training and implementation assistance to selected units in Barnes-Jewish Hospital (emergency department, obstetrics, newborn intensive care unit), Children’s Hospital (emergency department), Children’s Mercy Hospital (emergency department) and CoxHealth. However, most hospital systems do not have access to state-level technical assistance regarding improvement of PHBHI and population health.

For small to medium hospital systems (serving smaller communities), **there is a level of awareness and interest in population health and PHBHI, but there is a need for more assistance and support to help move down the path of implementation.** It is also noteworthy that Medicaid managed care organizations, Medicare Advantage plans, and commercial payers are not usually involved in community conversations about improved population health management.

Integration of children’s health and behavioral health services is a particular challenge. The number and distribution of child psychiatrists is too low and concentrated in urban centers to fully address the behavioral health needs of children across the state, so capacity needs to be enhanced in pediatric settings. The Missouri Child Psychiatry Access Project is being implemented to expand access through teleconsultation to pediatricians, but there are many barriers to adoption to overcome at the local level and there is a need to engage payers

beyond Medicaid to incentivize this innovation. Many of the communities we assessed were not aware of the Missouri Child Psychiatry Access Project. Fortunately, there are health systems and health centers that have developed local capacity to improve integrated care in pediatric settings using local resources; these strategies may be able to promote further progress.

WHAT DID WE FIND IN THE REGIONAL ASSESSMENTS?

Despite these challenges, there are remarkable local examples of progress across the state. There are initiatives at the provider, health system, and community levels that demonstrate the capability to make substantial progress even in the face of the challenges identified above. For example, the success of the Health Home program has created appetite for expansion, and consequently local initiatives are leading the way.

The regional successes we identified are variable in size and scope, but all are indications of the potential for improvement in this area. Large health systems have continued to grow and build, even as the communities surrounding them have struggled economically and experienced significant disparities and inequities. Communities are mobilizing for change, particularly in urban areas, and health systems are indicating an openness to partner with them. There is willingness to make a change, but much more systematic effort is needed. All communities and identified assets could benefit from an increased strategic focus on improving ongoing capacity, sustainability, reach, and inclusion, as well as more organized and intentional partnerships. Further, it is important to recognize that Missouri cannot rely solely on Medicaid and DMH to invest resources in behavioral health because over 75% of Missourians have other types of health insurance coverage.

Highlight on School-Based Behavioral Health Systems

Because of the comprehensive integrated nature of school-based behavioral health systems and the importance of focusing integrated population health and behavioral health on children, we have chosen to describe Missouri's school-based health and behavioral health system assets in this section. As part of the evolution of understanding about designing ideal systems for children, there is increasing emphasis on moving from school-based health and behavioral health services, and school/behavioral health collaborations, to the development of comprehensive "school health and behavioral health systems." In a comprehensive school health and behavioral health system, the elements of the ideal system are embedded within the fabric of the school, under the leadership of the superintendent and principals, so that students experience a formally organized trauma-informed "healthy community" environment within the school, with a focus on enhancing social and emotional learning along with academic achievement.

In comprehensive school health and behavioral health systems, there are proactive and systematic prevention programs and coordinating efforts with school-based health clinics to

identify children who are at risk physically, developmentally, and emotionally (with attention on both externalizing and internalizing behaviors). Further, there is usually a continuum of behavioral health interventions embedded in the school, ranging from school-based therapists, social workers, and counselors to specialty behavioral health clinicians within the school, to provide more specialized behavioral health interventions for children with higher levels of need and their families, as well as to provide consultation with the principals, teachers, and school counselors to inform a school-wide approach to helping children in need.

We were surprised to discover the extent of implementation of school-based health/behavioral health service implementation in the communities we assessed. The following communities have school-based health/behavioral health initiatives well underway: Boone County, Independence (Jackson County), Jefferson City, Kansas City, Kennett, Moberly, Normandy (St. Louis County), Springfield, and St. Louis City.

In the next section, we highlight some of the PHBHI and population health assets found in the Missouri communities we assessed.

COMMUNITY-LEVEL ASSETS

We have identified highlights in large urban areas (St. Louis and Kansas City), medium-sized communities (Springfield and Jefferson City) and less populous regions (Hannibal, Kennett, and Moberly). Although the scope of activities in larger communities might be greater, the assets identified in smaller communities are equally valuable for purpose of further system improvement. Note that we intentionally selected community assets to highlight information that the system can use for further improvement. There are many other assets in these communities that, unfortunately, space does not allow us to include.

HANNIBAL: PREFERRED FAMILY HEALTHCARE (INCLUDING CLARITY HEALTHCARE)



Purpose and Scope: Preferred Family Healthcare has created a model for integrated service delivery that brings together CCBHO, CMHC, CSTAR, and FQHC services to provide behavioral health, medical, and dental care to its population.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This asset illustrates the potential for integrating service delivery under a common structure at the community level, rather than at the organizational level, as well as how challenging it is to make such integration work—administratively and financially—in Missouri.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- Preferred Family Healthcare has overlapping designated areas of responsibility for Certified Community Behavioral Health Organization (CCBHO), Federally Qualified Health Center (FQHC), and Comprehensive Substance Treatment and Rehabilitation (CSTAR) services in a common geography. Specifically, Clarity, a FQHC that is a subsidiary of Preferred Family Healthcare, is the designated CCBHO for Marion County, and also serves Monroe, Ralls, Pike, and Montgomery Counties. The behavioral health division of Preferred Family Healthcare is also a CCBHO for neighboring Lewis and Clark Counties and has CSTAR designations throughout the region as well.
- Preferred Family Healthcare has worked hard as a leadership team to bring the services together so that clients experience integrated pathways, regardless of problems and payer sources—they serve individuals who are uninsured, in poverty, or covered by Medicaid, Medicare, and commercial payers.

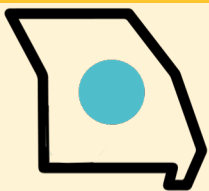
WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- Preferred Family Healthcare has implemented a common intake, with a methodology for linking disparate data systems.
- Clients can get connected to medical, dental, and any behavioral health service through one door.
- Staff are organized into cross-functional teams that can work with clients flexibly to provide care coordination across multiple different issues.
- Administration works as a team to leverage any one of a multiplicity of billing options that will best meet the patient's needs.
- In addition, they were asked to set up an integrated school health/behavioral health program in Moberly, even though they do not have CMHC status there.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- Models need to be developed that support integrated service delivery across multiple program lines within communities. Providing integrated services is made more difficult by the way the system is organized. Even within DMH, assignment of CCBHO, CMHC, comprehensive psychiatric rehabilitation, CSTAR, and even Assertive Community Treatment for Transition-Age Youth functions and funding are in different funding lines and connected to inconsistent geographies.
- This model would benefit from recognition that it is more than just co-located services under a common administration. The model of service in Hannibal is a demonstration of how to create an integrated experience for clients and staff across multiple payers.
- Other communities would benefit from replicating elements of this model in their contexts, whether within a single agency, or through interagency collaboration.

JEFFERSON CITY: COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI AND CAPITAL REGION MEDICAL CENTER AND PHYSICIAN'S GROUP



Purpose and Scope: The Community Health Center of Central Missouri and Capital Region Medical Center and Physician's Group represent two complementary integrated service models that work together to form a continuum.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This is an illustration of how entities providing PHBHI services to different populations in the same community can work together to create a more seamless continuum to meet population needs.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- **The Community Health Center of Central Missouri** is a model for implementation of behavioral health integration within an FQHC.
 - The chief executive officer (the former chief medical officer) has established a culture of customer service for both patients and providers, so that people with complex needs can have their needs met without gaps.
 - The behavioral health director of over 10 years reports that the organization does routine screening using the Patient Health Questionnaire, the Generalized Anxiety Disorder screener, and Screening, Brief Intervention and Referral to Treatment, and that they have mastered a sustainable “hybrid” behavioral health consultant and direct service model (1,200 30-minute sessions per FTE) that supports a PhD clinician, two licensed clinical social workers, and contracted prescribers (with 8 hours of medication-assisted treatment).
 - They maintain excellent collaboration with behavioral health prescriber staff and the shared residential nurse care coordinator from Compass, the CCBHO in this region, which ensures that those with more serious needs get connected to appropriate services. Note that Compass does not operate as a FQHC in this service area.
- **Capital Region** embeds behavioral health clinicians in their hospital-affiliated outpatient medical group to treat patients with mental health and substance use disorders who have Medicare or commercial insurance.
 - They have their own patient network (approximately 30,000 individuals in network out of 120,000 in their service area) for whom they prioritize services because they bear some level of risk. As such, they have begun to develop their capacity for integrated services by having behavioral health consultants in a primary care setting and a pediatrics practice as well as expanding integration with four additional behavioral health positions.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- Leadership has developed an effective collaborative partnership between Compass (CCBHO and Administrative Agent), FQHC, and the hospital-based physician's group.
- Between them, they have made integrated services available to the whole community, regardless of severity and insurance.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- A formal collaboration should be developed to address population health issues more broadly in the community.
- This asset could be utilized as a model for development in other communities. Note that the complementary services work well collaboratively rather than competitively even in the same geography. It would be helpful to establish expectation and supports for creation of similar services in other communities.
- Community Health Center of Central Missouri should be supported to provide technical assistance and consultation to FQHCs (and CCBHO partners) across the state who have been unable to develop sustainable funding for their integrated behavioral healthcare.

KANSAS CITY: CHILDREN'S MERCY

Purpose and Scope: Children's Mercy is a leading health system with a mission to "transform the health, well-being, and potential of children, with unwavering compassion for those most vulnerable."

WHY ARE WE HIGHLIGHTING THIS ASSET?

Children's Mercy is an emerging, integrated health system for children. By virtue of its Medicaid managed care functions and its current efforts to provide and improve integrated services, they are well-positioned to be a leader in demonstrating the impact of integrating behavioral health into primary healthcare for children on a broad scale.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- Children's Mercy has managed care capability, internal behavioral health resource capacity, and the ability to engage multiple pediatric practices to improve behavioral health integration, all of which represent strong assets to improve overall community health, starting with children.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- They provide at-risk managed care for 250,000 children in Missouri and Kansas, 60% of whom have Medicaid, through their Integrated Care Solutions subsidiary.

- They partner with community pediatricians and have developed a systematic quality improvement tool for helping providers integrate behavioral health into their practice.
- In addition to working on integrating behavioral health into pediatric practices, Children's Mercy also has its own outpatient specialty behavioral health clinics and integrates behavioral health professionals into all of their specialty services.
- They are working on a strategic plan with a structured improvement approach for population health and behavioral health for children in the region.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- Children's Mercy is seeking ways to become a more school-friendly health system and the Kansas City school system is looking for integrated health and behavioral health partners. Developing a partnership between Children's Mercy and the Kansas City school system could improve the continuum of child health and behavioral health services throughout the community.
- Bringing the FQHCs, CCBHOs, and neighborhood trauma prevention and intervention networks into a strategic collaboration with the school systems and Children's Mercy would provide a strong foundation for collective impact on population health.

KENNETT: SEMO HEALTH NETWORK'S KENNETT SCHOOL-BASED CENTER



Purpose and Scope: Kennett Consolidated School District has collaborated with SEMO Health Network FQHC to establish two school-based health and behavioral health centers in Kennett elementary schools.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This illustrates how integrated health and behavioral health services in schools can be supported by collaborations with FQHCs to promote overall "healthy schools" initiatives.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- Integrated school health centers are becoming a model of service for school systems in order to make services more accessible to children in need and improve coordination of those services with school counselors and nurses.
- SEMO Behavioral Health has made a commitment to integrated behavioral health and hired a director of behavioral health with expertise in children's mental health.
- Kennett Public Schools, under the leadership of its superintendent, has made a commitment to trauma-informed schools to promote the health and behavioral health of students.
- FCC Behavioral Health is a specialty mental health and substance use disorder provider for children and adolescents in Kennett that can provide access to services for those children and families who have more serious needs.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- They have opened two school health centers, one in each of the elementary schools in Kennett, to provide both health and behavioral health services to students and staff.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- The collaboration between SEMO Health Network and Kennett Public Schools can be further enhanced by developing a more intentional Children's System of Care partnership with FCC Behavioral Health, Children's Division, and family court services in Dunklin County, with the goal of building a complete continuum of trauma-informed, resilience-building services within the schools in that community.

MOBERLY: RANDOLPH CARING COMMUNITIES PARTNERSHIP

Purpose and Scope: Randolph Caring Communities Partnership is a community-level collaboration to help people with complex needs get connected to health, behavioral health, and human services.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This collaboration illustrates how a grassroots collaboration in a small community can develop the ability to connect people with complex health and behavioral health needs to services.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

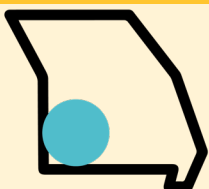
- Randolph Caring Communities Partnership has had sustained leadership and partnership development over decades.
- Committed leadership has enlisted the participation of local agencies, including the Randolph County Department of Health.
- They have obtained continued funding from project to project with a consistent focus on improving health outcomes.
- The University of Missouri developed CCMO, a shared data tool that Randolph Caring Communities Partnership utilizes to better help clients.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- They have created community-level trust.
- They have established opportunities for individuals to walk in "no wrong door."
- They have connected community health workers to health and human services.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- Current success is on the client coordination level, not on the system integration level.
- Leadership commitment is important, as is sustained funding from the local hospital system, FQHC, CCBHO, and CSTAR providers.
- Randolph County Caring Communities Partnership could be supported by the state to forge empowered rural community partnerships to address integrated system development.

SPRINGFIELD: JORDAN VALLEY FQHC

Purpose and Scope: Jordan Valley FQHC exhibits excellence in integration of behavioral health throughout the center.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This award-winning FQHC illustrates the capacity to develop and provide a broad array of evidence-based, integrated interventions for both mental health and substance use disorders in a Missouri health center, both through their own services and through collaboration with CCBHO/CMHC partners for case management.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- Jordan Valley FQHC provides behavioral health integrated services that expand beyond Primary Care Health Home with a large medication-assisted treatment service component.
- Committed leadership has obtained training resources to develop universal capacity across their provider system to integrate behavioral health services into primary care.
- Jordan Valley has maintained a consistent commitment to data-driven quality improvement.
- They have fostered an integrated clinic partnership with Burrell Behavioral Health in the Springfield region to provide case management for individuals who are identified as experiencing serious mental illness.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- They offer same-day access with a 7-day prescription and a 7-day follow-up and have served 1,500 patients with 16 to 17 medication-assisted treatment providers. About half of the patients receiving medication-assisted treatment have no payer source, so it is self-pay with a sliding scale.
- They received the Health Resources and Services Administration national quality award for behavioral health services last year and received a similar award again this year.

- They are at the highest level of integration according to SAMHSA, in which everyone receives medical and behavioral health screening along with some level of integrated intervention.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- Financial sustainability is a challenge for all such providers, which makes collaboration with the state imperative in order to develop more sustainable models, including access to state resources for low-income individuals with substance use disorders.
- Direct access to resources should be facilitated for provision of case management and care coordination for individuals and families with complex needs who are not assigned to Primary Care Health Home.
- In the Springfield region, the progress made toward integrated service delivery by Jordan Valley, Burrell, and CoxHealth illustrates the potential for developing PHBHI, but it also illustrates the challenges that persist with the current funding rules. Jordan Valley and its partners can facilitate provision of technical assistance and consultation to other FQHCs, CMHCs, and health systems around the state, as well as advocate for the state to eliminate regulatory and fiscal barriers to service delivery.

ST. LOUIS: MERCY HEALTH SYSTEM



Purpose and Scope: Mercy Health System is modeling implementation of integrated behavioral health services and population health management in a large, urban health setting.

WHY ARE WE HIGHLIGHTING THIS ASSET?

They illustrate the work that a large health system can do in one region to begin to integrate behavioral health into all its service lines. The capacity of health systems to do this is often under-recognized, so this example offers a window into what is possible and what is needed.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- As a mission-driven organization, they retain a priority for serving those most in need.
- The vice president of behavioral health has direct authority and responsibility to embed behavioral health services in ALL primary care and specialty care services, not merely to manage the behavioral health service line.
- Behavioral health has integrated responsibility over direct behavioral health inpatient and outpatient services, as well as responsibility for building population capacity in health services.
- Mercy has the financial capacity to manage integration across multiple payers.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- Mercy provides a full continuum of inpatient and outpatient services, including Journey, a specialized Medicare/commercial payer outpatient program for individuals with serious and persistent mental illness.
- Behavioral health capacity is now in place in multiple settings throughout the hospital.
- Multiple primary care practices have integrated care coordination into their services.
- They have moved to a small Accountable Care Organization model, with some population risk.
- Utilization of the 340B savings has enabled the implementation of Project BEACN—in collaboration with Behavioral Health Network (Places for People)—to focus \$1.6 million on 30–50 individuals with complex health, behavioral health, and social determinants of health needs who have costs of over \$3 million.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- Mercy would benefit from better recognition and connection to the System of Care, beyond just the linkage with Behavioral Health Network.
- Assistance with generating data at the hospital system level would allow Mercy to demonstrate how broad integration, and partnership with community providers addressing behavioral health and social determinants of health needs, produces value for the hospital as well as state and private payers.
- Expansion of behavioral health integration into the Accountable Care Organization would permit further implementation of population health strategies to improve cost and outcomes.
- Involvement of managed care organizations and commercial plans would help secure funding.
- Mercy can look to connect with other health systems working to scale up integration in the context of a learning community.

"DMH is outside of the hospital-based healthcare system delivery of behavioral health; Mercy doesn't have anything to do with DMH. Behavioral Health Network is the only connector. We need structurally to recognize that we need entities across the state that are recognizing the entire service delivery continuum and building a system of care that serves the whole community."

– Local Stakeholder

STRATEGIC FRAMEWORK: INTEGRATION OF BEHAVIORAL HEALTH INTO POPULATION HEALTH

The project advisory group identified and ranked strategic behavioral health priorities for Missouri. This led to the development of a strategic framework focused on integrating behavioral health into population health.

- [See Appendix D. Strategic Framework: Primary Health/Behavioral Health Integration for an example of our strategic framework with potential strategic actions and opportunities.](#)

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEMS

WHY IS IT IMPORTANT?

With new federal legislation requiring national implementation of 988 as a three-digit mental health crisis number by July 2022 (similar to the 911 number), there is increased recognition that all states and communities need to develop a full continuum of behavioral health crisis services. The [*Roadmap to the Ideal Crisis System*](#) by the Group for the Advancement of Psychiatry, published in March 2021 by the National Council for Mental Wellbeing (formerly the National Council for Behavioral Health), reinforces the growing awareness that behavioral health crisis response has long been underdeveloped. Consequently, people either do not get what they need, receive it too late, or become unnecessarily involved with law enforcement. The report states:

An excellent behavioral health crisis system is an essential community service, just like police, fire, and emergency medical services. Every community should expect a highly effective behavioral health crisis response system to meet the needs of its population, just as it expects other essential community services. A behavioral health crisis system is more than a single crisis program. It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent behavioral health crisis needs in a defined population or community, effectively and efficiently.

The ultimate goal is that every person receives the right service in the right place, every time.

WHAT IS IMPORTANT?

Within the framework of the ideal behavioral health system, the ideal crisis continuum has three major components, each with essential elements and best practices.

- **Collaborative Structure for Accountability and Finance:** Akin to emergency medical services, there should be a local collaboration that brings in resources from multiple payers (state, local, public, and private) to support the continuum of services. This would also enable the development and monitoring of quality metrics to ensure that each service in the continuum—separately and collectively—meets the needs of the whole population (regardless of the type of crisis or type of insurance) in terms of geographic availability, timely access, engagement, responsiveness, continuity, and equity.
- **Continuum of Capacities and Components, Taken to Scale:** (Partial list)
 - Responsiveness for all ages, comorbidities, and cultural/racial/linguistic backgrounds;
 - Medical and clinical leadership and peer involvement in all services;
 - Adequate staffing for each component to have needed capacity;
 - Call center with case tracking system;
 - Facilitated medical screening as needed;
 - Mobile crisis;
 - Behavioral health urgent care;

- Crisis center with secure drop-off and walk-in capacity (emergency rooms and non-emergency rooms);
 - 23-hour observation;
 - Medication-assisted treatment initiation;
 - Residential crisis services, including acute substance use disorder (SUD) stabilization capacity;
 - Peer-operated crisis response, including Living Room programs;
 - Intensive community-based (including home-based) crisis services;
 - Psychiatric inpatient beds, including specialty beds;
 - Adequate array of appropriate transportation; and
 - Smooth flow from acute to continuing crisis services to continuing ongoing care.
- **Best Practices for Crisis Intervention:** (Partial List)
- Welcoming, safe, and trauma-informed environment;
 - Cultural humility;
 - No force first;
 - Involvement of families, friends, and collateral service providers;
 - Facilitated information sharing;
 - Evidence-based practice guidelines for screening medical, suicide, and violence risk;
 - Evidence-based practice guidelines for all age groups for assessment and intervention for psychiatric crises, SUD crises, co-occurring mental health and SUD, co-occurring behavioral health and intellectual/developmental disability, suicidality, and violence risk;
 - Standardized level of care assessment; and
 - Guidelines for continuity and case sharing through the continuum.

WHAT ARE THE STATE-LEVEL FINDINGS IN MISSOURI?

There is lack of a consistent framework for defining community behavioral health crisis systems that organize a full continuum of behavioral health crisis services for all Missourians in each community or region. The Department of Mental Health (DMH) has standardized and funded the following service elements in each catchment area, usually through the Administrative Agent:

- Call center and basic mobile crisis services (often subcontracted after hours to Behavioral Health Response or CommCare),
- Crisis Intervention Team (CIT) training and coordination supported by local CIT councils,
- Emergency Room Enhancement (ERE) services for adults, and
- Community mental health liaisons with local law enforcement.

Youth ERE is present in the greater St. Louis region and substance use disorder liaison positions are currently present in some, but not all, communities. DMH plans to use American Rescue Plan SAMHSA block grant funds to expand community mental health liaisons & substance use disorder liaison positions throughout state, and to create housing liaison

positions. Note, however, that **these liaison positions and ERE services are efforts to work around the existing disconnections in the crisis system, but they do not completely fill the gaps or address the need for comprehensive behavioral health crisis system redesign.**

The DMH Fiscal Year 2022 budget reportedly has funding to expand and establish new crisis stabilization urgent care centers across the state, including locations in all nine Missouri Highway Patrol Troop areas. Planning is also underway for implementation of the federally required 988 mental health crisis line. There is a planning committee consisting of DMH, the Missouri Behavioral Health Council, call center providers, Missouri CIT Council representatives, and other stakeholders, which is working to not only implement 988 but also to expand the crisis service continuum. Missouri is the only state, however, that does not have a statewide tax or fee assessed on all landline or wireless cell services to support 911 emergency services, and it is not anticipated to pass such a fee for 988 to fund behavioral health crisis services.

Psychiatric inpatient facilities, whether freestanding psychiatric hospitals or general hospital units that can bill Medicaid for adults, are not always included as program partners in community behavioral health system planning conversations. Most of the national guidance suggests states should use their resources strategically to implement an assessment of their behavioral health crisis systems, using national models such as the [Roadmap to the Ideal Crisis System](#) referenced above, to create a vision for what the behavioral crisis system should look like and a plan for how to get there. From our initial assessment of Missouri's behavioral health crisis system, we have summarized additional state-level gaps below to consider for planning purposes.

State-Level Gaps

- Although there are some excellent crisis providers in Missouri, the current array of crisis services is limited, serving only a small percentage of people using community crisis services and only a subset of the scale of needs in the community. For example, of the 109,000 emergency room visits for behavioral health needs in 2017, 2% (2,124) were served by the ERE program. In most communities, mobile crisis is provided by rotating on-call clinicians who work full-time day jobs; it is, therefore, relatively rarely utilized.
- Crisis response centers for individuals with mental health and/or SUD needs are not universally available. There is a low rate of diversion from hospitalization; 29% of the 109,000 emergency room visits for behavioral health needs resulted in inpatient admission, about twice of what would be expected if there were a more comprehensive continuum.
 - There are currently no sobering centers; St. Louis has plans to open one in 2021.

- Acute stabilization for SUD ("detox") is very limited and not universally available. Approximately 12% of the nearly 43,000 patients who visited an emergency room for alcohol or drug disorders were admitted to a detox program.
- There are currently only four crisis walk-in/urgent care centers in the state. The existing centers are in St. Louis, Joplin, Springfield, and Jackson County.
- There are currently no secure crisis centers.
- Crisis diversion services for youth are essentially absent.
- The continuum of intensive, non-hospital crisis diversion services is not funded by Medicaid or insurance plans, except for Medicare and insurance payments for partial hospitalization. Limited existing crisis services have been incorporated into Certified Community Behavioral Health Organization (CCBHO) base funding, but the services are not Medicaid billable. Individuals with commercial insurance may not have access to evidence-based intensive crisis intervention services other than inpatient care, except through services paid for by the state of Missouri.
- Many areas of the state are hours from the nearest hospital, relying on expensive and limited ambulance services or law enforcement for transportation. Individuals are frequently transported hours to the nearest emergency room with access to psychiatric beds only to be released very quickly, sometimes with no plan for follow-up or transportation home.
- Although the Engaging Patients in Care Coordination program, which provides peer specialist outreach in emergency rooms to individuals who experience opioid overdose, has been widely implemented, very few emergency rooms initiate medication-assisted treatment for opioid use disorder while the person is present; instead, the person gets referred for follow-up at another location. Opioid overdose rates in Missouri have continued to rise during the pandemic.

Missouri has additional significant barriers to crisis services access:

- Emergency civil commitment is a cumbersome process requiring complex paperwork and approval by a judge. Missouri is one of a handful of states that has no routine mechanism for emergency civil commitment initiated by a licensed clinician.
- Medicaid payment for inpatient care for adults is limited because of the Medicaid Institutions for Mental Diseases (IMD) exclusion, with no IMD waiver in place to permit payment for adults in freestanding psychiatric hospitals. Further, the financial disincentives to providing Medicaid-reimbursable general hospital psychiatric care have led to closure of units in smaller hospitals during the past decade, leaving some regions of the state with limited access to psychiatric inpatient care close to home.
- Although CCBHOs have implemented an open-access model and rapid connection to services post-hospitalization—except where clients are engaged in an ERE program or already connected to Assertive Community Treatment or community psychiatric

rehabilitation—there are very few centers which are able to provide intensive short-term crisis intervention to adults or youth, except through the above programs. The standard follow-up appointment frequency after crisis (or hospitalization) is usually every other week.

Additionally, across all the focus groups with people with lived experience of recovery, participants consistently identified **a strong need for transitional housing, recovery homes, and sober living options for people in crisis who need substance use treatment.** Participants also identified a need for more hospital beds, crisis stabilization, and timely access to more treatment options for instances of relapse or other crises. Delays and wait lists cause deaths, and people of color are disproportionately impacted.

It is important to recognize that Missouri cannot rely solely on Medicaid and DMH (for those uninsured) to invest resources for behavioral health crisis intervention—over 75% of Missourians have other types of insurance coverage.

“Many times [when] somebody in crisis needed immediate help and couldn’t get it, they got put on a waiting list. Peer-run centers can keep people safe during the day, but sometimes the appointment (for additional services) is 3, 4, 5 months away.”
– Certified Peer Support Specialist

WHAT DID WE FIND IN THE REGIONAL ASSESSMENTS?

The regional assessments confirmed and expanded the state findings as described above, and they also identified local initiatives that are making progress in addressing existing gaps. Across the state, there are collaborative, community-level initiatives that demonstrate the capability to make substantial progress even in the face of the challenges identified above. The successes identified are variable in size and scope—usually creating new programs to fill gaps and or making tighter connections between different system partners—but all are indications of the enormous potential for improvement in this area.

There are new federal and state resources coming available, in part through 988 implementation and the American Rescue Plan, and there is willingness at all levels to develop much better crisis response, but much more systematic effort is needed. Commercial insurers need to pay their fair share as well, considering that their members access crisis services. All communities and assets identified below could benefit from an increased strategic focus on improving ongoing capacity, sustainability, reach, and inclusion, as well as more organized and intentional partnerships.

In the next section, we highlight some of the crisis continuum assets found in the Missouri communities we assessed.

COMMUNITY-LEVEL ASSETS

We have identified highlights in large urban areas (St. Louis and Kansas City), medium-sized communities (Springfield and Joplin) and a less populous region (Cape Girardeau). Although the scope of activities in larger communities might be greater, the assets identified in smaller communities are equally valuable for purpose of further system improvement. Note that we intentionally selected community assets to highlight information that the system can use for further improvement. There are many other assets in these and other communities that, unfortunately, space does not allow us to include.

SPRINGFIELD: HEALTHY LIVING ALLIANCE BEHAVIORAL HEALTH CRISIS CONTINUUM COLLABORATION



Purpose and Scope: The Healthy Living Alliance of Greene County collaborated with Burrell Behavioral Health and other partners to implement a continuum of behavioral health crisis services.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This illustrates how an empowered regional collaboration can provide shared resources and engage local commercial insurance payers to help expand a continuum of crisis services while still being accountable for meeting local needs. By doing so, the reach and capacity of state resources can be extended.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- **Healthy Living Alliance:** This continuing, executive-level collaboration commissioned a data-driven behavioral health system assessment in 2017 that created a shared focus on identifying gaps and improving the continuum of crisis services.
- **Funding:** The collaboration was able to attract over \$1 million in funding contribution from the Greene County Commissioners attached to a public safety tax levy that was being used to expand the jail.
- **Partnerships and Resource Sharing:** Burrell is the Administrative Agent for the region, and has made investments, including contributing a building, to add new services to its existing array of crisis services. Cox and Mercy health systems each contribute the salary of a mental health nurse practitioner. The Springfield police chief is a strong advocate based on his experience in other cities, so he can coordinate participation by law enforcement.
- **Crisis Continuum Planning:** Rather than focus on a single crisis center, community planning has looked at a continuum of collaborative services all working together.

- **Multiple Funding Sources:** Burrell and the community have worked with local businesses and insurers to encourage private payers to contract for the crisis services array, so that state and local revenue are not the only funding sources.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- **New Service:** Effective June 2020, Burrell opened a 24-hour voluntary walk-in Behavioral Crisis Center (BCC) with 23-hour observation capability in an existing building. Co-located services include social detox and residential substance use disorder services, and the BCC Rapid Access Unit can provide outpatient initiation of medication-assisted treatment, medical screening and medication provision, peer support, crisis intervention, and continuing care. Police can bring people directly who are willing to accept services; the Rapid Access Unit allows for a 20-minute turnaround for police drop-offs. The BCC capacity is 300 visits per month, and almost immediately the BCC was receiving 150 visits per month.
- **Existing Services Contribute to the Continuum:** Burrell has a 24-hour call center, mobile coverage of the Mercy emergency room, adult ERE, residential substance use disorder services with 18 detox beds, and a central Connection Center for arranging continuity. Mercy has 37 inpatient psychiatric beds and Cox has 72, which cover children, adults, and seniors. Burrell also has a voluntary Adult Crisis Stabilization Center with eight beds, which offers short-term crisis stays (average length of stay is 2–3 days). CIT-trained officers have iPads that can facilitate some level of telehealth assessment on site with the officer.
- **Improved Outcomes:** The return rate to the BCC Rapid Access Unit was initially 16%, compared to almost 40% in the Mercy emergency room, which serves a high volume of people experiencing homelessness.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- **Secure Diversion Capacity:** Even with this continuum of services, there are not enough beds available for people with acute needs. Developing capacity for law enforcement to bring people to the BCC with capacity for secure drop-off might reduce the need for inpatient admissions for many people. It would also divert law enforcement from the emergency room. However, allowing the BCC (or any other crisis center) to create a secure drop-off would require regulatory changes to the program requirements to make it financially feasible.
- **Services for Youth:** Most of the crisis service continuum is for adults. There are limited diversion options for youth, which creates more pressure for beds. There need to be a full continuum of crisis diversion services for children and youth.

**"I called for help for a mental health crisis. The person wasn't violent, but she was put in handcuffs; it left her more damaged. Being in crisis isn't the same thing as being violent."
– Person with lived experience of recovery**

- **Increased Payment Options:** Only a subset of the existing crisis continuum services is paid for by Medicaid or private insurances. For example, Medicaid does not pay for the Adult Crisis Stabilization Center or 23-hour observation. Expanding reimbursement for best practice diversion services would expand access and continuity and reduce pressure on inpatient beds, which are the most expensive resource.
- **Expanded Facilitation of Telehealth Assessment by CIT Officers and/or Expanded Mobile Crisis Access in Rural Counties:** The bulk of services and crisis volume occurs in Greene County. Smaller counties in the service area do not have access to after-hours crisis response other than the call center or emergency room. The other emergency room in the region with psychiatric capability is in Branson, which is quite a distance from Springfield. For example, Stone County is 45 minutes from both.

ST. LOUIS: BEHAVIORAL HEALTH NETWORK OF GREATER ST. LOUIS



Purpose and Scope: Behavioral Health Network (BHN) has done strategic planning and implementation to address multiple gaps in the regional crisis continuum as part of its larger system improvement efforts.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This illustrates the capacity of an empowered regional collaboration to engage its participants in strategic planning, data sharing, and continuous improvement activities that allow for local resource contributions to launch significant new program initiatives that help to flesh out the regional crisis continuum.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- **Formal Organization Structure:** BHN is a nonprofit with a governing board that represents 35 behavioral health providers, health systems, and human services agencies in the region. They also have a structure of advisory boards with representation from county health departments, universities, funders, and other stakeholders. This formal partnership allows for collective decision making that can address regional behavioral health system issues.
- **Delegation of Responsibility:** The Regional Health Commission has specifically designated BHN as a responsible regional behavioral health system "problem-solving" collaboration, which conveys more formal authority to what otherwise might be just a provider networking affiliation.
- **Sustainable Infrastructure Funding:** Although sustainability is a constant challenge and resources are less than what is needed for the scope of the regional behavioral health system, BHN has accumulated enough stable funding sources that contribute to overhead (DMH Hospital-Community Linkage funding, regional ERE funding, youth ERE funding, etc.) plus membership dues to support 20 staff.

- **Ten-Year History of Progressive Trust:** BHN has made steady progress in the scope of collaboration by carefully building trust with potentially competitive providers. Because BHN is governed by providers, this process has gone more slowly than it would have if BHN had authority over the providers. Nonetheless, in Fiscal Year 2021, providers for the first time agreed to allocate ERE funding based on performance.
- **Consistent Leadership:** The current executive director of six years has been extremely effective in building collaborations and innovations, given the limitations of the resources and authority available.
- **Formal Strategic Planning Using a Collective Impact Framework:** During 2019, BHN engaged in a comprehensive, data-driven, and well-organized strategic planning process that identified three key priority areas, all of which focused on addressing gaps in the crisis continuum and/or the need for capacity to provide complex care. This plan has informed implementation efforts.
- **System Collaboration to Design a Crisis Continuum:** Following the Regional Health Commission's *Behavioral Health Assessment and Triage Center Feasibility Study* from January 2019 that recommended a crisis center, BHN refocused on the need for not just one crisis center but on the need for multiple components needed in the continuum, as well as the need to engage multiple partners to make progress in implementation.

WHAT HAVE THEY DONE? (WHAT ARE THE CRISIS SYSTEM OUTCOMES?)

- **Big Picture:** BHN has implemented and continuously improved multiple components of the crisis continuum.
- **Starting Places:** BHN has worked with Behavioral Health Response as the anchor provider for the call center and (limited) mobile crisis services to reinforce the implementation of ERE services in the region. Youth ERE was added (only located in St. Louis region) and has served 86 youth in the past 6 months. 20% of these youth have private insurance, but the insurance does not pay for this service. St. Louis County CIT is notable for its successful deployment of mobile crisis intervention, including co-responder visits, providing about 8,000 mobile crisis encounters annually.
- **New Projects:** Building on their strategic planning, key areas of development in the crisis continuum include the SSM DePaul Behavioral Health Urgent Care center (north St. Louis County), the planned sobering center (partly supported by the City Department of Health), and various intensive service programs for individuals who most frequently access services, such as BEACN (Mercy) and Hospital to Housing (BJC). In the spirit of the partnership, all the providers rotate taking follow-ups from the Behavioral Health Urgent Care since it opened last year. Again, an unexpectedly high proportion of Behavioral Health Urgent Care clients have insurance.

WHAT COULD FURTHER STRENGTHEN THIS ASSET? (SPECIFICALLY WITH REGARD TO REGIONAL CRISIS CONTINUUM IMPLEMENTATION)

- **Focused Crisis Planning to Take Advantage of Newly Emerging Opportunities:** Given 988 implementation, new funding opportunities for crisis services, and new guidance available from SAMHSA and the Group for the Advancement of Psychiatry/National Council for Mental Wellbeing on how to design and implement a comprehensive regional behavioral health crisis system, it would be helpful to use the "Report Card" in the [*Roadmap to the Ideal Crisis System*](#) to assess the current baseline and make recommendations for a vision of what the system should ultimately become. This vision could then guide both short- and long-term resource development and implementation. Note that this vision needs to consider not ONE crisis center, behavioral health urgent care, or residential crisis program, but multiple such services geographically dispersed to serve the region. Similarly, mobile crisis services need to be expanded dramatically and changed so that law enforcement is not the default designated first responder for mobile crisis.
- **Increased Delegation of Responsibility to BHN for St. Louis Behavioral Health Crisis System Design:** Rather than provide money to Administrative Agents for individual agency crisis services, DMH and local funders could pool crisis planning and implementation resources to contract with BHN to take on the responsibility for regional (or St. Louis City/County) behavioral health crisis system design.
- **Increased Resources for Infrastructure to Support Planning and Data Collection:** The magnitude of designing and implementing a regional behavioral health crisis system requires infrastructure resources (apart from program and service resources) that exceed the limited current capacity of BHN. Shared investment in service resources is also required. As in Kansas City, large investments from multiple health systems are important contributions to the full continuum to take pressure off the medical emergency rooms that serve individuals who would be better served in crisis centers.
- **Engaging Private Insurers and Maximizing Benefits for the Full Continuum:** It is increasingly clear that the current behavioral health crisis system is inadequate even for people with insurance, let alone for those who are in poverty, uninsured, or on Medicaid. Multiple public and private funders should support the behavioral health crisis system just as they support emergency medical services.

**"We need a first responder that isn't a 'usual' first responder—someone who understands...it would be nice to have a mental health specialist rather than the police when you are sick."
– Person with lived experience of recovery**

CAPE GIRARDEAU: CAPE GIRARDEAU BEHAVIORAL HEALTH SYSTEM OF CARE COLLABORATION



Purpose and Scope: This grant-funded System of Care project is focused on gathering information to identify and recommend priorities for system improvements in behavioral health crisis response for the five-county Cape Girardeau region.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This illustrates that rural, regional collaborations for crisis services can identify and address multiple areas of crisis system improvement across multiple smaller counties.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

Note: The discussion in the Empowered Collaboration section describes elements of the collaboration itself. This section will focus more on how that collaboration has made progress in identifying and addressing gaps in the crisis system.

- **Resources:** Grant funding has provided resources for staffing, data collection, research, and planning.
- **Leadership:** The Community Counseling Center crisis director has moved into a full-time, grant-funded position to lead this initiative. She is known and respected in the community, knowledgeable about the subject, and well-regarded by her superiors.
- **Data Gathering:** They have conducted a systematic process of gathering data through surveys, focus group discussions, and research into crisis service models elsewhere in the nation.
- **Partnership:** Participants in the collaboration are largely drawn from the existing regional CIT Council who are familiar with existing gaps in regional crisis services and committed to improving the system.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

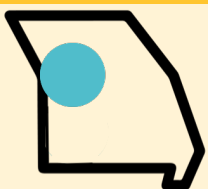
- **Survey:** They conducted a survey of 66 regional respondents who either deliver or refer to behavioral health services, including crisis services. Most respondents were in leadership roles at service agencies.
- **Data:** By collecting baseline data on the strengths and gaps of crisis performance from July 2020 to September 2020, they found:
 - 348 emergency calls (includes calls from hospitals, jails requesting face-to-face services) were received after hours by BHR. This is only a subset of total crisis encounters (911 to law enforcement, emergency room visits).
 - 138 individuals were referred to mobile crisis from emergency calls.
 - 252 individuals were seen face to face for crisis (138 mobile, 114 walk-ins).
 - 86 individuals were seen in the emergency rooms, and 55 were hospitalized.
 - CIT is well-developed in some counties (Perry, Cape), but not others.

- *Community Counseling Center supports the county jails, but services are limited (one community mental health liaison for five counties).*
- *There are no hospitals in the region; sometimes there is an emergency room wait of 2–3 days. Universal Health Services is opening 102 beds in Cape Girardeau, but many individuals would respond to crisis intervention.*
- **Prioritization:** Preventing justice involvement and unnecessary hospitalization has been prioritized as their focus.
- **Sequential Intercept Mapping:** They applied for and received technical assistance from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) GAINS Center to do sequential intercept mapping and are conducting training for southeast and northeast Missouri stakeholders, with an intended focus on intercept zero (the crisis interventions that prevent law enforcement involvement).
- **Suggested Models:** The strongest recommendation they are considering is to establish a 24-hour secure crisis center that would accept walk-ins and police drop-offs. In addition, they are considering initiating co-responders with some of the CIT officers. As of spring 2021, there was no implementation decision or implementation plan, however.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- **Sustainability:** Although this collaboration is built on the sustainable foundation of the regional CIT council, the resources for continued planning and implementation of a crisis center are reliant on a short-term grant rather than a sustainable funding source.
- **Formal Authority:** The participants in the collaboration primarily represent service provider leaders rather than individuals who have the authority and access to resources to make decisions about the crisis center and proceed with implementation.
- **Funder Involvement:** Involvement of the county leaders, mental health funds from five counties, chief executive officers of large organizations (hospitals, FQHCs, and Community Counseling Center), business leaders, and insurers would provide more capacity for implementation and supplement state funds.
- **Consultation:** Assistance from experts in crisis system development might help them not only identify desired models but also create a collaborative plan to implement the best array of services within their community with the resources available.

KANSAS CITY/JACKSON COUNTY: ReDiscover’s KANSAS CITY ASSESSMENT AND TRIAGE CENTER



Purpose and Scope: This emerging collaboration seeks to expand upon the Kansas City Assessment and Triage Center (KCATC) to improve the crisis continuum.

Note: When KCATC was implemented by ReDiscover through a community collaboration several years ago, it was the first crisis diversion center of any kind in the state. Since then, however, the need for additional access and capacity have become clearer. There is ongoing activity in Jackson County to plan and implement more comprehensive crisis services.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This asset illustrates the emergence of spontaneous interest among local leaders in developing a regional collaboration that can address the need for an improved crisis continuum, and it also illustrates the level of support and assistance that might be needed for continuous assessment, planning, and implementation of both the collaboration and the continuum.

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- **Empowered Community Collaboration:** Judge Locascio, presiding judge of the Kansas City Municipal Court, championed an original collaboration that brought together mental health centers, hospitals, and city/county leaders to design the original KCATC. This resulted in a plan for shared funding primarily between hospitals (for emergency room diversion) and DMH for a 10-bed facility designed ONLY for police drop-off and emergency room referral, operated by ReDiscover. This combined with what became the prototype for the state ERE program to be the first crisis diversion center in Missouri. Although this collaborative funding has continued, there has been no continuing formal collaboration for ongoing improvement and implementation of the community crisis system.
- **ReDiscover Innovation:** As operator of the KCATC program, ReDiscover is most directly aware of the limits of the crisis system. Mobile crisis is very underutilized. KCATC cannot accept direct walk-ins. Northern parts of the city, particularly in Clay and Platt Counties, do not use KCATC. There is still considerable pressure on emergency rooms and, in turn, on already-limited hospital capacity. In 2020, during the COVID-19 pandemic, ReDiscover used one of its own buildings to open a behavioral health urgent care. The service is both in person and virtual and is open 7 days a week from 9 a.m. to 7:30 p.m. with a prescriber and Medicaid specialist. They offer a 90-minute turnaround, minimum medical screening, and treatment for people with mental health and substance use disorder conditions. They are billing Medicaid because the service is in their CCBHO catchment area, though they are seeing utilization from all over the area. The need is great enough that they could expand their hours to 24 hours a day, 7 days a week.
- **Empowered Community Collaboration Present:** ReDiscover joined a new steering committee in the city (out of the municipal court and mayor's office) that began last year to research what is needed for expanded crisis services. They researched co-responder models, such as Oregon's Crisis Assistance Helping Out On The Streets (CAHOOTS) and another model from Harris County, Texas. There is also a 911-diversion discussion going on. Kansas City does not have a jail, and Jackson County has now stopped their use of the county jail. ReDiscover is advocating for a jail diversion crisis center instead of building a new jail. The committee presented initial findings to the Kansas City Council in December 2020. There is potential for a broader and more sustained collaboration, but it is necessary for the County, Kansas City, and other municipalities to work together and engage multiple funding contributors. There will be a Phase 2 Steering Committee

Workgroup, and ReDiscover has recommended that all Community Mental Health Center leaders participate in it. Metro Council (Missouri and Kansas) has been kept up to date as well.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- **Current Programs:** In addition to the call center, ERE, and mobile crisis, there has been implementation of KCATC and the ReDiscover behavioral health urgent care.
- **Beginning Assessment and Research:** A committee has gathered information on crisis continuum service gaps and what might be needed for improvement.
- **Continuing Project Specific Collaboration:** There are plans for a collaborative workgroup with broader involvement of Community Mental Health Centers.
- **Children's Mercy:** In a separate effort, Children's Mercy has identified a need for children's crisis services and is attempting to develop a plan for a crisis center for children and youth.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- **Formal Continuation of a Regional Behavioral Health Crisis Collaboration:** Developing a regional behavioral health crisis system is a continuing project that will involve an enduring formal leadership collaboration with involvement from multiple city and county stakeholders. It would be helpful to move from a short-term project focus to a continuing system improvement approach, which would require ongoing resources to sustain planning, implementation, and quality improvement infrastructure.
- **Comprehensive System Assessment:** Like other communities, the Kansas City/Jackson County region could benefit from a comprehensive assessment of what an ideal community behavioral health crisis system would look like for their region so that they could subsequently develop an ongoing strategic plan for taking that to scale in the context of national/state 988 implementation.
- **Consultation and Technical Assistance:** Developing a regional collaboration that can address the need for an improved crisis continuum is new territory for most communities and, as such, they would benefit from outside assistance as well as a statewide learning community on crisis.
- **Population Focus:** Current crisis system efforts have focused on adults, not children and adolescents, and have not addressed racial inequities head on. A stronger effort would focus on the whole population (all ages); tie in diversity, equity, and inclusion; and bring together all current efforts to address these issues.
- **Involvement of Multiple Funding Partners:** As with all crisis systems, funding is best viewed as a collaborative effort by all stakeholders, including not only DMH, Medicaid, counties, and cities but also private insurers and hospital systems.

JOPLIN: OZARK CENTER

Purpose and Scope: Ozark Center, with assistance from community partners, has added a behavioral health urgent care center to its crisis continuum.

WHY ARE WE HIGHLIGHTING THIS ASSET?

This illustrates one of the few examples in Missouri where regional partners have not only identified crisis continuum gaps but also have come together with the leadership of the CCBHO to significantly increase capacity. Ozark Center's Urgent Behavioral Solutions—a behavioral health urgent care center—is one of only four behavioral health urgent care centers in the state (as of June 2021).

WHY DOES IT WORK? (WHAT ELEMENTS ALLOWED THEM TO GET TRACTION?)

- **Ozark Center:** In Joplin's four-county region, Ozark Center has taken a significant leadership role in modeling continuous improvement of behavioral health services. Their longstanding focus on innovation has led to progressive development of crisis services within the community, beyond what DMH specifically prescribes. The increased resources available through CCBHO funding since 2018 have supported this innovation.
- **Partnerships:** The partnerships fostered by Ozark Center are connected to both its parent health system (Freeman Health System) as well as to its ability to develop relationships even with competitive health systems, such as Mercy. Ozark Center has long had a behavioral health assessment team in the Freeman emergency room, and recently Mercy requested to have a behavioral health specialist in the Mercy emergency room as well.

WHAT HAVE THEY DONE? (WHAT ARE THE OUTCOMES?)

- **Trauma-Informed Approach:** Ozark Center has won awards for implementing a center-wide trauma-informed culture. This has reinforced the awareness that the current system of emergency room use is inherently traumatizing for individuals in a behavioral health crisis and has sparked a desire to add new services.
- **Baseline Crisis Capacity:** Before implementation of the behavioral health urgent care, Ozark Center had already implemented its own call/text/chat line, with expanded mobile crisis services. Ozark Center moved to an open-access model and reduced return emergency room visits by 60% after making connection with clients. They also have ERE services and acute inpatient capacity. Even still, they recognize that more is needed because of the high volume of people in the emergency room who could be better served in another location.
- **Urgent Behavioral Solutions (Behavioral Health Urgent Care):** Ozark Center obtained a grant to fund the Urgent Behavioral Solutions center, which opened September 1, 2020, and operates 11 a.m. – 9 p.m. weekdays, 1 – 9 p.m. weekends, with medical screening

donated by Family Care Health Center. Staffing includes a psychiatry resident from Freeman, a clinician, case worker, and a peer support specialist. This is a remarkable innovation as there are so few behavioral health urgent care centers in the state and none in small communities like Joplin.

WHAT COULD FURTHER STRENGTHEN THIS ASSET?

- **Formal Behavioral Health System Collaboration with Initial Focus on Crisis:** Informants were clear that the community would benefit from bringing executive-level leaders from the counties, municipalities, health systems, and providers together with community members and people with lived experience to have an ongoing discussion regarding continuous improvement of behavioral health services, especially crisis services. This would facilitate more ongoing planning, evaluation, and funding.
- **Comprehensive System Assessment:** Like other communities, the Joplin region could benefit from a comprehensive assessment of what an ideal community behavioral health crisis system would look like in their region and subsequently develop an ongoing strategic plan for taking that to scale in the context of national/state 988 implementation.
- **Consultation and Technical Assistance:** They would benefit from outside assistance as well as a statewide learning community on crisis services as they collaborate with regional partners to address crisis continuum gaps and increase service capacity.
- **Involvement of Multiple Funding Partners:** As with all crisis systems, funding is best viewed as a collaborative effort by all stakeholders, including not only DMH, Medicaid, counties, and cities but also private insurers and hospital systems.
- **Transportation:** Current transportation from one site to another either involves a law enforcement burden (and handcuffs) or expensive ambulance services. Investment in less expensive, and less traumatizing, alternatives can achieve better results for less cost.

STRATEGIC FRAMEWORK: COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEMS

The project advisory group identified and ranked strategic behavioral health priorities for Missouri. This led to the development of a strategic framework focused on community behavioral health crisis systems.

- [See Appendix E. Strategic Framework: Community Behavioral Health Crisis Systems for an example of our strategic framework with potential strategic actions and opportunities.](#)

APPENDIX A. REGIONAL INTERVIEW GUIDE

Region _____ Date _____ Interviewer _____

Introduction

Missouri Foundation for Health in St. Louis and Health Forward Foundation in Kansas City have launched an exciting new endeavor – the first ever system and service asset mapping of Missouri’s behavioral health system. The purpose of this statewide initiative is to gain a comprehensive understanding of how multiple systems and stakeholders intersect with and influence Missouri’s efforts to help individuals and families with behavioral health challenges.

In-depth regional interviews are being conducted to learn more about the behavioral health system in your community. The regional interviews are designed to look at populations of all ages and all types of health insurance coverage, prevention as well as treatment, and the overlap between behavioral health, primary healthcare, and other human service systems in the community. The interviews are structured to learn how individuals, programs, agencies, and systems work together at the local or regional level to provide more effective services – and better results – for individuals and families with mental health and substance use challenges, as well as other health and human service needs.

The primary purpose of these interviews is to learn what is working well in your region, and what unique and creative solutions your community may have developed, as well as to learn where your community could use more help and support to improve its ability to meet community BH needs. The intent is to gather information that can identify opportunities for local and statewide stakeholders to build and support more effective community behavioral health systems in Missouri.

Key Informant Questions¹

Key Informant Information

Key Informant Name		Title	
Organization		Department	
Experience How long have you worked in this capacity?			
Have you had other positions within this system?			

¹ Note: These questions will be modified if interviewing a group or collaborative. In addition, the questions will be modified based on the informant’s area of expertise. For example, if the informant is a crisis provider, they will be asked detailed questions about crisis services, but may be asked very few questions about prevention. Conversely if the informant is a prevention provider they will be asked predominantly about prevention activities.

Organization Service Population, Capacities, Strengths, and Gaps

Service Population	<p>Please describe the target service population of your organization (agency, program, collaborative, etc.) and its primary mission or service priority.</p> <ul style="list-style-type: none"> • If organization <u>primarily delivers BH services</u>, please describe the types of complexities or overlapping needs that you address within your services. • If the <u>focus is on prevention</u>, please describe the targets of prevention activities. • If organization <u>delivers other types of services</u> (e.g., health, housing, education, justice, etc.), please describe the prevalence and impact of BH issues in your service population.
	Please describe your service area or the community your organization serves.
Service Array and Service Gaps	Describe the overall strengths and capacities of your organization's services, including how the service volume compares to the need.
	<p>How do individuals access your services?</p> <ul style="list-style-type: none"> • Are there barriers or limitations to access based on funding (e.g., insurance coverage, including private coverage) or geography? If so, what are they? • Are there partnerships or collaborators that help to promote service access for all people in your target population regardless of insurance, diversity, complexity, location, etc.? If so, please elaborate.
	<p>Describe the types of complex challenges that your clients experience (e.g., <i>MH, SUD, health, education, legal, housing, financial, cognitive, cultural, veterans</i>).</p> <ul style="list-style-type: none"> • How does your organization address the needs of people with complexity? • Are there partnerships to help you improve integrated services in your organization? • Are there partnerships that help with service coordination?
	<p>Describe service transitions for your population.</p> <ul style="list-style-type: none"> • Does your organization provide for continuing care, or do you have partnerships that facilitate transition planning for people with various types of needs? <p>What do you perceive to be the biggest BH service gaps in the region (or other geographical constraint) for your target population?</p> <ul style="list-style-type: none"> • What services should be added to the current service system and what would they look like?

Local and Regional System Intersections, Collaborations, and Coordination

Local System Intersection and Coordination	<p>Does your system have local funding for MH? (e.g., <i>local MH fund; children's fund; senior fund, foundations</i>). If so, tell us about how that funding works and how it is used to facilitate services and system coordination. If not, do you think it would be helpful to create opportunities for local funding, and if so, how?</p> <ul style="list-style-type: none"> • If such collaborations are absent or incomplete, please discuss what you think would be helpful to improve system coordination and outcomes in your community. • What geography and what partner systems should be the targets for inclusion?
	<p>Are there examples of service excellence in your community in terms of prevention, trauma informed services, implementation of best practices, model programs, etc.?</p> <ul style="list-style-type: none"> • How do local system partners work together to make these successes happen? • Has your community considered a Stepping Up collaboration to address BH and CJ issues? • Has your community developed a formal collaboration using Children's System of Care principles? • Are there state projects or funding streams that support these efforts?

Local System Intersection and Coordination (cont'd)	<p>What are the biggest strengths in terms of how service providers, people with lived experience, payers, oversight bodies, and other stakeholders work together as a system to ensure coordination and integration of services?</p> <ul style="list-style-type: none"> • Are there one or more formal collaboration structures for your community? Describe how each one works in terms of geography covered, membership, functionality, and results. • Are there state level efforts that support these collaborations?
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Local System Service Capacities, Strengths, and Gaps²

Life in the Community	Describe what you know about prevention efforts in your community (e.g., <i>broad collaborations to improve community health or build trauma-informed systems, and/or targeted efforts focusing on suicide, overdose deaths, SUD, or other issues</i>).
	Describe (to the extent you can) how your community promotes screening, identification, and early intervention for adults who are involved in the justice system, homeless services, child protection, aging services, colleges, churches, developmental disability services. What goes well and what could be improved?
	How does your community address stigma against MH and SUD?
	What efforts are there to promote reintegration of people in recovery?
	Based on your knowledge of the service delivery system, what do you think we would hear from consumers, families, and advocates about accessing services?
	Describe any efforts by local health systems and/or health payers to invest in health promotion, population health, or prevention. Is this an improvement opportunity?
	What is the status of health and BH equity in your community? How is this being addressed?
Primary Health/ Behavioral Health Integration (PHBHI)	Describe your impression of how well BH is integrated into primary care and healthcare in your community. <i>Consider adults and children, MH and SUD, FQHCs and other health systems.</i> <ul style="list-style-type: none"> • Are there certain populations where this goes well and others where more work is needed? • Are there certain types of insurances that support or do not support integration?
	What is the role of various types of health providers in providing integrated care for MH and/or SUD? <i>Consider FQHCs, private group practices, and hospital systems.</i>
	How do state level funders and policy makers support the development of PHBH Integration in your community?
Adult/Older Adult and Child/ Adolescent Specialty MH and SUD Services	Describe services for specialty MH SUD care for all age groups in your community.
	Describe access for both adults and children, and comment on what programs seem to be particularly helpful. <i>If you have strong collaborations with certain programs or agencies, please indicate.</i>
	Are the MH and SUD programs co-occurring MH/SUD capable? <ul style="list-style-type: none"> ○ Do they integrate with primary health? ○ Do they provide MAT?

² This section is designed to follow the ideal system map for adults and children in the community. Not all respondents will have information on all these areas, so the questions will be adjusted accordingly.

Adult/Older Adult and Child/Adolescent Specialty MH and SUD Services (cont'd)	Is there a continuum of outpatient, intensive outpatient, home based, and rehabilitation services (outpatient and residential)? <ul style="list-style-type: none"> • Is the continuum available regardless of payer source, or only for some payers (e.g., Medicaid, private insurance) and not others? • Are there state initiatives that are more helpful (or less helpful) in your community in supporting the continuum of services?
	Describe access to specialty evidence based best practices for children/youth, such as trauma-specific treatment, home-based wraparound services, intensive services for pregnant and parenting women with SUD and other complex needs, and services for youth at risk of or experiencing first-episode psychosis.
	Describe access to specialty evidence based best practices for adults/older adults, such as trauma-specific treatment, home-based wraparound services, intensive psychiatric rehabilitation services, supported education and employment, supported housing, and intensive continuing care community SUD services.
	Describe access to best practice psychopharmacology for MH and/or SUD conditions.
	Describe specific efforts to address specialty BH needs in partner systems: schools, child protective services, juvenile justice, homeless services, criminal justice services, jails/prisons, older adult agencies, vocational services.
	Describe programs for other specialty populations (e.g., <i>I/DD + MI</i>) when available.
Crisis Continuum	What percentage of people (adults or children) enter the “system” in crisis (e.g., <i>psychiatric, medical, housing, police involvement, physical or emotional abuse</i>)?
	Describe the array of crisis services in your community. <ul style="list-style-type: none"> • Does everyone get served by the current crisis continuum, or are there gaps and backups? • How is this influenced by payer source? • What state programs are particularly helpful?
	What would be required to improve the continuum of BH crisis services for adults and/or children in the community?
	Is there a BH crisis system collaboration?
Recovery Supports	Describe the continuum of recovery supports in your community, highlighting the strengths and successes. <i>If not stated, prompt for: adult peer support specialists, recovery coaches, family partners, and youth peers; consumer-operated service programs; recovery community organizations and clubhouses; housing, employment, and education supports.</i>
	Are there more needs for recovery support services than there are available? What would help improve this gap?
	Describe the ways in which peer and family voice are included in service design and advocacy in your community. <ul style="list-style-type: none"> ○ Are there opportunities to strengthen that contribution in the community’s collaborative efforts? ○ Are there opportunities to improve the battle against stigma and discrimination in your community?

Building Capacity to Meet Population Needs

Advocacy	What are the opportunities for engaging consumers and families in advocacy efforts in your region? Are there any coordinated efforts?
Financial Resources and Funding Alignment	Are there services you believe should be offered in your community that are not available due to a state-level fiscal, licensing, or regulatory constraint? Please describe the services and the constraints.
	Are there populations that have service limitations or gaps that need to be addressed through better coordination at the state level (e.g., indigent, private insurance, MCOs, vets, undocumented immigrants, formerly incarcerated, etc.)?
Human Resources and Workforce Development	Describe how you recruit, train, and retain a workforce that is inspired and equipped to provide the services your population needs.
	To what extent is the BH workforce in your area meeting the service need?
	What partnerships or collaborations help you with workforce development?
Cross-Sector Data Sharing	Does your organization maintain any formal data sharing partnerships?
	Are there types of information that would be particularly helpful to share or coordinate for serving (or improving services to) your population?
	How would you characterize the timeliness of communication and data sharing between your organization and other community agencies and partners?
Policy Alignment and Implementation Support	Please describe state level efforts that facilitate your local system's ability to collaborate across systems to serve children and youth, and adults and/or older adults. Identify areas where you experience state level efforts as helpful, as well as where you feel more direction or guidance would be helpful.
	Describe your community's success in implementing new services and measuring progress in meeting community needs. What would help your local system to continuously improve on process, quality, and outcome metrics that reflect the behavioral health of the population? What would help your community improve its ability to implement new services or programs in a way that can successfully meet the needs of the population?

Other Stakeholders

Identifying Other Partners	Are there important potential systems or partners that we haven't asked about? Who else do we need to be sure to interview? (e.g., providers, payers, other service systems, collaborations, foundations, consumers, families, advocates)
	Are there organizations in your community that have the potential to be much better partners but would need specific outreach or support in order to engage?

Project Outcome Questions

Expectations	What do you hope will come out of the BH system asset mapping and the associated recommendations?
Recommendations	What are the best ways for us to produce recommendations that are actionable?

APPENDIX B. TEMPLATE FOR REGIONAL FOCUS GROUPS FOR PEOPLE WITH LIVED EXPERIENCE OF RECOVERY

PURPOSE AND GOALS

- Ensure that people with lived experience are visible, vocal, and valued in the asset mapping process
- Identify assets related to recovery and peer support throughout the system
- Identify gaps or challenges related to recovery and peer support throughout the system
- Identify essential elements particularly relevant in the current environment of the pandemic and concerns about racial equity

Agenda Item	Structure or Method	Topic, Invitation & Prompt	Roles	Timing
		Capture list of participants and make sure have email addresses. Add * before our names.	-	15-30 min prior to meeting
Welcome, orient to Zoom	-	Explain how info will be used, what is the benefit for the individuals and for MO. Clarify interest in both mental health and substance use ("behavioral health"). Zoom: chat, breakouts. ASK PERMISSION TO RECORD. Introduce selves in chat: name and hope for 2021.	Guide: Lynda / local host (and Lynda for Zoom instructions) Zoom host: X Chat tender: Joe	8 min. (8 total)
Get people engaged	Spiral Journal + Chat	As you think about services you (and others) receive: Something that works quite well for me... An example of when I got support I needed... Something I wish there were more of... A question emerging for me...	Guide: Joe Zoom host: X Chat tender: Lynda	10 min. (18 total)

Agenda Item	Structure or Method	Topic, Invitation & Prompt	Roles	Timing
Focus on what worked	Conversation Cafe	Think about a time when you or a loved one were struggling with a mental health or substance use challenge and by reaching out you got some good help. Why did it work? What are key needs or gaps that you see? What are the next steps you'd like to see in the XXX area?	Guide: Lynda Zoom host: X (breakouts of 5[4] for 30 minutes) Chat tender: Joe	35 min. (53 total)
Prioritize needs	1-3-all	We are looking to prioritize with this next step. As you think about the services and supports available--or what could be available--what is most helpful in supporting your own recovery?	Guide: Joe Zoom host: X (breakouts of 3[4] for 8 minutes) Chat tender: Lynda	20 min. (73 total)
Gather more detailed info	Chatfall	Using Chat, complete each sentence: To me, recovery means... Because of the pandemic... Barriers to receiving services for mental health or substance use... I'd like to see more of... I'd like to see less of... My family learns about wellness and recovery... It has been most helpful to me... We can engage our communities in behavioral health and wellness... We can better use people's lived experience... I'm involved in designing local services... I participate in state or local advocacy... If I could implement one change today... My dream for behavioral health services...	Guide: Lynda Zoom host: X Chat tender: Lynda	8 min. (81 total)

Agenda Item	Structure or Method	Topic, Invitation & Prompt	Roles	Timing
Gather quantitative data	Poll	Rate on scale from “not at all true” to “very true”: I’m in charge of and directing my recovery. The BH services I receive respect me and my culture. It is easy for me to access behavioral health services.	Guide: Joe Zoom host: X Chat tender: Lynda	5 min. (86 total)
Next steps / close out	-	-	Guide: Joe/Lynda/local host Zoom host: X Chat tender: Lynda	4 min. (90 total)
Optional post-meeting time	-	Time for extra questions or feedback	BE SURE TO SAVE CHAT	-

APPENDIX C. STRATEGIC FRAMEWORK: EMPOWERED LOCAL COLLABORATIONS

Local Collaborations: Summary of High-Level Findings from the State-Level Assessment

Missouri has many state level collaborations that address various aspects of health and behavioral health, some regional collaborations with a specific focus on behavioral health, and local community collaborations that address community health and wellness, including behavioral health. Some local systems in Missouri are engaging to varying degrees in broader regional or local system collaboration and coordination. Most of these focus on broader health and wellness, or community needs in general, with initiatives that address behavioral health as part of that broader focus. These collaborations have been developed primarily through local initiative and energy, using diverse funding sources such as local mental health or children's funds, state contracts, and foundation grant. Examples of such collaborations include:

- Behavioral Health Network of Greater St. Louis
- The Greater Kansas City Behavioral Health Coalition
- The Healthy Living Alliance of Greene County
- The Randolph County Caring Community Partnership
- Children's System of Care Collaborations

There is also a legacy state-level structure for assigning geographic responsibility for public mental health services to Community Mental Health Centers that usually does not align with the geographic mapping of other types of services and systems. There is no consistent intermediary structure for inter-system, inter-agency, population-wide behavioral health collaboration at the county or community level.

Working Draft of the Strategic Framework for Empowered Local Collaborations

The following strategic frameworks and strategic actions have been informed by the state-level assessment findings with feedback and input from a small group of the project's advisory group members.

Major Finding

Improving community BH systems requires empowered and sustained collaborations between leaders of multiple community systems and services. In Missouri, it is rare for communities to have the level of collaboration to maximize success. Our findings indicated that it is also rare that people with lived experience of recovery have an empowered role at the decision-making tables.

Assets

Missouri has some examples of successful high-level collaborations in some communities that can be starting places or models for assisting other communities to develop similar efforts. Healthy Living Alliance has a health and BH focus under the sponsorship of the Greene County Public Health Department, and has taken a lead role in developing crisis diversion. Behavioral Health Network intersects with other collaborations in the St. Louis region, such as the St. Louis Regional Health Commission, Integrated Health Network, Children's Services Coalition, and Generate Health, all of which have various areas of focus on health and behavioral health.

Opportunity

Important strategic priorities can best be achieved by developing and sustaining community collaborations in individual counties or multi-county regions to coordinate resources and initiatives at the local level to improve services for the population. It is helpful when one empowered collaboration can hold responsibility for multiple initiatives and priorities. In all types of collaborations, it is essential to bring the voice of people with lived experience to the table to help design services in a way that is most responsive to community needs.

Challenge

There is no statewide strategic approach for establishing and implementing empowered local BH collaborations. High-level collaborations must: a) include leaders/decision-makers, as well as the empowered voice of people with lived experience of recovery, b) reflect the diversity of the community served, including special sub-populations, c) align with state goals and objectives to maximize impact, and d) include multiple sectors of care with equal investment.

VISION

Every community (county, region) shall establish a high-level collaboration of key leaders to assume collective responsibility for improving the health and behavioral health of the population.

Strategic Actions

All of the strategic action areas considered health equity/disparities, children, and the involvement of people with lived experience of recovery.

Policy

- Definition of "high-level collaboration" by funders and policymakers, with encouragement for each community to develop such collaborations.
- Policy to permit/encourage local MH funds to support effective collaborations.
- Policy for state leaders to work in partnership with local collaborations to implement system improvements.
- State policies directly instructing/guiding local representatives of different agencies or service sectors to participate in local BH system level collaborations in line with the overall policy aim.
- Policies to facilitate regional BH collaborations in regions where there are currently multiple administrative agents and/or CMHCs and/or SUD providers.
- Possible reconsideration /modernization of the decades-old administrative agent structure and role.
- Policies to permit/define/encourage/require aggregate data sharing across sectors within formal BH collaborations and distinguish the data sharing from the sharing of PHI in an HIE or under HIPAA.

Legislation

- Legislation to create funding incentives for local collaborations to address prioritized issues through funding matching.
- Legislation about funding incentives and matching for local collaborations should include requirements and mechanisms for enforcing accountability among the community partners.
- Legislation should include direction for state agencies to be engaged at the local level.
- Legislation should include provision for technical assistance to community BH collaborations and support for learning communities to help them be successful.

Funding

- Create guidelines for state and local funders to develop, support, and sustain high-level collaboration.
- Work with MH and children's funds, community foundations, and United Way to disseminate examples from model communities.
- Require MCOs to coordinate with *and be accountable to* established local collaborations to meet community needs.
- Funding for collaborations should include capacity for measuring, reporting, and highlighting outcomes to demonstrate value at the local and state level.
- Funding strategy to promote the value of local ballot initiatives for community collaborations to better leverage the local impact of state dollars and address gaps not addressed by state prioritization rules.
- Education and incentives for all counties to use children's funds to support CSOC collaborations.
- 988 funding initiatives are an opportunity to incentivize development of community collaborations to plan and operationalize 988 systems.

Implementation

- Identify communities that wish to build on existing collaborations to create more power and sustainability. Provide TA, consultation, and organize learning communities.
- Utilize existing model collaborations as peer mentors for other communities.
- Train peer leaders to be effective voices at the leadership table in each community.
- Develop and share materials to help communities identify their priorities and organize implementation strategies that involve "collective impact."
- BH collaborations should align priorities and work together with other types of collaborations in each region or community to define shared vision and goals to amplify the impact.
- Within each broad policy area, create a process to help community collaborations be responsible to decide what concerns should be prioritized and addressed in meaningful ways.

Data and Evaluation

- Establish achievable metrics for launching an effective collaboration using existing model communities.
- Teach communities how to use data for improvement purposes for any priority area that may be selected.
- Use data to identify and engage disparity populations.
- Provide communities access to resources for baseline assessment to identify priorities and provide baseline data for improvement.
- Consider standardized approaches to identifying metrics of progress and documenting relevant outcome data across different sectors within local systems, as well as across communities.
- Consider identifying two to three key outcomes for each policy area that each region wants to change through their collaboration then help them to prioritize human and fiscal resources around those priorities.
- Ensure there is a communication strategy for sharing outcomes and for recognizing and celebrating successes at both the local and state level.

Workforce

- Develop a model for training local leaders to be facilitators of high-level community collaborations. Use leaders of successful communities to train others.
- Provide a training program for individuals and families with lived experience to be effective representatives at the community collaboration table and train the other leaders on how to engage and value those representatives.
- Develop core competencies within the (formal and informal) leadership teams of the collaboratives. Include competencies and training in meeting facilitation, communication, networking, organizing, etc.

APPENDIX D. STRATEGIC FRAMEWORK: PRIMARY HEALTH/BEHAVIORAL HEALTH INTEGRATION

PHBHI: High-Level Findings from the State-Level Assessment

The majority of people with behavioral health conditions can be served in primary care settings that successfully integrate behavioral health screening and intervention services. Missouri was an early adopter of PHBHI and the first state to implement health homes in its Medicaid program. The 29 MPCA member agencies serve as the medical home for 530,000 Missourians, ages 6 and above, and all members provide some level of PHBHI. While data sources don't allow full assessment of the availability of integrated care across all payers, MO Healthnet has robust data on the impact of health homes which served 24,000 people in 2017. Evaluation of primary care health homes showed reduced costs and improved outcomes for people with complex medical conditions.

For full population health management, a collaboration among all payers to identify data and a systemic approach to measuring PHBHI is needed.

Integration of screening and intervention for substance use disorders in primary care settings has been initiated by the Division of Behavioral Health (DBH) and MO Healthnet.

- SBIRT has been supported by the Missouri Primary Care Association and the state Medicaid plan has codes for reimbursement of these services.
- DBH received Targeted Opioid Response funding and some primary care practices were funded to provide medication-assisted treatment (MAT).

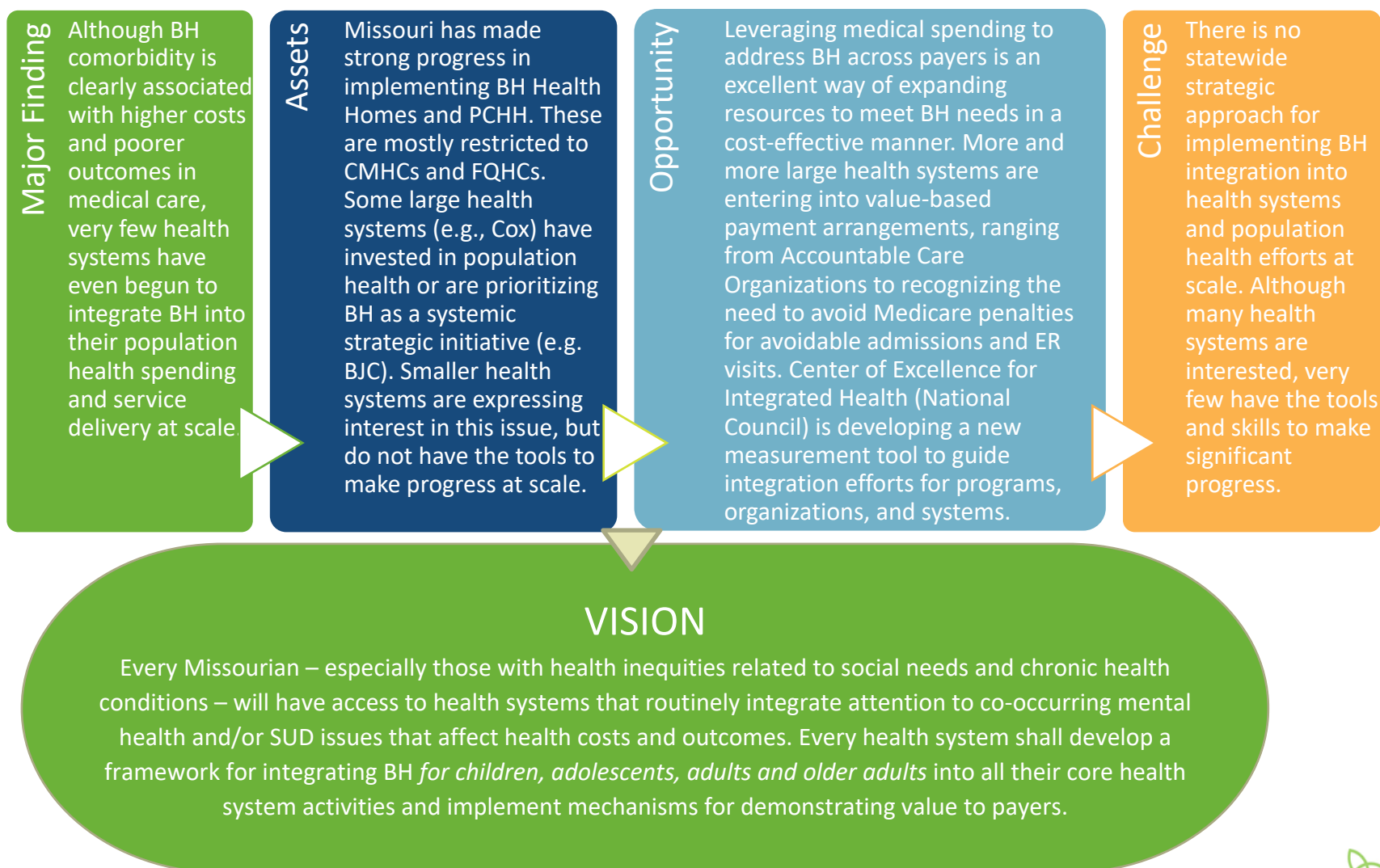
While integration of screening and intervention services for SUD in primary care has been initiated, it has not been scaled up to meet the need indicated by the prevalence in the Missouri population.

The number and distribution of child psychiatrists is too low and concentrated in urban centers to fully address the behavioral health needs of children across Missouri. MO-CPAP is being implemented in a multi-year statewide rollout to support the behavioral health needs of children predominantly served by pediatric practices by providing just-in-time child psychiatry consultation. In its start-up year, it enrolled 119 providers who fielded 108 calls, 91 of which were for psychiatry consultation.

MO-CPAP is an excellent approach to creating access to child psychiatrists in pediatric practices. Bringing this consultative model to scale will take continued focus and resources for the next 5–10 years. There are many barriers to adoption to overcome at the local level and a need to engage payers beyond Medicaid to incentivize this innovation.

Working Draft of the Strategic Framework for Integration of Behavioral Health into Population Health

The following strategic frameworks and strategic actions have been informed by the state-level assessment findings with feedback and input from a small group of the project's advisory group members.



Strategic Actions

All of the strategic action areas considered health equity/disparities, children, and the involvement of people with lived experience of recovery.

Policy

- Statement of vision and policy direction by state and local leadership, advocates, provider organizations, and other stakeholders
- Policy statement by Medicaid regarding the goal of advancing BH integration into all primary health and specialty health settings serving people with complex needs.
- Policy statement regarding the importance of global investment in prevention and early intervention strategies for social-emotional well-being (children's mental health).
- Policies regarding health system and public/private health payer investment in prevention and early intervention (EPSDT) programs with demonstrated outcomes.

Legislation

- Legislation defining the aspirational standards for health systems in Missouri to be leaders in improving effectiveness and efficiency of medical services through BH integration.
- Legislation to create a local funding stream (e.g., county mill tax) to support capacity building for PHBH integration at the local level to increase access to care.
- Legislative guidance for mental health, children's, and senior boards regarding funding capacity development for integrated care for high need populations (with guardrails against paying just for direct health services).
- Legislation supporting incorporation of ACES as a standard screening and metric, as has been done in Vermont.

Funding

- Implement a funder learning community with both public and private intermediary payers, FQHCs (Missouri Primary Care Association), MO Hospital Association, and the Missouri Behavioral Health Council to delineate current and future incentives for going beyond the current health home plan to address improving BH integration at scale.
- Ensure adoption of BH collaborative care codes by all payers to incentivize payment for care coordination, health behavior management, and BH consultation as part of medical care benefits.
- Work with Medicaid to secure payment for prevention and early intervention programs; also secure payment for interventions that are currently labeled as preventative when there is no diagnosis code.
- Identify a value-based funding approach to address integrated services for the next group of individuals with high health costs and health needs (beyond health home and DM3700).
- Have Missouri Foundation for Health convene a funder learning community for PHBH.

Implementation

- Initiate a learning community for large health systems to work toward implementation of integration at scale. Look at primary care and specialty care, service delivery, and at-risk funding arrangements together.
- Initiate a learning community for smaller community health systems regarding how to initiate population health efforts that include BH integration throughout their continuum of services.
- Expand the MO Child Psychiatry Access Project (MO-CPAP) to be accessible to all pediatricians. This will require attention to implementation challenges, broader marketing, and development of a resource of physician champions in each community.
- Work with MO Primary Care Association and the Missouri Council for Behavioral Health to support a learning community for expanding existing health home integration efforts to the whole population in need. Include MO Chamber of Commerce and Industry, MO Association of Counties, MO Rural Health Association, and medical societies to reach different types of providers and a larger population.
- Fund technical assistance and consultation through a MO Center for Excellence for Population Health Integration.
- Include peer specialists on treatment teams in BH Health Homes, PCHs, and FQHCs.
- Build on existing efforts stemming from the pandemic, such as Show Me Hope crisis counseling (funded by FEMA).
- Educate legislators and the governor about integration implementation within Medicaid expansion.

Data and Evaluation

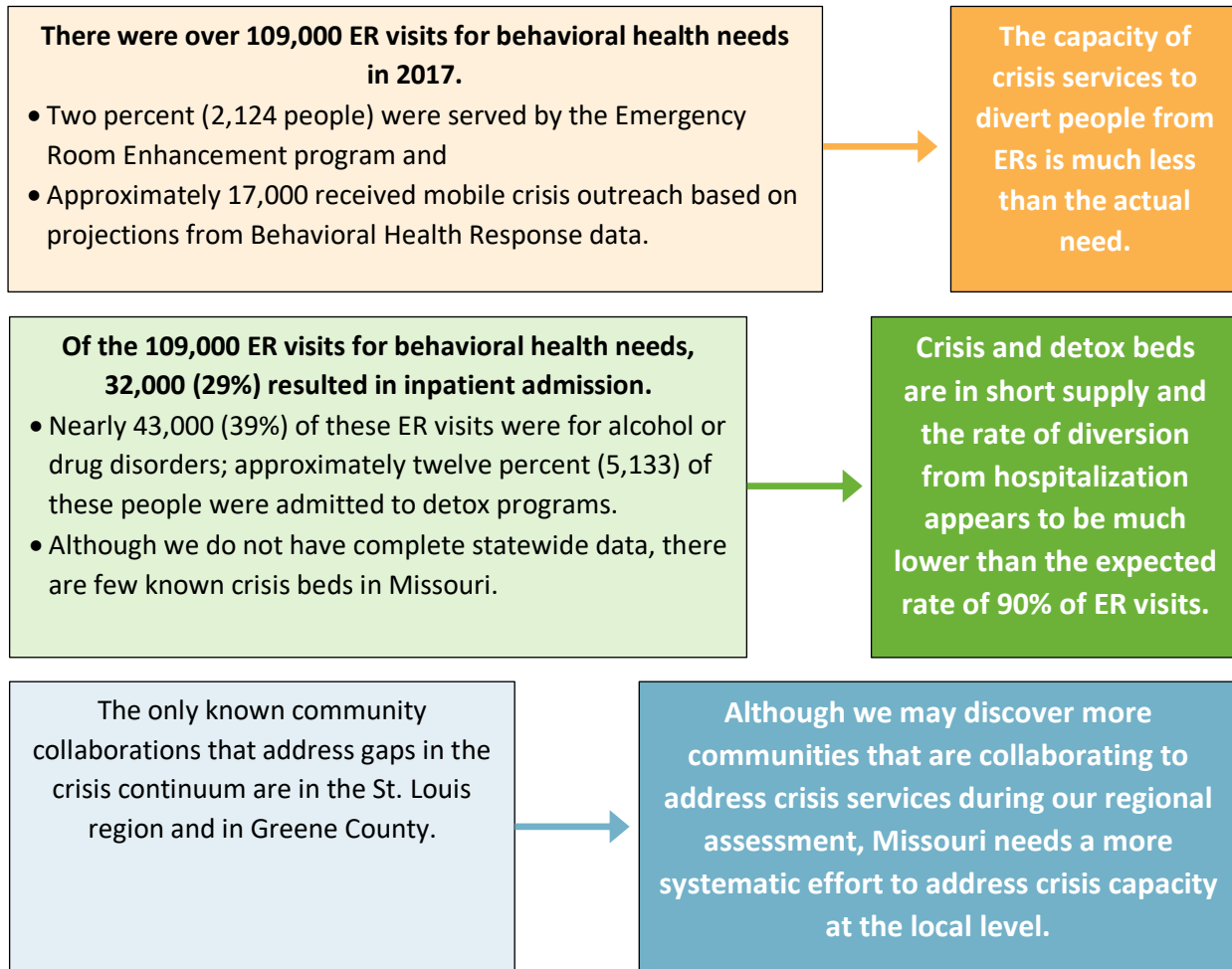
- All systems can begin to gather data on the prevalence of BH issues in their service populations, based on service location, age, cost, etc.
- All health improvement efforts should include data and outcomes related to BH comorbidity in the target population. Share data locally in a way that produces useful information for improvement.
- Measurement should address equity of access and health metrics for populations of color, urban poverty geographies, and rural areas.
- Utilize next generation measurement tools for measuring and improving integration at the level of each primary and specialty medical practice, as well as health organizations and population health systems.

Workforce

- Establish training for all health and BH professionals to work in integrated care settings.
- Provide ECHO and other methodologies to help programs and practices improve.
- Focus on pediatric populations as well as adults.
- Train people with lived experience of BH recovery to have community health worker skills.

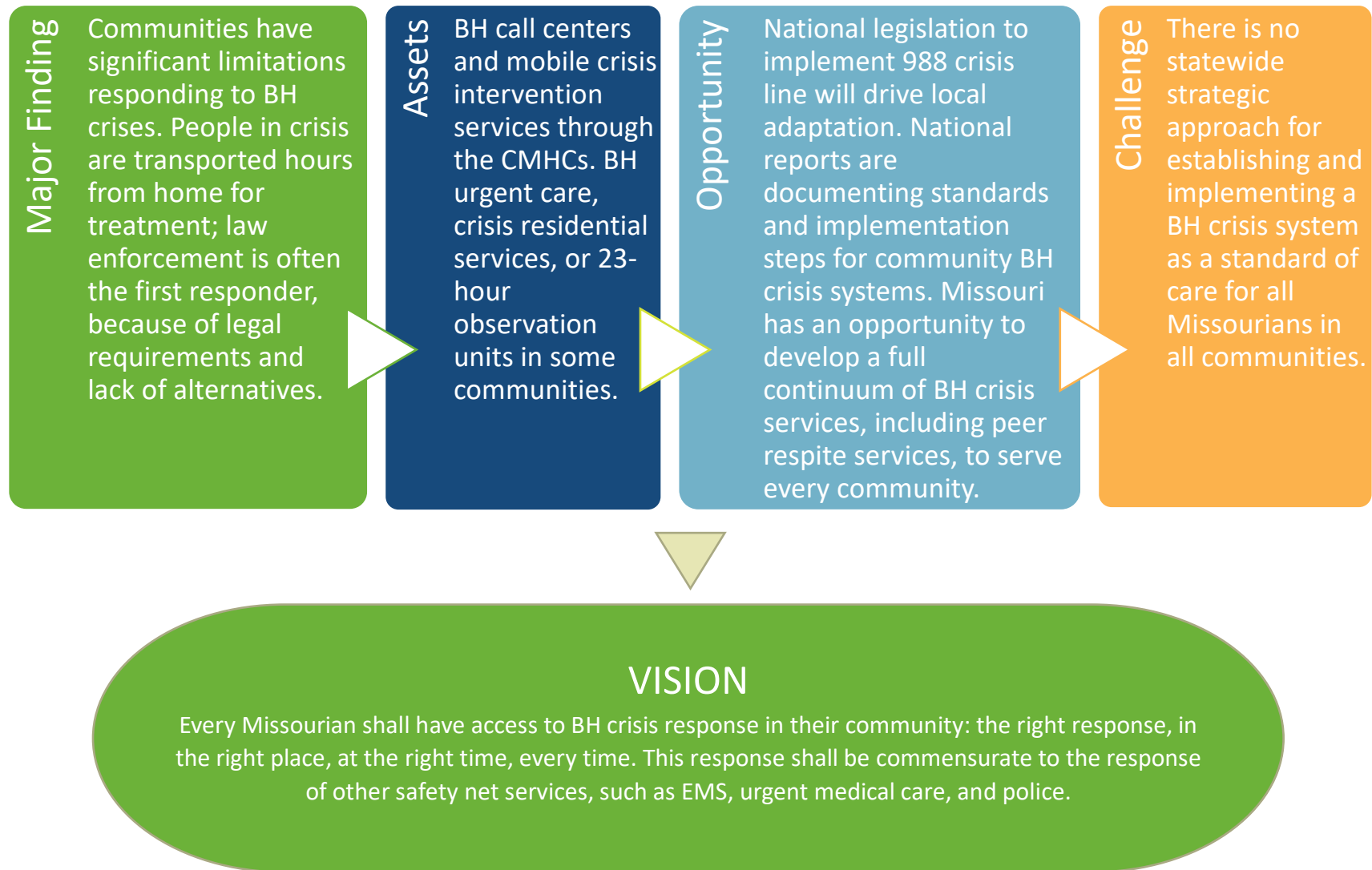
APPENDIX E. STRATEGIC FRAMEWORK: COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEMS

Crisis Continuum: High-Level Findings from the State-Level Assessment



Working Draft of the Strategic Framework for Community Behavioral Health Crisis Systems

The following strategic frameworks and strategic actions have been informed by the state-level assessment findings with feedback and input from a small group of the project's advisory group members.



Strategic Actions

All of the strategic action areas considered health equity/disparities, children, and the involvement of people with lived experience of recovery.

Policy

- Statement of vision and policy direction by state and local leadership, advocates, provider organizations, and other stakeholders, including individuals with lived experience.
- Policy statement regarding network adequacy goals in each community for all payers.
- Policy statements include children, people of color, and adequacy of services in rural counties.
- Policy regarding inclusion of people with lived experiences in the staffing mix of crisis services, including hospitals.

Legislation

- Legislation to adopt emergency commitment procedures that do not require law enforcement or judicial involvement but can be initiated by licensed clinicians. Legislation must balance access to care for people in need, along with expectations of a clinically appropriate evaluation and intervention in a non-traumatizing fashion, with protection of civil liberties and protection from abuse of power. Further, new language must protect people from inappropriate responses, such as being transported for hours in shackles to be released or deemed by hospitals as “too acute” for hospitalization and therefore taken to jail or sent out with no help.
- Legislation defining the standards for BH crisis systems and a time frame for implementation (e.g., Iowa’s legislation re: Crisis Access Centers). Standards need to have geographic adequacy; services close to home to minimize the need for extended transport to receive evaluation and intervention.
- Legislation directing public and private funders to support the full continuum of services.
- Legislation to establish a statewide call center and information exchange and/or regional “bed board” with real-time data to make sure hospitals, police, and other aspects of the system are linked and connected to evaluate bed capacity. This can be connected to implementation of 988.
- Legislation to establish alternative transport systems for behavioral health patients in crisis (not involving law enforcement or ambulances).
- Standards and incentives for psychiatric hospitals accepting patients, regardless of level of acuity, so people are not turned away.

Funding

- Require Medicaid, Medicaid MCOs, and commercial insurers to pay adequate rates for the full continuum of BH crisis services.
- Engage private insurers as partners to identify ways in which they can contribute to more effective payment for crisis services for all Missourians. Private payers are currently required to pay for wraparound services (e.g., community support, case management) not typically covered by insurers. Commercial payers should cover the entirety of best practices as part of the continuum.
- Engage large businesses that hire the commercial plans to put pressure on plans to provide the right services for their employees and their families.
- Medicaid should provide adequate rates for psychiatric inpatient services to incentivize development (and no more closures) of inpatient units in each region, especially in under-served geographies for both mental health and substance disorders.
- Develop and fund ambulance and non-ambulance transport so that there is routine access to transportation for people in BH crisis.
- Create flexibility for local communities to identify local funding match. Incentive to free up law enforcement and provide better response for the community.
- IMD waiver (in progress) for psychiatric inpatient and residential SUD would provide more flexibility for designing services.
- Work with payers and regulators to establish funding incentives for hospitals to be able to accept the most acute referrals.
- Fund peer respite centers as a routine part of the care continuum.
- Restore funding for peer warm lines.

Implementation

- Fund local communities to form collaboratives to self-assess their community crisis systems and develop strategic implementation plans. Provide targeted TA on forming effective and empowered community collaboratives. Existing collaborations in Jasper and Greene counties can be peer mentors for other communities. Existing or new collaboratives can be established as “quality oversight” of the performance of 988 systems, just as there are local authorities to oversee 911 systems.
- Create a team of crisis system change leaders as a learning community across the state and ensure that individuals with lived experience are part of this team.
- Coordinate efforts to educate the public on the use of 988 vs. 911.
- Implement best practices to scale. ERE is an intensive crisis intervention model only covered by DMH; it can be easily saturated without parameters. The model is nontraditional but effective; it needs to be developed and funded by multiple payers to respond to children and adults with significant needs.
- Include expectations regarding crisis continuum development (in direct services and community collaboration efforts) in the next phase of CCBHO implementation.

Data and Evaluation

- Establish a set of routine quality metrics for local communities, delineating access and engagement in BH crisis services. (These metrics are included in some of the national standards reports.)
- Include health equity in the metrics.
- Collect baseline data from each community/region.
- Track and share implementation of services, and the degree to which those services have an impact on the whole population (and locally).
- Establish local QI oversight analogous to that for EMS.

Workforce

- Establish crisis response practice guidelines based on standard core competencies. Ensure coverage of all ages, comorbidities, and cultural/linguistic populations.
- Establish guidelines for CCBHOs and staff regarding roles and responsibilities of on-call clinicians covering mobile crisis, including adequacy of response.
- Establish requirements and training for peers to be an expected part of the multidisciplinary team in ALL crisis programs, including inpatient units and CSUs.
- Create peer respite centers as part of the crisis system. Develop specific training and guidelines for peers in a peer respite setting.