

Children's MOSAIC Project

System of Care Development and Implementation Manual



The Children's MOSAIC Project
serving the city of Springfield

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Introduction

The Children's Mental Health Initiative, Building Systems of Care, Community by Community (CMHI) projects funded by Illinois Children's Healthcare Foundation (ILCHF) represent diverse communities and therefore reflect diverse care systems. Though the systems are different, each community has attended to a similar set of processes to develop their system to where it is today.

This manual, a requisite project element, highlights the methods this community engaged in to develop their unique care system from the initiation to the conclusion of ILCHF funding. Each of the four community manuals include descriptions of the collaborative activity among the mental health, education, medical, and other community stakeholder systems. Each area represented potential barriers and innovations in the system. These processes reflect varying levels of adherence to the Child and Adolescent Service System Principles (CASSP).

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PREFACE—A NOTE FROM JAN GAMBACH

Childhood is our common denominator, which, for better or worse, defines us as adults. Unfortunately, childhood is a tough, treacherous time for too many of our kids. Earlier in my career as a crisis therapist, I saw countless families and children in crisis in emergency rooms. Particularly memorable was this one night at 2 a.m. when I was called in to see a young man who had some obvious developmental delays, in addition to mental illness. He related that he “graduated” from a group home in St. Louis a week earlier and his aftercare plans fell apart. He ended up in the ER with no place to go, no resources, and very little street smarts. I remember the helplessness I felt as I provided him with a few meager referral sources before sending him back out. For some reason, he is one of the many encounters that remains one of my ghosts. Social services work can feel like tilting at windmills. It can be heartbreaking. I suspect all of us who work in this field are haunted by the ghosts of those traumatized, broken, and battered individuals who did not get the assistance they needed not only to survive, but to thrive.

The MOSAIC system of care was born out of a group of us in education, primary care, mental health, economic development, social services, and philanthropy who are deeply concerned about the welfare of our families and children. We are committed to the vision that all children have the support they need to be happy, healthy, and successful. Prior to this project, this group had intersected on a number of projects involving children’s welfare and success. When Illinois Children’s Healthcare Foundation announced the Children’s Mental Health Initiative in 2009, we already had a strong foundation to pursue this funding to develop a system of care.

The MOSAIC project was founded on the following premises:

- 1. It is personal.** We have to support a system of care that meets that child and family at their doorstep, at the right time, and in the right manner.
- 2. We need to show up.** An absent system of care is no system of care. So, for that child or family that struggles in isolation, we have failed them.
- 3. We need to confront social justice and social determinants of health issues,** such as safety, housing, employment, and cultural sensitivity because they directly impact children’s mental health, and they cannot be untangled.
- 4. A child and the child’s family need us to work together** around their particular issues. The more we can work in tandem and unity, the more successful a child will be. Therefore, we have to focus on building and gluing the mosaic of care by embedding, co-training, networking, and coordinating all of our efforts—healthcare, social services, education, afterschool, and natural supports. At best, working in isolation from each other does no harm, and, for simple cases and issues, is no big deal. At worst, it is iatrogenic for an at-risk child or a child with complex issues—we have done more harm than good by working in isolation from and, often, in conflict with each other.
- 5. The people who are important in a child’s life, whether that be a parent, family member, teacher, physician, or other support person, need access to and the support of a good system of care.**
We need to make it easier for them to do a good job. We need to make sure that they have the right tools, training, support, and connections.

HISTORICAL PERSPECTIVE

The city of Springfield began laying the foundation for The Children’s MOSAIC Project two years before the Illinois Children’s Healthcare Foundation announced its Children’s Mental Health Initiative (see the timeline in Appendix A). The various initiatives described below were seeking to improve the lives of children and families in Springfield. All of the initiatives involved overlapping organizations, representing multiple sectors—education, health care, mental health care, social services, city and county government, business, and philanthropy. More importantly, these initiatives involved many of the same individuals who began to get to know each other and became the “connectors” between different systems of care.

Continuum of Learning

In March 2008, Springfield and Sangamon County launched the Continuum of Learning, an initiative co-founded by the United Way of Central Illinois, Sangamon County Community Foundation (now the Community Foundation for the Land of Lincoln), and The Greater Springfield Chamber of Commerce. The purpose of the Continuum of Learning is to ensure that all who live in Sangamon County are Ready to Learn, Ready to Work, and Ready to Succeed. Over the years, this community collaboration can be credited with several spin-off initiatives. For example, the Continuum spearheaded the Ready to Learn Kindergarten Readiness Initiative in 2009. Ready to Learn's accomplishments include adopting a universal developmental screening tool for all children in Sangamon County, conducting annual screenings, and collecting and reporting Kindergarten readiness data.

In 2015, through the efforts of the Center for State Policy and Leadership at the University of Illinois at Springfield, the Continuum of Learning released the Sangamon Success report, a set of 25 recommendations for local evidence-based programs to improve education outcomes for less-advantaged youth in Sangamon County. The report profiled The Children's MOSAIC Project as a model program for developing children's social-emotional skills.

In 2017, the Continuum launched its Community Partners Network, a group of service providers and community members who serve as a sounding board and meet quarterly to provide feedback on the Continuum's strategic direction.

Children's Healthcare Partnership

In 2008, Brian Allen, then President of Mental Health Centers of Central Illinois (MHCCI, now d/b/a Memorial Behavioral Health), wrote a white paper outlining the many disparities that central Illinois children and families faced with regard to accessing mental health and developmental disabilities services. In response to the needs described above, MHCCI, The Hope Institute for Children and Families, and Southern Illinois University (SIU) School of Medicine Department of Psychiatry–Division of Child Psychiatry formed the Children's Healthcare Partnership. The common goal was to expand and unify essential healthcare under one roof for children with developmental disabilities or mental illness, regardless of their ability to pay for services.

The Partnership accomplished a significant milestone when Noll Medical Pavilion opened in June 2008 with MHCCI's Children Center, SIU Child Psychiatry, The Autism Program of Illinois, and The Hope Institute co-located at the facility. SIU School of Medicine Department of Family and Community Medicine later joined the Children's Healthcare Partnership and opened a primary care clinic at Noll in 2010.



Noll Medical Pavilion, 5220 South Sixth Street Road, Springfield

On behalf of the Children’s Healthcare Partnership, MHCCI submitted an application in August 2008 to the Illinois Children’s Healthcare Foundation (ILCHF) for a planning grant and received \$50,000 to conduct Phase 1 (Planning for Quality) and Phase 2 (Building a Learning Culture) by December 2009. The primary goal of the planning project was to develop two interdependent models: (1) integrate behavioral health-care within SIU Family and Community Medicine clinics, and (2) develop a model Medical Home located at Noll Medical Pavilion for children and adolescents, to include primary care, mental health, rehabilitative care, psychiatric, dental, and vision services, coupled with integrated clinical care management. The two models complemented one another, and, therefore, needed to be developed and implemented concurrently.

As a result of the ILCHF-funded planning grant, the Children’s Healthcare Partnership worked to pass legislation that amends the Illinois Public Aid Code. Public Act 096-0691 created a pilot program in Sangamon County that supports cost-based reimbursement, making it feasible to establish an integrated system of care at Noll Medical Pavilion. In the interim, SIU School of Medicine had begun the process of submitting an application for status as a Federally Qualified Health Center look-alike.

The primary purpose of the partnership was to establish a medical home and center of treatment excellence for children with mental illness and developmental disabilities. This collaboration eventually dissolved; however, the activities of the Children’s Healthcare Partnership proved to be an important, if not necessary, precursor for MOSAIC.

Leadership transition at MHCCI



Shortly after MHCCI submitted the initial planning grant proposal to ILCHF on behalf of the Children’s Healthcare Partnership, Jan Gambach, *pictured at left*, transitioned to the role of the agency’s President. Under her leadership and collaborative spirit, MHCCI immediately broadened its outreach to other organizations that shared common goals related to serving children and families in Springfield, including schools, social service providers, businesses, city government, and local funders.

U.S. Department of Education—Safe Schools Healthy Students

Within Gambach’s first year in leadership, Springfield Public School District 186 formed a steering committee to explore the Safe Schools Healthy Students (SSHS) initiative and develop the infrastructure to support the District’s application to the U.S. Department of Education when the next round of funding became available. The SSHS Steering Committee included leaders from the Illinois Department of Human Services—Division of Mental Health, District 186, City of Springfield, United Way of Central Illinois, the Community Foundation for the Land of Lincoln, and social service agencies, including MHCCI. Unfortunately, the federal program was suspended before District 186 secured funding.

The District’s plan to implement SSHS was intended to build upon existing supports available for children enrolled in Springfield Public Schools and their families. Examples of existing programs include Family and Community Involvement Teams, Social and Emotional Learning, Positive Behavioral Interventions and Supports, and Response to Intervention. This initial SSHS partnership produced several community initiatives and formed the foundation we needed to create a mental health system of care.

Promise Neighborhood

Coinciding with the community’s efforts to integrate children’s mental health services with primary care and public education, the Continuum of Learning was exploring how the highly-acclaimed Promise Neighborhood model could support vulnerable children and families in Springfield. The Continuum of Learning organized a delegation of ten Springfield leaders to attend the Harlem Children’s Zone conference in New York City in November 2009. The conference inspired the team to return to Springfield and collaborate to support children and families.

The Continuum of Learning partners (Community Foundation, Chamber of Commerce, and United Way) immediately formed a team to prepare and submit a proposal in June 2010 to the U.S. Department of Education to establish the East Springfield Promise Neighborhood, later renamed the Neighborhood of Hope (see Section 1.1). Other team members represented The Springfield Project, Springfield Public Schools, MHCCI, the local Urban League and Boys and Girls Clubs affiliates, and Illinois Department of Public Health–Center for Minority Health Services. Although Springfield’s proposal for a federal Promise Neighborhood planning grant was not funded, the MOSAIC planning team blended the underlying principles of the Promise Neighborhood model with the principles of integrated mental health care model.

Federally Qualified Health Center (FQHC)

SIU School of Medicine–Center for Family Medicine (SIU-CFM) was one of the founding members of the Children’s Healthcare Partnership and was involved in a number of the above coalitions. Dr. Albers, Medical Director of SIU-CFM, had been an active member of a number of groups focusing on the health and welfare of children. She is now the chair of the Department of Family and Community Medicine. Dr. Albers, Dr. Kevin Dorsey (former Dean of SIU School of Medicine), and Dr. Jerry Kruse (current Dean) are national leaders in community health. Dr. Dorsey also is a strong champion of including social determinants of health in family and children’s health and served on the Board of the Illinois Children’s Healthcare Foundation.

The leadership at SIU School of Medicine quickly realized that the Federally Qualified Health Center (FQHC) structure would provide SIU-CFM with additional resources needed to provide health and supportive services to children and families. Therefore, they began the application process for their own FQHC status in 2010 and convened the first FQHC Board in July 2012. Gambach and others involved in the various children’s initiatives served on the first board with Dr. Gerald Suchomski serving as the first Board chair. SIU School of Medicine is one of the few schools of medicine that also have a FQHC. This status provides children and families with better access to primary care and early screening for behavioral health issues. It was only fitting that SIU-CFM agreed to be MOSAIC’s first primary care partner by providing social and emotional screening for all children presenting for services at the SIU-CFM clinic. They also were the first primary care site to embed mental health therapists, who worked with the primary care teams, to provide early behavioral health intervention. SIU-CFM is a strong leader in Springfield, addressing the social determinants of health, unmet behavioral health needs, and health care integration. Under Administrative Director Iris Wesley’s leadership, SIU-CFM continues to grow and expand to other communities and into the behavioral health field. Demonstrating its support of SIU-CFM’s growth, Memorial Health System funded the expansion of the clinic, doubling the original space as shown in the picture below.



SIU-Center for Family Medicine, 520 North Fourth Street, Springfield

Children's Mental Health Initiative

A few months after the Safe Schools Healthy Students Steering Committee began meeting, ILCHF announced the availability of funding for the Children's Mental Health Initiative. Communities across Illinois were invited to submit collaborative grant applications for a 13-month planning phase, beginning June 2010, to explore the feasibility of creating a mental health system of care for children. Springfield was ready.

MHCCI led a community-wide effort to develop and submit a proposal to the Illinois Children's Healthcare Foundation in December 2009 to establish a mental health system of care for Springfield children. As described in detail later, the team that developed Springfield's CMHI planning proposal included the Children's Healthcare Partnership, the Continuum of Learning, and the Safe Schools Healthy Students Steering Committee, all of which led significant initiatives discussed in this section.

Convergence

No one orchestrated the convergence of the various initiatives described above. The process occurred, for the most part, because like-minded individuals, representing a range of child-serving organizations, acknowledged that they could more effectively impact the health, happiness, and success of children and families by consolidating their efforts. As a result of these countless conversations and planning efforts spanning two years in multiple settings focusing on similar but separate initiatives, the time was ripe for transformation.

As the lead agency in Springfield's application for the initial CMHI planning grant, MHCCI received \$300,000 from ILCHF to broaden the concept of establishing a children's medical home at Noll Medical Pavilion to create a comprehensive mental health system of care for children in Springfield across multiple domains.

Progress to date

The Children's MOSAIC Project continues to evolve and intersect with other initiatives involving children's academic, social, emotional, and physical health. From its inception, the MOSAIC model was designed to expand gradually, beginning where the need is greatest and extending its reach one school, one primary care office, and one neighborhood at a time until all Springfield youth are connected to the mental health system of care.

We see many signs that indicate the system of care is becoming institutionalized and that the community will sustain the MOSAIC model for the long term. For instance, the MOSAIC Moms program, a collaborative initiative that stemmed from MOSAIC's focus on infant mental health, expanded neighborhood- and home-based services for families (see Section 4.1). MOSAIC inspired a group of local philanthropists to shift their focus to support mental health and wellness among Springfield's women and girls (see Section 11.3). And, perhaps, the best example of how MOSAIC has been assimilated is that two of Springfield's largest primary care practices now employ their own behavioral health therapists to provide integrated care in their physicians' offices. Furthermore, our primary care partners have expanded universal screening to include adult patients. SIU Center for Family Medicine also implements the MOSAIC model in their rural clinics outside of Springfield.

Word of MOSAIC's impact is spreading among educators. And so, MOSAIC's school-based component continues to expand, one school at a time, within Springfield and beyond (see Appendix B). MOSAIC currently embeds mental health clinicians in 11 Springfield schools, as well as in four schools in Lincoln, Tri-City, and Jacksonville school districts—a total current reach of 5,000 students. In addition to expanding its reach beyond Springfield's city limits, MOSAIC also inspired a related initiative that impacts area residents: Mental Health First Aid (see Section 4.10).



To date, MOSAIC partners have conducted approximately 40,000 universal mental health screenings, about 7% of which indicated a need for further assessment. The majority (83%) of the positive screens were for school-age youth, ages 6 and older; 17% for children, ages 0-5. About one of every five (21%) positive screens resulted in a referral for on-site therapy or other treatment.

NOTE: These figures represent available data for documented activities. We estimate that MOSAIC's impact is considerably higher. See Section 12 for a discussion of the challenges related to data collection.

1.0. Planning

Upon notification of funding for the planning phase, MHCCI's planning team engaged in several activities to build the case for its application to ILCHF to implement The Children's MOSAIC Project. The executive planning team included executive-level leaders from the following organizations: City of Springfield—Office of the Mayor; Community Foundation for the Land of Lincoln—Continuum of Learning; MHCCI; SIU School of Medicine—Center for Family Medicine; Springfield Public Schools; Springfield Urban League—Head Start/Early Head Start; The Springfield Project; United Way of Central Illinois; and University of Illinois at Springfield—Center for State Policy & Leadership.

During the planning phase, the team identified, and MHCCI hired, Melissa Stalets to serve as the MOSAIC Project Director (see timeline in Appendix A). The Springfield Project convened over a four-month period a series of focus groups with local church members, youth, and local and state youth-serving organizations. MHCCI also conducted a series of key informant interviews and follow-up conversations with representatives of 30 stakeholder organizations.

The purpose of the group discussions and one-on-one interviews was to identify services available for children, assess the community's strengths and weaknesses with regard to service delivery, and determine each organization's interest in participating in the project. From these conversations emerged several common themes that subsequently shaped the system of care. The planning team also compiled available data to describe the need for children's mental health services in Springfield and conducted a comprehensive environmental scan to identify and assess the scope of community services available to Springfield children.

Our research confirmed what we already knew—the city of Springfield presented a rich environment of comprehensive mental health services for children and adolescents, as well as many networks formed around common goals and attributes. Their full potential to impact the lives of Springfield's youth, however, would not be realized until the various networks became interconnected through a central hub—the system of care. Thus, the planning team developed and submitted a proposal to ILCHF to implement the Children's MOSAIC (Providing Meaningful Opportunities for Success and Achievement through Service Integration for Children) Project.

1.1. Planning phase

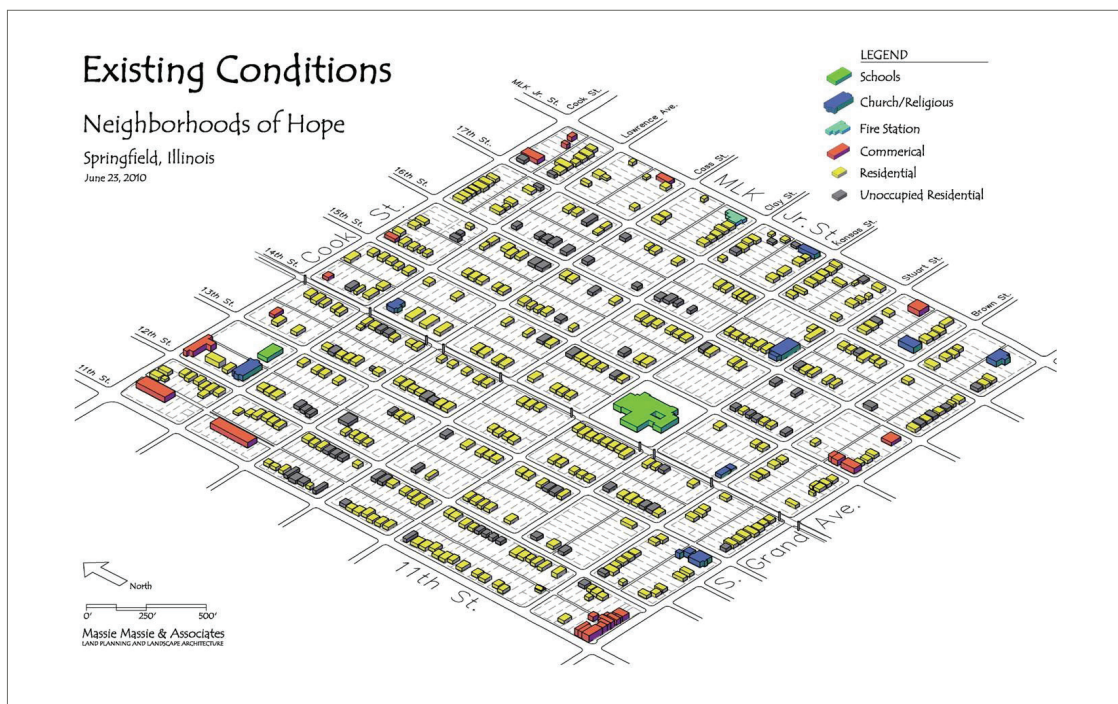
The first step during the planning phase was to identify and engage the initial neighborhood to target. The Community Team (see Section 2) was tasked with determining which neighborhood to select for the initial implementation. The team used two strategies to gather information to inform their recommendation:

- Map out and understand the risk factors present in neighborhoods with the goal of choosing a neighborhood with a high concentration of risk factors. Examples include the following: a high childhood poverty rate; prevalence of single-parent households; poor academic achievement; and high rates of

truancy, crime rates, youth violence, juvenile delinquency, alternative school referrals, teen pregnancy, and unemployment. Neighborhoods with these characteristics contain the children who are most at-risk of developing mental, emotional, and behavioral problems during their lifetimes.

- Identify assets in the neighborhood, administer neighborhood surveys, and conduct focus groups with families in the target area to determine strengths, concerns, and preferences. These activities introduced the concept of the Children’s MOSAIC Project to the residents of the neighborhood, identified and galvanized natural neighborhood champions, and determined the assets and commitment of the neighborhood.

The Community Team selected Springfield’s Neighborhood of Hope, the focus of the unsuccessful Promise Neighborhood planning grant. Situated within the boundaries of Springfield Public School District 186, this 49-square-block neighborhood (pictured below) consists of approximately 200 households with children under the age of 18. Due to poverty, elevated levels of violence, and other social factors, all of the children in the Neighborhood of Hope are potentially at risk for developing emotional and behavioral disturbances. Consistent with our deliberate and intense incremental approach to expansion, MOSAIC targeted one quadrant of the Neighborhood of Hope (about 50 households) in Year 1. Our goal was to expand our reach one quadrant at a time until we were serving the entire Neighborhood of Hope.



One of the anchors in the selected neighborhood was the Capital College Preparatory Academy, a middle school that incorporated a number of innovative, educational approaches, such as equipping every student with a notebook computer (one of the first schools in the region to do so) and teaching students in gender-specific groups. The school was an ideal location to offer MOSAIC’s services.

In addition to selecting this neighborhood based on social determinants for health, our rationale also included the opportunity to capitalize on our partnership with The Springfield Project (TSP), which had extensive experience with economic development and neighborhood stabilization in at-risk sections of our community. Furthermore, TSP had demonstrated success with engaging the difficult-to-reach population in the Neighborhood of Hope. TSP Executive Director Tim Rowles posited that MOSAIC and TSP could be the perfect marriage between economic and social development: TSP would continue its efforts to stabilize and revitalize the neighborhood, and the MOSAIC Project would engage the neighborhood to build a system of care specific to the needs and desires of neighborhood families.

The second step of the planning phase involved forming the mosaic of existing programs to address the spectrum of mental health interventions across the natural settings of care, including the home, neighborhood, school, and health care office. The Community Team used some of the same tools mentioned above, as well as Communities that Care, Reflective Listening Groups, and Learning Communities models. We envisioned that the MOSAIC Project Director, much like a service coordinator in a medical home, would act as the super service coordinator for the neighborhood and mental health system of care. The Project Director would need to have knowledge of the array of existing evidence-based approaches that are sufficient as-is or need to be enhanced, as well as a sense of strategies that need to be developed within the community.

The third step identified the gaps in the system of care and outlined appropriate responses and approaches to address those gaps (see Appendix C).

As the culmination of the planning phase, we developed and submitted an implementation plan to the Illinois Children's Healthcare Foundation. In August 2011, ILCHF announced that it had selected Springfield as one of four communities to receive \$2,000,000 to implement the proposed mental health system of care.

1.2. Vision

Springfield needs a mental health system of care that meets the needs of children and families at their doorstep, at the right time, in the right amount, and with the right kind of support.

JAN GAMBACH, *President, Memorial Behavioral Health*

As described previously, the Children's MOSAIC Project was created from a confluence of circumstances, will, determination, and a spirit of collaboration among key stakeholders. They imagined the possibility of a community-wide system of care in which families could access mental health services for their children in the places where they live, play, and attend school. As MHCCI conducted the key information interviews (described above), excitement began to build, and, one by one, organizations began expressing their desire to join the effort.

One of the premises of the Children's MOSAIC Project is that individual organizations and programs working in isolation cannot provide the maximum long-term impact necessary for the healthy development of our children and youth. We anticipated that the common desire to develop a seamless system of care through the Children's MOSAIC Project would unite people and organizations that contribute to the healthy development of children and youth. Rather than create new structures and services for the sole purpose of change, MOSAIC was designed to leverage existing resources and adapt them to transform the system. Part of this process involved removing the silos of service delivery through planned integration, cross-training, and structured communication.

Another premise is that when a family is unaware of or does not access available resources, the system of care has failed that family. Therefore, children and families must be considered as essential community partners—reaching out to support themselves and each other, neighborhood by neighborhood.

The preliminary plan was to develop a mental health system of care that applied the principles of the Promise Neighborhood model, which incorporates aspects of assertive community treatment, the recovery model, and the medical home for the neighborhood by service coordination, outreach workers, utilizing natural supports, and bringing services to the neighborhood. It focuses on assets—not deficits—and applies a “nothing about us, without us” approach. We anticipated that the Promise Neighborhood model would increase early referral to services for children at risk for mental illness and coordinate mental health promotion activities. Furthermore, we envisioned that a person-centered approach to service delivery would disrupt the status quo and become the norm rather than the exception.

During the planning phase, the project's mission statement crystallized. As stated in the implementation plan, the mission of the Children's MOSAIC Project is to braid resources together to cultivate the social and emotional health of children and families in the Springfield community.

1.3. Goals

The Children's MOSAIC Project has brought early identification and intervention for social and emotional development needs to the forefront of so much of our work with students. We're seeing powerful collaborations between school and community mental health providers so that we are functioning more and more as one team serving children and families. This is where successes in helping connect services to needs are really happening. Teachers and administrators whom I encounter every day know of The MOSAIC Project and want to be part of it.

CYNTHIA KNIGHT, *Former Supervisor of Student Support Services, Springfield Public Schools*

MOSAIC's overall goals are to:

- Implement the Screening, Assessment, Referral and, Treatment (SART) model for all children living within Springfield Public Schools boundaries;
- Build the community's capacity to offer all services/supports that children need to develop to their fullest potential; and
- Enhance and expand interagency communication and collaboration.

2.0. Governance structure: decision-making and oversight at the system level

As we have been working on developing stronger coalitions with our community partners, building trust has been an important factor in our budding relationships. Just the process of collaborating on co-sponsored grants is an act of trust—there is no guarantee of a pay-off and, for a true partnership to emerge, narrow interests must give way to the greater good . . . Partnerships involve recognizing the "truth" of each partner's business and self-interest and merging it together to build a better future for the people we serve. Partnerships take trust and a shared belief in a new reality.

JAN GAMBACH, *President, Memorial Behavioral Health*

As lead applicant representing MOSAIC's initial stakeholders, Mental Health Centers of Central Illinois (MHCCI, now d/b/a Memorial Behavioral Health) convened the initial Community Team meeting to determine the direction for the proposed project. From those conversations emerged a tripartite leadership structure for a system of care that incorporated the work of three established collaborative community networks: the Children's Healthcare Partnership, the Continuum of Learning, and the Safe Schools Healthy Students Steering Committee. This structure was intended to facilitate a smooth and coordinated implementation process until such a time when the mental health system of care became self-sustaining and operations became absorbed into the broader system of care.

To formalize the leadership structure of the Children's MOSAIC Project, the ten organizations that form The Children's Healthcare Partnership, the Continuum of Learning, and the Safe Schools—Healthy Students Steering Committee, made a commitment to actively participate on the MOSAIC Community Team (see Appendix D). The Community Team acts as an advisory council, guiding the planning, implementation,

and monitoring phases of the Children’s MOSAIC Project. Initially, they met monthly but later transitioned to quarterly. Over the years, several organizations have joined the MOSAIC; others have diminished their involvement.

In addition to the Community Team, the organizational structure as originally proposed included the following entities: workgroups for schools, primary care, neighborhood, and human resources/professional development; issue-specific, ad hoc committees, as needed; a neighborhood advisory board; and an Executive Team to act as a steering committee.

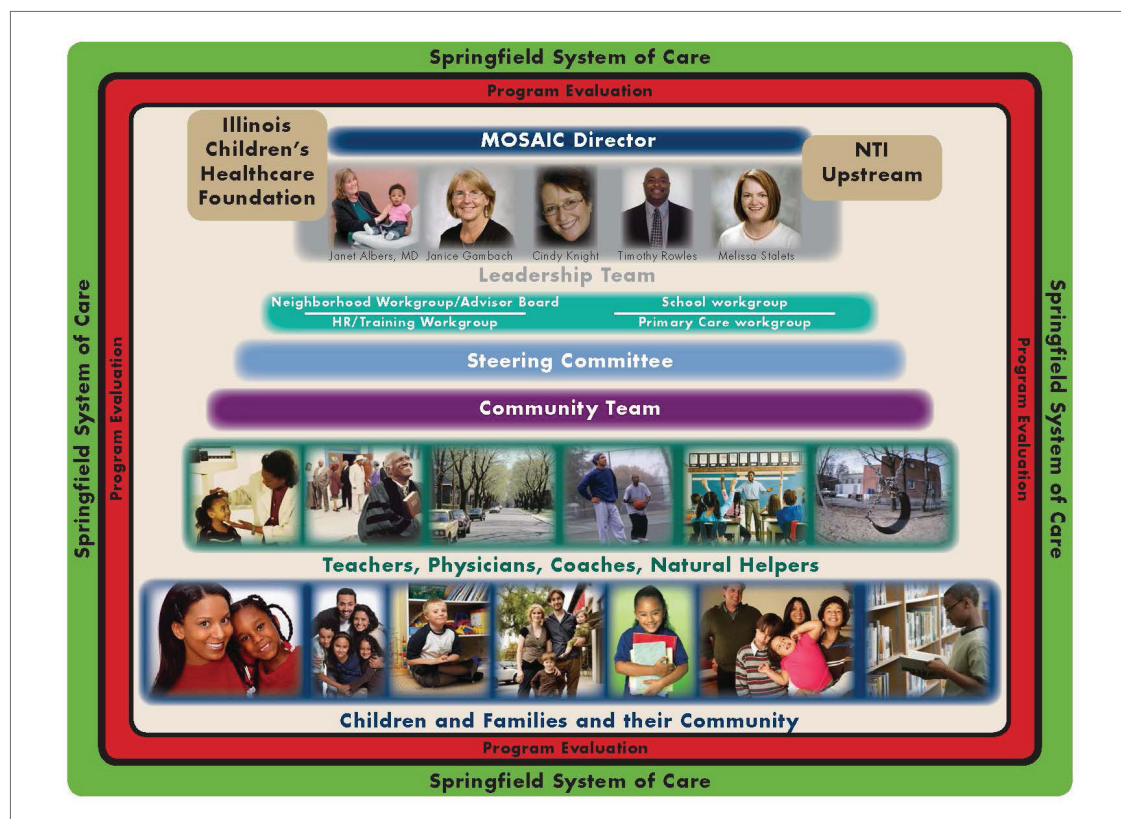
CORE LEADERSHIP: EXECUTIVE TEAM

The original Executive Team consisted of representatives from SIU School of Medicine–Center for Family Medicine; Springfield Public Schools; The Community Foundation for the Land of Lincoln; University of Illinois–Center for State Policy and Leadership; and The Springfield Project. During the planning year, the Executive Team members met frequently—often weekly—to maintain the project’s momentum, ensure regular communication, prevent potential burn-out due to perceived isolation, and develop consistent messaging to differentiate MOSAIC from other efforts. In Implementation Years 1, 2, and 3, the Executive Team met monthly to provide overall project guidance, serve as champions for MOSAIC in the community, and facilitate communication with stakeholders. By Year 4, the Executive Team’s role had evolved and is now an effective avenue for planning and overall program guidance. They continue to meet monthly.

A testament to the commitment of MOSAIC’s founders—and the longevity of leadership among the various organizations represented—all but two of the original members of the Executive Team continue to serve in that capacity. In both cases, the members left the positions at their corresponding organizations; their replacements joined the Executive Team in their stead.

DECISION-MAKING PROCESS

The graphic below illustrates MOSAIC’s governance structure. The Steering and Community Teams merged over the years as the focus shifted from implementation to sustainability.



From MOSAIC's inception, its organizational structure has supported a **bottom-up approach** to facilitate decision-making at the workgroup level by the individuals responsible for implementing the program in their respective settings (primary care, school, or neighborhood). While buy-in at the top levels is necessary, it is not sufficient when developing a system of care. Buy-in among the direct service providers, however, is crucial. Without their support, the system of care will disintegrate. But with their support, the system of care will become institutionalized and self-sustaining.

As originally conceived, members of each workgroup would meet to discuss implementation in their setting, and the workgroup facilitators would present their recommendations to the Community Team for review and discussion. Rather than forming one workgroup for school settings and one workgroup for primary care settings, we found we had to plan with each site as there were differences in culture, process, and partners. For instance, MBH President Gambach and MOSAIC Director Stalets met separately with MOSAIC's champions in each of the primary care practices, rather than convene a group with representatives from each practice. The conversations needed to be site-specific. Likewise, as MOSAIC prepared to expand to a new school, Stalets—and later on, Project Manager Sweet—met with MOSAIC's champions in the school district, as well as the principal of the prospective school. The Director/Manager then presented the plans to the Community Team.

At each prospective MOSAIC site, we intentionally cultivated relationships with individuals who had the authority to act on behalf of their respective organizations. Such organic leadership has proven to be an efficient and effective approach to decision-making. We have found it unnecessary to appoint official leadership positions, and we have avoided inevitable delays related to seeking authorization from partner organizations.

Although the workgroup structure evolved, the spirit of the bottom-up approach remained—the persons closest to the work made decisions and moved the process along without unnecessary delays related to committee meetings and prolonged discussion. Yet, the process still kept the Community Team informed, providing them with an opportunity to question and influence decisions as appropriate.

From the beginning, we also sought to **build consensus**. This approach to decision-making typically takes more time than other approaches (e.g., Robert's Rules of Order); however, it is a more appropriate strategy for collaborative initiatives. Once the Executive Team reached consensus on MOSAIC's purpose, tensions among seemingly competing entities dissolved. The leadership—including the Springfield Public Schools Superintendent—understood that MOSAIC would add school sites based on student and family need and site readiness. The Team developed a framework to guide implementing MOSAIC in the schools (see Appendix E), and the leadership conveyed this process to their respective staff members and constituents.

By the beginning of Year 4, the governance structure included only the Executive Team and the Community Team (see organizational chart in Appendix G). The decision-making process remained informal, applying a bottom-up approach, relying on organic leadership, and building consensus. As schools and primary care practices joined MOSAIC, the Director/Manager engaged the leaders at each prospective site to guide implementation decisions.

Along the way, we discovered that the bottom-up approach generated concerns about fairness. For example, some stakeholders questioned why we selected some schools for MOSAIC services but not others. We acknowledge our choices may not seem fair; however, we deliberately offered services on a limited basis, focusing our resources on the schools with the greatest need, the necessary infrastructure, and sufficient buy-in. To manage expectations, we frequently and intentionally communicated our rationale, formally in team meetings as well as informally in discussions with individual stakeholders. Over time, as we experienced success, we gradually broadened our reach—serving more children, more families, more schools, more neighborhoods, and more primary care offices—moving closer to our goal of serving

all children and families in Springfield. Another concern about the bottom-up approach is that it takes longer to implement. For example, after seven years, only one-third of Springfield's public schools are MOSAIC sites.

As we built the system of care, we struggled to balance the activities that ILCHF funding supported (screen, assess, refer, and treat) with the activities that the federal definition of system of care includes (connect the broad array of services around a child and family). Ultimately, we designed a system of care based on what we thought would work locally.

ROLE OF PARENTS IN THE BOTTOM-UP APPROACH

Although parents did not have a role in MOSAIC's governing structure, they helped guide our process, not just in the planning years, but throughout implementation and into the monitoring and evaluation phase. Beginning with the focus groups during the planning phase and continuing to present day, listening to and learning from parents about how we can "meet them where they are" remains an essential component of MOSAIC's bottom-up approach.

In terms of service delivery, MOSAIC is much more flexible than MBH's outpatient programs because families have discussed the barriers to care, and we do our best to overcome those barriers. We adhere to a person-centered treatment planning process. Examples include offering services at times that accommodate parents' work schedules and in alternative settings (home- or community-based) when the school building is not available.

3.0. System management: day-to-day decision-making

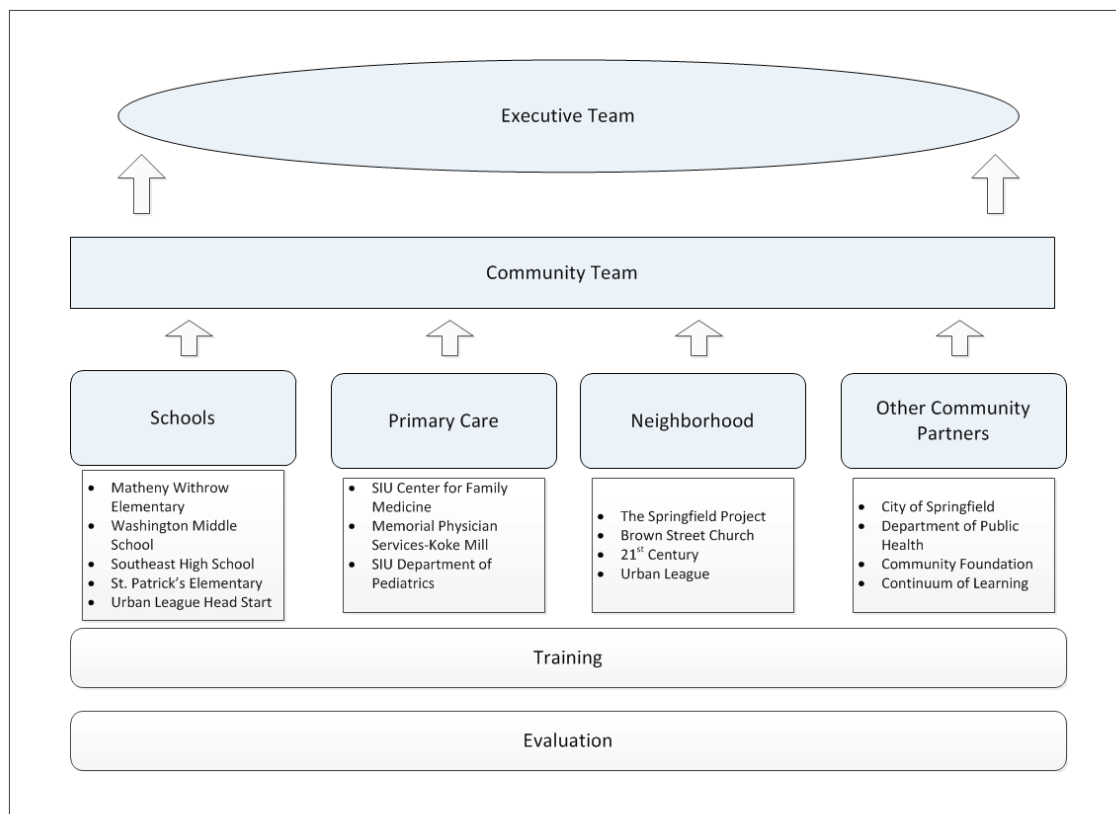


From the beginning, Project Director Melissa Stalets, *pictured at left*, was responsible for managing MOSAIC's day-to-day operations. Year 1 responsibilities primarily included cultivating interest in and commitment to MOSAIC and planning for future expansion. Other responsibilities included researching evidence-based models for the team to consider, cultivating relationships, monitoring existing sites, planning meetings, developing agendas, presenting the MOSAIC concept to community groups, preparing/monitoring budgets and contracts, supervising staff in multiple off-site locations (see Appendix F), and compiling/submitting program reports. We discovered that some tasks assigned to the Project Director were quite labor intensive. For example, adding a school to the MOSAIC model takes three to six months of planning and preparation with school personnel before they begin implementing MOSAIC services.

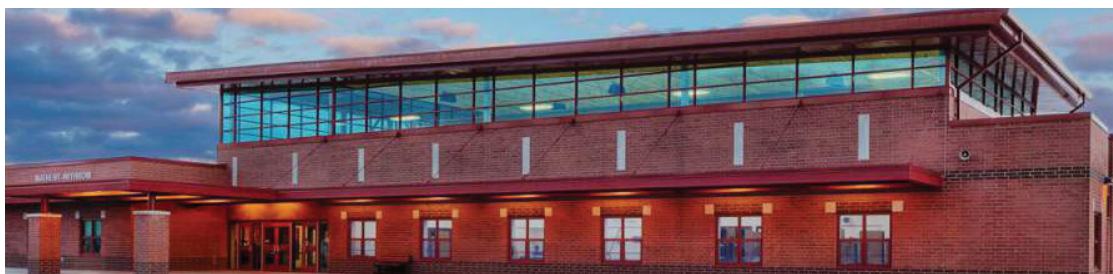


In Year 3, MOSAIC went through a leadership change when Stalets became the Director of Quality for Memorial Behavioral Health, and we hired Heather Sweet, *pictured at left*, to lead MOSAIC. Stalets mentored and supported Sweet during the transition. An organizational chart depicting MOSAIC's overall structure and two charts that depict the changes in the leadership structure are included in Appendices H and I. As of December 31, 2017, the project period funded by ILCHF ended. MOSAIC will continue as a program within MBH-Springfield Children's Center.

Over the course of the project period, the day-to-day decision-making process has evolved into a more defined system of care. The following section describes the decision-making process in each of MOSAIC's settings—schools, primary care, and the neighborhood. On the following page is another chart that illustrates MOSAIC's day-to-day decision-making model.



Schools. The school workgroup consists of the MOSAIC Project Director and two individuals within Springfield Public Schools—the Director of Student Support Services and Special Education and the Supervisor of Student Support Services. At first, adding a school to the MOSAIC network required intensive involvement from the MOSAIC Project Director. Over time, the school district leadership took ownership of the process and assumed more of the responsibility for onboarding new school sites. Now, when the team identifies a school as a potential MOSAIC site, they work with the school’s principal, social worker, and teachers to implement MOSAIC services. Once a site is established, the school leadership team meets with each school on a regular basis, and they convene quarterly meetings with all of the principals, school social workers, and MOSAIC staff to address system issues.



Matheny-Withrow Elementary, a MOSAIC school since 2012.

Primary care. For the first three years, Stalets supervised the clinicians embedded in the partnering primary care practices. When she transitioned to her new position, her successor, Sweet, was not qualified to supervise the clinical staff; therefore, MBH restructured the lines of supervision (see Section 8).

Today the Manager of MBH, Counseling Associates Amber Olsono, is responsible for the day-to-day supervision, decision-making, and management of MOSAIC’s primary care component. She works closely with the MOSAIC leadership and with the primary care providers to monitor the universal screening and



One of MOSAIC's larger primary care partners is Memorial Health System-Koke Mill Medical Center, 3132 Old Jacksonville Road, Springfield

early intervention services for their pediatric patients. Like schools, each practice has its own leadership and champion. Our goal in the primary care settings is to ensure all of the physicians, advance practice nurses, and their teams are screening and referring, and our MOSAIC clinicians are thoroughly integrated into the practices.

Community. The Community Leadership Team members, which consisted of the MOSAIC Director/Manager and The Springfield Project (TSP) Executive Director Tim Rowles, worked together to implement MOSAIC in community-based settings. TSP is a local nonprofit organization that collaborates with public agencies

and private partners to facilitate community development and revitalization, foster diversity development initiatives, and support community problem-solving efforts. Initially, MOSAIC hired two Community Outreach Workers to engage the residents of the Neighborhood of Hope. When we discovered this structure was not effective, MOSAIC contracted with TSP, which, in turn, subcontracted with Primed for Life to implement MOSAIC services in the community (see Section 4.1—Evolution of Services).

Primed for Life is a local, nonprofit organization that provides youth- and family-focused services and is better-suited to provide culturally sensitive social-emotional services in the Neighborhood of Hope. Activities include monthly parenting groups, youth sessions in afterschool settings, and representing MOSAIC at community events.

4.0. Services

The Children’s MOSAIC Project led to increased mental health screening and treatment for some of our community’s most vulnerable children. Bringing groups from throughout the community together—school, mental health, primary care, public health, government, and community service organizations—and developing a common mission and collaborative effort has led to incredible outcomes for children in Springfield.

JANET R. ALBERS, MD, *Medical Director, SIU Center for Family Medicine*

4.1. Service array

The following table highlights the current service array available to children and families.

Schools	Primary care	Neighborhood
TIER I. UNIVERSAL INTERVENTIONS		
<ul style="list-style-type: none">■ Conduct annual or semi-annual screenings at each MOSAIC school.■ Facilitate group education sessions for parents.	<ul style="list-style-type: none">■ Conduct screenings at every routine office visit.	<ul style="list-style-type: none">■ Conduct screenings at community events.■ Facilitate support groups for pregnant and post-partum mothers.■ Conduct outreach/home visits for early identification, intervention and treatment.
TIER II. TARGETED BRIEF INTERVENTIONS		
<ul style="list-style-type: none">■ Facilitate parent/child groups for early intervention and treatment.■ Participate in Individualized Education Program meetings.■ Refer students to mentoring programs or problem-solving groups.■ Refer families with unmet basic needs.	<ul style="list-style-type: none">■ Provide brief interventions such as stabilization and transitional services.	<ul style="list-style-type: none">■ Offer infant mental health services.■ Offer mental health community support services.■ Facilitate parent/child groups.■ Facilitate youth groups.■ Provide home-based services.■ Refer families with unmet basic needs.
TIER III. INTENSIVE INTERVENTIONS		
<ul style="list-style-type: none">■ Based on the screening and initial assessment results, youth may be referred for individual/family counseling, specialized assessment, and/or psychiatry, among other forms of treatment. With the exception of psychiatry, all services are delivered in the setting in which they were identified.		

NOTE. Across all MOSAIC sites, the designated staff person communicates positive screening results to the parents, provides a triage assessment in the same setting as the screening, develops a treatment plan, provides brief interventions and therapy to children with elevated screens, and provides care coordination.

MOSAIC’s service array also includes the following education and consultation opportunities for practitioners:

- Provide behavioral health consultation for teachers, home visitors, and case managers.
- Facilitate in-service trainings for teachers and staff at each MOSAIC school.
- Train primary care providers in the integrated care model.

EVOLUTION OF SERVICES

As described in Section 1, the individuals who envisioned the Children’s MOSAIC Project carefully and deliberately sought the input of key stakeholders to inform how the system of care would develop. Given the limited resources available, the coalition partners felt it was important to “do it right” from Day 1.

While they could not anticipate how the project would evolve over the past seven years, they understood that the actual implementation might look a little different from the initial plan. Processes and service delivery may, for practical purposes, need to be modified over time. Furthermore, the evaluation may indicate specific changes to be implemented to ensure positive outcomes. The following section describes the evolution of services in each of the three settings.

School services

The two core services—universal screening and embedding mental health therapists in MOSAIC schools to provide further assessment and brief therapy—have remained unchanged over the project period. We have refined the model over time to respond to emerging issues, but MOSAIC’s role in the schools is the same.

The teachers have significant responsibility for the social-emotional screenings that occur once or twice during the school year. The school social worker reviews screening results and refers children with positive screens to the appropriate level of intervention (e.g., PBIS or MOSAIC therapist). Teachers also refer children outside of the screening cycle if they have concerns. Therefore, we educate the teachers to ensure they get consistent screening results and make appropriate referrals. We also work with the parent educators in the schools regarding making referrals for MOSAIC services. Toward the end of the project period, the school workgroup perfected the model of embedding and integrating MBH staff within the schools. In particular, the workgroup improved communications and data sharing, allowing MOSAIC staff access to the school district’s secure email systems, allowing school personnel to schedule child/family appointments on the MOSAIC therapist’s calendar, and creating a shared data collection tool. The school social workers also assumed the responsibility of completing intake paperwork with a family, freeing up the MOSAIC therapist to provide direct services. To increase continuity of care during the summer months when school is not in session, the MOSAIC staff continued to work with their assigned children and families through home visits, a practice not included in the original program design.

Our initial proposal was to staff a Behavior Interventionist position in the schools; however, after a trial period, we discontinued the position. Based on teacher and parent input, the implementation plan for Years 1–3 included staffing a Behavior Interventionist (later called Behavioral Health Specialist) position to provide classroom teachers with intensive coaching and support to address increasingly challenging student behavior in the elementary schools. Springfield Public Schools agreed to create the position with 50% salary support from MOSAIC. Duties included assisting with developing crisis response protocols, providing crisis support to students and school personnel until resolved, conducting classroom observations and behavior analysis, providing in vivo coaching and ongoing support to teachers, and assisting teachers in developing and implementing classroom management plans. The Behavior Interventionist was assigned to one of the initial MOSAIC schools. If outcomes data demonstrated effectiveness, the school district was committed to replicating the position in other buildings in subsequent years.

The position was filled at the beginning of Year 2 but faced some resistance from other school staff who thought the job description lacked defined duties. The lack of assigned responsibilities was, by design, to free up the Interventionist to assist in classrooms, as needed. At the beginning of Year 4, the district assumed full financial responsibility for the position, changing the title to Behavioral Health Specialist, adding structure to the Specialist’s schedule, and increasing explicit duties, while maintaining some flexibility to respond to crises. The intent was for the Specialist to be involved in all public MOSAIC schools, providing overall behavioral health prevention strategies to teachers and staff, complementing the MOSAIC on-site clinician’s work with school personnel regarding classroom behavior management. The individual filling the position in Year 4 had a background in mental health but less experience with classroom behavior management. Despite the modifications to the position, however, the school district was dissatisfied with the situation and decided not to renew the individual’s contract.

District administrators used the following year to further revise the job description, including qualifications. In the fall of Year 6, the district created a full-time hybrid position—50% supported by funding from a School Improvement Grant and 50% by MOSAIC—that integrated the Behavioral Health Specialist with a second MOSAIC on-site clinician assigned to one of the MOSAIC schools. We anticipated the hybrid staffing model would prove beneficial to students and teachers, justifying the district’s investment and the need to seek additional funding to replicate the model in other MOSAIC schools. The Behavioral Health Specialist position was experimental from its inception, so we expected it would take some time for us to determine what would and would not work.

Primary care services

As with the schools, the two core services—universal screening and embedding mental health therapists within the primary care practices—have not changed. In Year 1, we developed and collected resources,



Dr. Janet Albers, SIU Center for Family Medicine

pamphlets, and other educational materials on the new integrated model of care to present to the physician teams and the patients.

Dr. Janet Albers, Director of SIU Family Services, (*pictured left*) was the strongest advocate for an integrated primary behavioral health model. She recruited Dr. Mary Dobbins, board certified in both pediatrics and child and adolescent services to lead the SIU-CFM efforts.

MBH leadership partnered with SIU-CFM leadership, including Iris Wesley, CEO of SIU-CFM, to embed behavioral health specialists. During the project period, Dr. Dobbins became the Director of Integrated Care and worked to implement her vision of integrated care. In Year 6, she modified SIU-CFM’s referral process for behavioral health services to improve efficiencies, namely to address a growing backlog of referrals that produced only a 60% show rate. Going forward, referrals for behavioral health services may be initiated only during a medical appointment. And only those patients who desire further mental health care will be referred for additional services. The on-site MOSAIC clinicians provide brief interventions to patients and answer the staff’s questions. On-site psychiatrists consult with the embedded clinicians to evaluate patients and develop a treatment plan. We anticipate that combining same-day integrated care with on-site traditional behavioral health services will decrease patients’ wait times, lessen the strain on scarce staff resources, and facilitate integrated care.

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Under Dr. Dobbins leadership, SIU-CFM now hires their own therapists. Currently, there is a blended model of ownership with some of the MOSAIC clinicians being hired and embedded by MBH and some being



Dr. Virginia Dolan, Koke Mill pediatrician

hired by SIU-CFM. We continue to expand our relationship with SIU Center for Family Medicine to serve more of their pediatric patients.

Memorial Physician Services (MPS) continues to expand the number of MBH embedded therapists within their practice and improve screening and referral rates and patient outcomes. Dr. Virginia Dolan (*pictured left*) has been the MPS champion of integrated care from the beginning of MOSAIC and is a member of the Steering Committee. She currently leads the integrated care and population



Dr. Bette Ann MacIntosh, MBH Child Psychiatrist at Koke Mill

focused on a lower income neighborhood on the east side of Springfield (see Section 1.1). We hoped to establish a neighborhood-based capacity to screen and treat children. To this end, we hired Neighborhood Outreach Workers to develop relationships with local families and to take responsibility for screening (see Section 4.6).

We anticipated that the Outreach Workers could go door-to-door, building trusting relationships over time. Despite their best efforts, the Outreach Workers encountered substantial barriers to conducting screening in people's homes. We found that parents were not available—due to work schedules and



Nikki Williamson and Marcella Kincaid, MOSAIC's Neighborhood Outreach Workers

other responsibilities—during the hours that the outreach workers tried to engage them at home. We also found that parents were suspicious of the Outreach Workers when they did encounter them, even though we deliberately hired individuals from the community.

The underlying barrier, however, was our inability to address the needs of the adult who answered the door. Our grant-funded mandate was to provide mental health services to children and their families. When the Outreach Worker assessed a family's needs and determined they would benefit from assistance in obtaining food, housing, primary care, transportation—even mental health services for an adult, the Outreach Worker was unable to offer such assistance (see Section 4.3). Even today, we have no options to bill for Medicaid reimbursement for MOSAIC services related to engagement and linkages to community services to meet basic needs. For instance, one of the Outreach Workers encountered four single mothers with eight children living in one house. They were willing to engage in services, just not mental health services.

Although a valid approach to engage families where they live, the door-to-door process did not meet MOSAIC's productivity expectations. Consequently, we decided to shift our focus away from conducting home screenings, and, instead, connected with parents in group settings (see Section 3). To this end, the Outreach Workers conducted educational sessions for parents on a variety of topics relevant to the social-emotional well-being of their children. In addition, Primed for Life (see Section 3) provided training for parents on the subject of parental resilience and related topics.

We revisited the neighborhood outreach model with the Enos Park project, a joint initiative between Memorial Medical Center and St. John's Hospital. The project funded community health workers to activate the community by going door-to-door to assess health needs and link families and individuals with

health initiatives for MPS. During the project period, we added some child psychiatry time to the MOSAIC budget, an extremely popular service. Currently, the psychiatric team consists of one child psychiatric advanced practice nurse and one child psychiatrist, Dr. Bette MacIntosh (pictured left).

Neighborhood services

A key feature of MOSAIC, as initially planned, was to extend its reach gradually toward encompassing the entire geographic area covered by the Springfield school district. The initial plan

focused on a lower income neighborhood on the east side of Springfield (see Section 1.1). We hoped to establish a neighborhood-based capacity to screen and treat children. To this end, we hired Neighborhood Outreach Workers to develop relationships with local families and to take responsibility for screening (see Section 4.6).

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needed health and social services. The Enos Park neighborhood program is showing incredible success, as indicated by the following results: employment increased 64%; healthcare coverage increased 8%; police calls to the neighborhood decreased 22%; income increased 52%; and the rate of school- and community-based screenings and services increased. Another result is that one of the schools located in the Enos Park neighborhood became a MOSAIC site, with the hospitals paying some of the MOSAIC costs. See Lessons Learned for further discussion.

MOSAIC Moms

Because most mothers are the primary caregivers for children, and because mothers with limited social supports—which defines the majority of the MOSAIC population—can have mental health challenges of their own, Memorial Behavioral Health (MBH) sought private funding (see Section 11.3) to establish the MOSAIC Moms program. MBH collaborated with Springfield Public Schools, Family Service Center,



A MOSAIC Moms participant with her daughters.

M.E.R.C.Y. Communities, and Community Connection Point to connect low-income single mothers and their children to critical social and emotional supports. Services included parent/child groups, support groups for pregnant and post-partum women, and home-based mental health services. For example, the MOSAIC Moms therapist facilitated weekly social-emotional support groups to low-income mothers living in transitional housing. The MOSAIC Moms therapist also provided professional consultation to home visitors and case managers who work with this population of mothers. We later expanded the

service to mothers of children enrolled at Springfield Public Schools' Early Learning Center, but the schedule varied widely. All parent/child groups evolved away from the original focus on early intervention to a general focus on parenting and building social-emotional support.

4.2 Provider network

Primary care. In the Springfield area, most pediatricians and primary care providers are located in five major practices: Southern Illinois University School of Medicine (SIU), Memorial Physician Services, Central Counties Health Centers (CCHC), Hospital Sisters Health System (HSHS), and Springfield Clinic. Our strategy was to integrate behavioral health into each practice by uniformly screening for social-emotional issues and providing care coordination and brief office-based interventions.

SIU School of Medicine's Center for Family Medicine and Memorial Physician Services' Pediatrics Department at Koke Mill Medical Associates became early champions of MOSAIC and later expanded their involvement in the number of participating physicians and locations. During the project period, the integrated practices expanded quickly to offer depression and anxiety screening for all patients, youth, and adults alike. SIU's Department of Pediatrics became a MOSAIC partner at the beginning of Year 3 and dropped out in Year 7. Our understanding is the Department of Pediatrics was no longer willing to contract for an embedded behavioral health consultant. They may have hired their own staff person for that role.

In Year 2, we signed a contract with CCHC, one of the Federally-Qualified Health Centers serving Springfield residents, but before the year ended, the CEO was removed and support for MOSAIC evaporated. Today, our understanding is that CCHC prefers to offer integrated services themselves rather than partner with MOSAIC.

Despite multiple attempts, we have been unable to develop partnerships with Springfield Clinic and HSHS. As with CCHC, Springfield Clinic may have a small therapist presence, but we do not believe that either practice has a robust early screening and intervention program for children.

Schools. During the project period, MOSAIC expanded into about one-third of the schools in Springfield School District 186 with continued plans to slowly integrate MOSAIC into remaining schools. In Year 6, MOSAIC expanded beyond the Springfield city limits to the north and east. MBH operates a satellite office in Lincoln (Logan County). In partnership with the Abraham Lincoln Memorial Hospital Foundation, MOSAIC began serving Lincoln Junior High School in District 27. To the east, MOSAIC now serves the elementary and junior high schools in the Tri City School District located in eastern Sangamon County. At the beginning of Year 8—after the project period expired—MOSAIC expanded to the west, serving students at Four Rivers Special Education District’s Garrison School in Jacksonville.

As word continues to spread about MOSAIC’s impact on children and families, our provider network will continue to expand (see Appendix B).

4.3. Meeting basic needs

We discovered that families living in the targeted neighborhood needed help with maintaining housing, accessing food pantries, paying utility bills, among other forms of assistance. The work of our Neighborhood Outreach Workers to meet families’ basic needs, however, was not an allowable expense through the Illinois Children’s Healthcare Foundation grant. Although we thought that providing assistance presented an opportunity to engage families, we did not have sufficient funds from other funding sources to do so. As a result of the funding gap, the Executive Team decided to shift the responsibility of addressing MOSAIC’s neighborhood component to one of our key partners, The Springfield Project. They, in turn, subcontracted with Primed For Life, Inc. (PFL), a social service agency that provides neighborhood outreach within the neighborhoods where MOSAIC services exist. PFL helps families connect with resources outside the scope of MOSAIC’s activities (e.g. rent and utility assistance, food). When school social workers and MOSAIC clinicians identify children and families with unmet needs, they inform PFL staff, who, in turn, refer families for rapid assistance with basic needs.

Most of our efforts in the school and primary care settings focused on the social and emotional needs of the children, not the social determinants of health, primarily because of the ILCHF funding constraints. The social determinants of health are gaining more visibility, however, especially within Memorial Health System. Innovative funding streams need to continue to develop so that families’ essential needs are met, including safe and affordable housing, access to healthy food, and linkage to resources.

4.4. Evidence-based practices

The MOSAIC model incorporates a number of evidence-based practices, a few of which are highlighted below.

Integrated mental health & primary health care involves “a team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.” MOSAIC’s design reinforces the concept of a children’s medical home that the Children’s Healthcare Partnership envisioned years earlier in that mental health clinicians are embedded in pediatricians’ offices. The integrated mental health and primary care model is well researched (<https://www.integration.samhsa.gov/integrated-care-models/APA-APM-Dissemination-Integrated-Care-Report.pdf>).

We implemented two evidence-based models for integrated care: the **Collaborative Care** model and the **IMPACT** model of care. The key to integrated behavioral health treatment in primary care is universal screening of behavioral issues by the primary care team and an embedded therapist who can offer immediate assistance when behavioral issues are present. The primary care team can introduce the

family to the therapist, who may provide further assessment and brief, stepped treatment at that time or schedule a follow-up appointment. The embedded therapist also refers families to traditional services as needed.

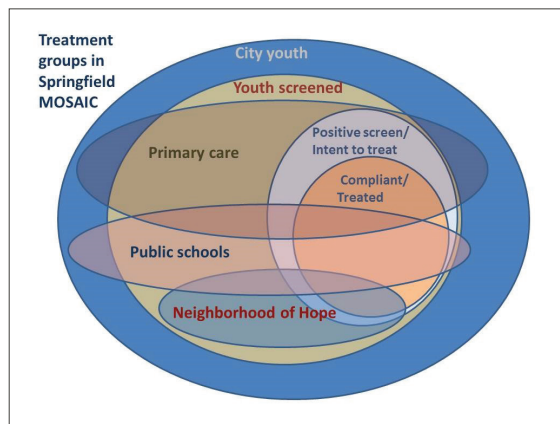
MOSAIC has incorporated this integrated **Screening, Assessment, Referral & Treatment (SART)** approach, identified as the essential components in the Collaborative Care and IMPACT models, with some modifications across all three settings (neighborhood, primary care, and schools). The early identification and intervention services are billable activities (Peek, 2013. Available at: /sites/default/files/Lexicon.pdf]).

Infant mental health is “the developing capacity from birth to three to (1) experience, regulate, and express emotions; (2) form close relationships; and (3) explore the environment and learn.” Prior to MOSAIC, there were no clinicians in the community—outside of Early Intervention and Caregiver Connections—who were trained to provide infant mental health services. Through a Child Parent Psychotherapy learning collaborative with the Erikson Institute and consultation and training provided by the Illinois Children’s Mental Health Partnership, a growing number of clinicians have developed skills in infant mental health and are working with infants and caregivers. Furthermore, MOSAIC partnered with the Illinois Association for Infant Mental Health (ILAIMH) to establish a Central Illinois chapter of ILAIMH. We hired a Licensed Clinical Social Worker in 2013 to provide infant mental health groups at the Sangamon County Department of Public Health, which is based in Springfield. When we launched the MOSAIC Moms program in 2014, we discontinued offering infant mental health groups, as originally structured. Because the MOSAIC Moms program provides another avenue to meet the needs of young children and their caregivers, it is not necessary to duplicate the service through the Children’s MOSAIC Project. In addition, last year our larger collaborative funded a nurse-family partnership through SIU Center for Family Medicine for low-income mothers pregnant with their first baby. SIU-CFM partners with MOSAIC and the other parent support programs.

MBH therapists participated in training on an approach to parent engagement called **Global Engagement**. Developed by Dr. Mary McKay and her colleagues, Global Engagement provides specific strategies to be implemented from the initial telephone call with a parent asking about services, to the first interview with a therapist, and throughout the treatment process to get and keep families actively engaged in treatment. Global Engagement has been shown to reduce barriers to treatment and significantly increase the likelihood that families and children keep their initial and follow-up appointments.

4.5. System access

MOSAIC is designed to meet children and families “where they are” in the community. MOSAIC seeks to transform service delivery from a “pull” system, in which families have to seek services, to a system in which services are readily available. In some cases, MOSAIC uses a “push” system, in which services are offered without the family having to do anything. MOSAIC seeks through universal screening to



address needs and offer assistance proactively before issues become problems that spiral into illnesses and disabilities. Our goal is for children and families to access MOSAIC services through three gateways: schools, primary care offices, and the neighborhood. School social workers notify parents if their children have an elevated screen. The pediatrician and mental health consultant meet with parents when they bring their children for wellness visits. Neighborhood outreach workers engage families in neighborhood settings. In all three cases, parents have

the option to engage in the services recommended for their child in locations that are convenient and acceptable to them. During the project period, we expanded access by offering a confidential online screening tool for depression and anxiety. See <http://screening.mentalhealthscreening.org/CENTRALIL>.

4.6. Screening, assessment and evaluation

MOSAIC was designed to provide universal screenings and early intervention in schools, primary care offices, and neighborhood venues as illustrated in Section 4.5 above. Flowcharts for the primary care and school settings are included in Appendices J and K.

SCHOOLS

Until the last year of the project period, universal screenings were conducted in every MOSAIC school. Beginning in Year 7, Springfield Public Schools implemented a policy requiring all students in every school be screened for social-emotional concerns. Each school scheduled a time, often at the beginning of the academic year, to screen their students. Similar to the decades-old practice of screening for vision and hearing concerns, this approach was much less disruptive to the work flow in the schools than in the primary care offices. Screening all students also reduced the stigma that may prevent families from seeking individual screening. Some schools opted to conduct the screenings twice a year.

During the early years of implementation, parents had the opportunity to complete the screening tool on their child, but it was not required. Very few parents took advantage of this option in the school setting, possibly because it was not heavily promoted or because it required parents to come to the school. If parents did not opt out of the social-emotional screen conducted by school personnel, their children would be screened. As a result of the lack of participation in parent screens, we no longer offer the option in the schools. We have observed that parents are more likely to complete the screen in the doctor's office.

Each participating school initially used the Behavioral and Emotional Screening System to conduct annual universal screenings for all children whose parents did not opt out. The school social worker set up the screening for each classroom teacher to administer to the students via an online platform. The system generated reported, so the social workers could review, the screening results. MOSAIC funded the screen for MOSAIC schools and assisted with the scoring and implementation. When the school district implemented districtwide screening, they adopted a different and more affordable universal screening tool called the *Social, Academic, and Emotional Behavior Risk Screener*.

Although the screening process in the schools was much more efficient than in primary care, the referral mechanisms in the schools were more complex. The school social worker reviewed the results to determine the appropriate level of intervention. If screening results were highly elevated (a score in the clinical range—95th percentile or higher), the social worker contacted the family with the results and, with parental permission and involvement, referred the student to the on-site MOSAIC clinician or the school psychologist. If screening results were elevated, but not within clinical range (80th to 94th percentile), the school social worker and the student's teacher reviewed the child's current supports and determined if additional supports, such as mentoring or problem-solving groups, were warranted. MOSAIC schools used a standardized referral form to improve efficiency and effectiveness in providing students with the services they needed in a timely manner.

In addition to the universal screening, teachers, parents, and children can refer at any time for MOSAIC services. We found that older students encourage their friends to stop in and see the MOSAIC therapist. If a child is experiencing difficulty, a teacher or the principal involved the MOSAIC therapist.

Support for some kind of mental health screening in the schools predates MOSAIC. As part of its school improvement plan, Springfield Public Schools began operating the Positive Behavioral Interventions & Supports program in 2004. MOSAIC's initiative to encourage and support universal screening resulted in systematic implementation of universal screening districtwide.

PRIMARY CARE

Pediatricians and family physicians at participating primary care practices used two screening tools: **Pediatric Symptom Checklist (PSC)** for children, age six and older, and the **Ages & Stages Questionnaire (ASQ)** for children younger than six. Screening occurred on a rolling basis as patients kept appointments. Whereas children attend school daily, they may only see their pediatrician once a year, or, in the case of young children, a few times per year for their regular well child visits. Participating providers must incorporate the social-emotional screening into a busy work flow for collecting data on a wide variety of other patient characteristics.

The primary care providers referred children with a positive screen to the on-site MOSAIC clinician for further assessment. Even in the absence of a positive screen, a doctor may perceive a need and refer the child to the clinician for help. In some cases, depending on the situation presented by a patient, the mental health clinician provided immediate, short-term therapeutic services. In other cases, the clinician scheduled one or more appointments for the child to receive more intense interventions, either in the primary care setting or at MBH-Springfield Children's Center.

As in the schools, support for screening existed to some degree at SIU Center for Family Medicine and Koke Mill Medical Associates before we implemented MOSAIC, but it appears that screening is becoming part of routine care. Results from a physician survey indicate that the on-site clinicians are able to meet with patients on short notice and that the brief interventions they provide have reduced the need for referrals to community-based services. Physicians also report that having an embedded mental health clinician increases the likelihood that patients will engage in treatment.

The Depression Project, which standardizes patient depression screening and follow-up services across Memorial Physician Services (MPS) locations, was piloted in Year 5 at the MOSAIC primary care site at MPS-Koke Mill. The Depression Project ensured yearly depression screenings for patients, ages 11 and older, and outlined referral and treatment recommendations for positive screens based on scoring. The staff used both the adult and adolescent versions of an early identification tool called the Patient Health Questionnaire (PHQ). All MPS MOSAIC primary care sites began using the PHQ the following year, increasing the need for embedded Behavioral Health Consultants at MPS sites that do not have integrated behavioral health, as well as increasing the need for multiple clinicians across primary care sites. This project also activated more of the primary care providers and teams to conduct universal screens and refer patients to the embedded therapists. As a result of The Depression Project, the rates for screening and referrals rose dramatically. In addition, more patients engaged in intervention and, as a result, experienced overall improvement in their depression scores.

NEIGHBORHOOD

The Neighborhood Outreach Workers offered screenings at community events that were held in the target neighborhood, such as health fairs and the Juneteenth celebration. They also went door-to-door, offering to screen children in their homes. They used the PSC and ASQ screening tools, depending on the age of the child, as described in the Primary Care section above. When a child had an elevated screen, the Outreach Workers offered home-based services, including a comprehensive assessment and brief interventions.

STANDARDIZATION

Although screening is becoming institutionalized in both the primary care and school settings in Springfield, we acknowledge there is inconsistency in how it was implemented across all sites. We cannot assume that every professional administering or scoring the screening tools understood it in the same way. For example, as indicated in the 2015 local evaluation report, screening at SIU Center for Family Medicine resulted in low positive rates on the screening tool for children under six years old. Evaluators suggested that physicians may be taking a "wait and see" approach with young children. Exercising their clinical

judgment may affect not only the screening results but also the frequency of service referrals. Young children develop so rapidly during the first five years of life that initial signs of trouble may dissipate. Doctors may be reluctant to refer a child with a positive screen because they think that early difficulties may be transient. We need to implement safeguards to ensure that all providers administer and score the screens in a consistent manner. Springfield Public Schools also noted some scoring discrepancies among teachers who showed disproportionately high or low levels of screening results. Further training and monitoring is necessary to ensure more standardized screening results.

4.7. Decision-making at the service delivery level

Although the screening process was more challenging in the primary care offices than in the schools, the referral process was quite the opposite. Primary care had the ability, upon the determination of a positive screen, to connect a child and the parent immediately with the MOSAIC clinician. The school social worker, however, must first obtain parental consent prior to referring the child for further assessment. This process often caused considerable delays in service delivery. Once parents grant permission for their children to engage in MOSAIC services, the school social worker referred children to the on-site mental health clinician. The parent and child then met with the MOSAIC clinician to begin the assessment and treatment plan process. When a MOSAIC clinician discovered that children and their families needed services that were not available through MOSAIC, the clinician referred them to the appropriate agency in the community. The clinician followed-up with the family later to make sure they successfully connected with the services they needed.

4.8. Care management/coordination

Care coordination began informally with the first contact with parents, typically within the same week as the screen, although, in primary care, the initial contact can be immediate. As is true of other MOSAIC services, the care coordination component varied according to the setting in which children were identified for needing social-emotional support. The on-site mental health clinicians provided care coordination for children and families they served in the primary care settings. The school social worker provided this function for public school students. The Neighborhood Outreach Workers coordinated care as desired by the children and families who live in the targeted neighborhood. As indicated earlier, care coordination, especially around the social determinants of health, was difficult to fund. We were able to leverage traditional fee-for-service Medicaid payments through mental health, which did allow for care coordination for identified clients.

4.9. Crisis management at the service delivery level

Effective crisis management across multiple sites of service delivery required each on-site mental health clinician to remain flexible to changing circumstances, be available to respond quickly, and offer helpful solutions. The MOSAIC model of service delivery did not conform to the traditional model of providing therapy in convenient 50-minute sessions. MOSAIC clinicians must be ready for the unpredictable. As they demonstrated their ability to be flexible, responsive, and helpful, the clinicians built good will among our partners and promoted integrated mental health services.

Screening, Assessment, and Support Services (SASS) was the Medicaid crisis intervention program operated by the State of Illinois. If a child was in crisis, anyone could call the CARES hotline. The CARES staff authorized the intervention and contacted the SASS organization; MBH was the SASS organization for our six-county region. Our SASS team provided crisis intervention and follow-up services in schools, homes, and hospital emergency departments among other settings where a child was in crisis. Medicaid reimbursed us on a fee-for-service basis.

As the MOSAIC model matured, we became more intentional about integrating SASS with MOSAIC services, especially in the school setting. SASS staff were typically bachelors-level clinicians. Since SASS staff were often in the schools already, we paired SASS staff with masters-level clinicians to provide

MOSAIC services. Efforts to integrate SASS included cross-training staff members in both models. Therefore, the SASS staff members were prepared to provide MOSAIC services, such as counseling services for MOSAIC families. Likewise, the MOSAIC staff members, who are Masters-level clinicians, were prepared to conduct the SASS screens and then follow-up with children at their respective MOSAIC schools, offering therapeutic services, as needed. This modification was made for two reasons: the use of SASS fee-for-service structure to sustain the MOSAIC positions and the high turnover among the MOSAIC clinicians. The SASS clinicians were able to continue offering limited behavioral health services in the school setting until the MOSAIC position could be filled. We anticipated that this staffing model will provide more real-time crisis intervention. Currently, if a child is having a psychiatric crisis, the school called the CARES line, and they, in turn, called the SASS agency to send a SASS worker to the child in the school. That whole process took time, with the SASS staff often showing up at the school 20 to 60 minutes later. Having embedded staff, increased efficiencies in that the staff were already on-site at the point of crisis and better able to provide follow-up services to prevent future crises.

4.10. Crisis management at the system level

When a middle-school student committed suicide, the school's Student Support Services office requested assistance. MOSAIC staff provided supportive sessions to students and staff.

MOSAIC also informed other initiatives, such as Mental Health First Aid. In response to the 2015 Community Health Needs Assessments completed by Memorial Health System's four hospitals, Memorial Behavioral Health received funding from the Health System to begin providing Mental Health First Aid (MHFA) training to the community. The decision to initiate MHFA in Springfield grew, in part, from the positive community experience with MOSAIC. MHFA is an internationally known program aimed at giving community members the tools they need to assist people with mental illnesses. As the name implies, MHFA is first aid instruction that focuses on mental illness rather than physical illness or injury. The eight-hour course helped participants identify the signs of mental illness and connected individuals with community resources to help them on the path to recovery. One version of the training was adapted for youth participants. Since September 2016, MHFA-certified instructors trained approximately 800 youth and adults in a four-county region, including Sangamon County. In addition to teaching practical skills that participants can apply in every aspect of their lives, MHFA also gave people a common language to discuss mental health and helped them develop a greater, more compassionate understanding of persons with mental health conditions.

5.0. Workforce recruitment and retention

Recruitment in MOSAIC's early years presented a significant problem, especially for masters-level positions. The time to fill a masters-level position—from posting the vacancy to offering employment—averaged about eight weeks. For the most part, we used traditional recruitment strategies, such as placing ads in the newspaper. Furthermore, the Human Resources Manager was responsible—in addition to his other duties—for screening all applicants by phone and processing their applications.

By Year 6, recruitment for MOSAIC positions became easier and the time to fill positions decreased. For example, we recently filled a masters-level, on-site clinician position in less than four weeks. We identified two reasons for the improvement: (1) MOSAIC became more established and visible in the community, and (2) we aligned our recruitment process with the health system with which we are affiliated, broadening our search strategies and capitalizing on the health system's considerable resources. For example, we now benefit from having a dedicated recruiter who develops a targeted sourcing plan for each MOSAIC vacancy. Our current recruitment strategies include posting and sourcing for both passive and active candidates through radio, television, and social media outlets and occasional print ads, as well as national job boards, as appropriate, and virtual and in-person hiring events. We also offer bonuses for certain positions. We still experience difficulties, however. For instance, in our rural primary care sites, recruiting Licensed Clinical Social Workers is difficult, and positions have remained unfilled for several months at a time.

In the early years, we deliberately used a different approach to recruiting individuals to fill the Neighborhood Outreach Worker positions. We leveraged our partnerships with The Springfield Project and other neighborhood-based organizations to identify strong candidates for vacancies. In order for the Outreach Workers to be effective, they needed credibility among the residents of the neighborhood. Involving residents in the process built trust, but it also slowed the process somewhat. We later discovered that the Outreach Worker positions were not sustainable in terms of billing for mental health services. Furthermore, both individuals resigned in Year 3 to accept positions at another organization in Springfield that offered better salaries. Clearly, we needed to change our approach. Therefore, as discussed in Section 4.3, MOSAIC contracted with The Springfield Project to staff the Outreach Worker positions. In addition, SIU-CFM began to hire community health workers to staff the Enos Park project (see Section 4.1—Evolution of Services).

STAFF RETENTION

Recruitment and retention are interrelated, and staff retention within a community mental health system is a foremost issue. MOSAIC experienced ongoing challenges regarding staff retention, hiring 26 individuals throughout the seven-year project period with six MOSAIC staff continuing beyond the end of the grant funding from ILCHF (see Section 11.5). We essentially had 100% turnover over the course of seven years. A few of the MOSAIC positions became vacant as the result of the employee receiving a promotion within our agency; however, most of the vacancies were due to ordinary turnover.

We have been unable to offer competitive salaries, especially for masters-level therapists embedded in the school setting. The MOSAIC school-based therapist positions are funded solely by medical billing; therefore, therapists must generate a caseload adequate enough to support their salary. The excessive amount of paperwork that State Rule 132 requires for each case, however, limits the number of cases each therapist can support. Springfield Public Schools pays social workers approximately \$20,000 more than MOSAIC pays for similar work. As a result, several of our therapists resigned to accept positions with the school district or primary care practice in which they had been embedded. Others accepted higher paying positions at other agencies. Some therapists opted out completely due to the non-traditional approach, the isolated nature of an embedded position, or the lack of peer support.

6.0. Family involvement at all system levels

SERVICE LEVEL

MOSAIC was designed to engage the family and the community in natural settings, such as the school and the pediatrician's office. Here are some examples:

- The school social worker offered to attend the family's first session with the MOSAIC clinician in order to increase family members' comfort level.
- The social worker and clinician proactively assessed barriers to family participation in intervention and worked with the families to reduce or remove the barriers.
- When needed, the school social worker and MOSAIC clinician met with parents at their home.
- In primary care settings, the caregiver was almost always present and involved. The parent/guardian had to give consent and was often directly involved in the therapeutic interventions.
- We used evidence-based global engagement strategies during the initial telephone call from a parent to the agency or during the first interview with a therapist. Using this global approach to engaging families decreased barriers and increased the likelihood that families and children would keep initial and follow-up appointments.
- We used a person-centered treatment planning model that identified the family's needs, priorities, and preferences.

BARRIERS TO INVOLVING FAMILIES AT OTHER SYSTEM LEVELS

As discussed at length in Section 4, it was more difficult to engage families in neighborhood settings. It is unclear if our efforts would have been more successful had we received technical assistance from ILCHF, since some of the barriers were related to ILCHF funding limitations and exclusions. With regard to the governance structure, we did not perceive that involving parents at that level was expected. If we had been required to include parents in the decision-making process, we certainly would have sought guidance in soliciting their involvement. Although the steering committee included the school district's Parent Liaison (a peer position), no peer can adequately reflect the totality of the caregiver experience. Because most of us in leadership positions had lived experiences as caregivers, and, in particular, as caregivers with children with special needs, we thought that would suffice. That being said, it is important to establish formal structures to ensure the voice of caregivers with lived experience of special needs children is heard and considered. They offer a valuable perspective that we may miss, if not intentionally included.

7.0. Youth involvement, support and development

I have practiced pediatric medicine for 25 years with gentle learning curves and improved service measures in small increments. The slope of the improved-care curve rose geometrically with the MOSAIC project. Practicing pediatrics will no longer be the same—in such a wonderful way! No longer do the teacher, the school nurse, the parent, the neighborhood, the pediatric office, and the child therapist revolve in their singular world. We have a means to begin to communicate. This fosters previously unknown truths of a child's environment; this fosters shared learning for successful and unsuccessful interventions; this fosters the much-needed continuity of care for these young people with their limited voices in an adult-centered world.

VIRGINIA M. DOLAN, MD, FAAP, *Memorial Physician Services—Koke Mill*

MOSAIC has not had formalized youth involvement in the development of the system of care. The Springfield Project conducted a number of focus groups among youth in the planning year to get youth perspective on what they needed to be healthy and to gauge where their gaps lay in understanding mental health. But, as discussed in Section 6, the governance structure did not include youth in any formal way. We leveraged our partnerships with youth-serving community agencies to act as representatives for and to deliver universal social-emotional awareness to youth.

In Years 2 and 3, MOSAIC offered a variety of services designed for middle and high school youth, such as the following:

- Instead of initiating a new, stand-alone youth group, the Neighborhood Outreach Workers partnered with the 21st Century Community Learning Centers afterschool programs to provide groups to community youth.
- The Neighborhood Outreach Workers and school clinicians participated in Springfield Public School District 186 “Making the Grade” events in which community members met with students to discuss their grades, goals, and barriers.
- MOSAIC clinicians were present at Parent/Teacher Conferences at Southeast High School and Washington Middle School and provided information on social-emotional health topics and parenting tips.
- Primed for Life provided groups for youth in Years 4 and 5. The purpose of Primed for Life spearheading these groups was to engage hard-to-reach youth. PFL connected with these youth, providing information and skill-building on healthy display of emotions and behavior, all in an effort to bring awareness of mental wellness.

MOSAIC would have benefited from a more formalized youth council and/or youth representation on the governance council. However, the budget was extremely lean, there was not an ILCHF mandate or support on this issue, and it would have required significant extra effort.

8.0. Clinical staff involvement, support and development

STAFF SUPERVISION

At first, the MOSAIC Project Director supervised the MOSAIC staff. As the number of staff members increased, we decided to divide the supervisory responsibilities. The Project Director continued to supervise the school-based clinicians, and the Manager of Memorial Counseling Associates assumed supervision of the therapists embedded in primary care settings (see Appendix H). Among other services, Memorial Counseling Associates (MCA) provided therapy for persons with private/commercial insurance. Most commercial insurers required all therapists to be licensed; Medicaid had no such requirement. Therefore, it seemed logical for the licensed therapists who saw clients with a more diverse payor mix to be supervised by the MCA Manager and the non-licensed therapists to be supervised by the Project Director.

The following year, one of our Lead Clinicians at MBH Springfield Children's Center transferred to the MOSAIC staff. She assumed the role of supervisor (also illustrated in Appendix H) for the school and neighborhood staff, freeing up the Project Director to focus more time on program implementation and cultivating new sites. In Year 4, the Project Director accepted a promotion within Memorial Health System, and MBH hired an individual with a Master of Public Health degree to fill the Project Director (now called Project Manager) position. Assigning supervision to the Lead Clinician proved beneficial during this transition and for the remainder of the project period because the new Project Manager was not a licensed clinician, and, therefore, not qualified to supervise the clinical staff. Clinical licensed supervision is required for Medicaid billing and to ensure appropriate clinical oversight of non-licensed and bachelors-level staff.

In Year 5, MBH modified MOSAIC's supervisory structure again, in anticipation of the end of the grant period. MOSAIC became a program of MBH-Springfield Children's Center. MOSAIC school clinicians were clinically supervised by Kendra Patton, the Manager of the Springfield Children's Center (see Appendix I). She met with the school-based staff regularly and conducted telephonic peer supervision to supplement the in-person sessions.

PROFESSIONAL DEVELOPMENT

MOSAIC staff benefited from a broad range of professional development opportunities, including attending trainings and professional conferences and participating in learning collaboratives. Selected examples are listed below.

Trainings

- Behavioral Health Consultant training at Cherokee Health Systems
- Chicago Parent Program

Professional conferences

- "The Brain and Early Childhood Development" by Dr. Ira Chasnoff
- "Global Engagement" by Dr. Mary McKay
- "Working with Children Who Have Complex Histories: A Brief Sampling of Trauma-Informed Approaches" by Christine Schmidt, Julianna Wesolowski, and Tiffany Conroy
- "Posttraumatic Stress in Children and Adolescents: Assessment and Evidence-Based Treatment" by Dr. Michael Scheeringa
- "Collaborative & Proactive Solutions for Behaviorally Challenging Kids and Their Caregivers" by Dr. Ross Greene

Learning collaboratives

- Child Parent Psychotherapy
- DHS Multi-Family Group

Leaders from Springfield Public Schools (SPS) and MOSAIC realized that, together, we need to be more intentional in training both school staff and mental health staff on our integration model. We now recognize that conducting one training for new MOSAIC schools, as well as new staff at current MOSAIC schools, is not sufficient. We need to offer booster sessions at every MOSAIC school throughout the year to ensure that school personnel maintain a clear understanding of the role of the MOSAIC on-site clinician. More specifically, the school staff members need to be reminded that the MOSAIC staff members are not another social worker—they provide specialized behavioral health services in the form of individual or family therapy, community support/case management services, and other services that can be billed to Medicaid or commercial payors. The MOSAIC clinicians offer an additional layer of support for students with a diagnosable mental health illness. Unlike social workers who can see any student for any reason, embedded clinicians are bound by professional ethics to refrain from talking with a student about their social-emotional development until the case has been opened officially. As teachers and other school personnel become fully cognizant of the clinician's role in the school setting, they can help students and parents understand the limitations as well.

In addition to keeping the model of embedded clinicians in the forefront of the school staff's awareness, we also recognize that MOSAIC on-site clinicians need to be educated about working in public schools in general, as well as about details specific to the school to which they have been assigned. In the last year of the project period, the SPS and MOSAIC leadership examined the current integrated school mental health model and developed a procedure for jointly training an individual new to a MOSAIC onsite clinician position. The training includes not simply an orientation and job shadowing at MBH-Springfield Children's Center, but also an orientation and job shadowing at the clinician's respective school. We hope this will help eliminate mission drift and confusion about roles and responsibilities, as well as facilitate a more streamlined integration within the school.

9.0. Stakeholder and community orientation, training and communication

COMMUNITY TEAM

Membership is open to all MOSAIC stakeholders to sustain broad support across the community for a mental health system of care. As originally proposed, the Community Team's role was advisory, and they were to meet semi-annually to receive progress reports, discuss issues that relate to the project in general, and provide overall direction for the project. They decided that meeting quarterly was more effective. When the Community Team convened for a special meeting such as a Learning Collaborative, members received program updates by e-mail to avoid scheduling additional meetings.

COMMUNITY OUTREACH

Media coverage. MOSAIC funding announcements appeared in the *State Journal-Register*, on WICS television station, on WUIS, WMAY, and WTAX radio stations, as well as in publications within Memorial Health System and the Community Foundation for the Land of Lincoln.

MOSAIC programming was featured in the *Sangamon Success* report (see Historical Perspective Section), the annual report of the Center for State Policy and Leadership, Memorial Health System's three-year strategic plan to address the community health needs assessment, the *State Journal-Register*, and *Springfield's Own*.

Presentations to community groups. From the beginning, MOSAIC leadership was deliberate about educating the community about MOSAIC—the concept, the purpose, the services, and progress toward achieving project outcomes. Examples include the following: private meetings to keep key leaders

10.0. System level advocacy

The individuals involved with creating the MOSAIC system of care in Springfield have been, and continue to be, strong advocates for children's behavioral health in general. More specifically, they have advocated for integrated children's behavioral health and a reimbursement model that allows for intensive onsite therapy services and preventative approaches to social-emotional wellness.

MOSAIC has garnered a great deal of attention over the years, which helps raise awareness about the need for mental health services and how a system of care functions. Selected examples of MOSAIC's visibility are listed below:

- *2016 TO PRESENT.* Jan Gambach continues to work with the Shriver Center through the ILCHF CMHI Advocacy grant, developing content for legislative/policy change around integrated behavioral health reimbursement models.
- *SEPTEMBER 2016.* Leu Baker, Cynthia Mester, and Heather Sweet presented a breakout session at the 21st Annual Conference on Advancing School Mental Health in San Diego. The session was titled "Braiding Together Schools & Community Mental Health: Building a System of Care from the Ground Up."
- *SUMMER 2016.* The State of Illinois enacted SB100, which requires school districts to review their student discipline policy, implement a restorative justice approach to student behavior, and develop reintegration plans for students who miss class time due to discipline measures. The law allows MOSAIC to continue supporting current MOSAIC schools, as well as positions us for further integration.
- *NOVEMBER 2015.* Conference attendees heard a presentation about MOSAIC at the 20th Annual Conference on Advancing School Mental Health in New Orleans.
- *AUGUST 2015.* The Sangamon County Continuum of Learning Coordinating Council published featured MOSAIC in its *Sangamon Success* Report.
- *APRIL 2015.* Conference attendees heard a presentation about MOSAIC at the National Council for Behavioral Health in Orlando.
- *MARCH 2015.* Conference attendees from across the U.S. heard a presentation about MOSAIC at the 28th Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health in Tampa.
- *APRIL 2014.* Local and state policymakers heard a presentation about MOSAIC at the Annual Convocation of the Center for State Policy and Leadership at the University of Illinois at Springfield.
- *2014.* The Center for State Policy and Leadership featured MOSAIC in its 2014 Annual Report.
- *2014.* Jan Gambach participated in a legislative Violence Prevention task force and provided information on MOSAIC as a model to identify at-risk students and engage them and their families in services.

11.0. Financing

11.1. Purchasing/contracting

MBH's fiscal department distributed grant funds according to the budget categories established by ILCHF.

- *STRUCTURE:* salaries and fringe benefits for MBH personnel (MOSAIC leadership and marketing).
- *EXECUTION:* direct client care and travel associated with direct client care.
- *EVALUATION:* quality monitoring by MBH staff.

MBH used MOSAIC funding (Execution budget category) to contract with The Springfield Project to provide community outreach and coordinate community events that focused on mental health awareness. The Springfield Project subcontracted with Primed for Life for certain deliverables related to community outreach. A large portion of the Evaluation budget category was allocated for our contract with the Center for State Policy & Leadership at the University of Illinois at Springfield.

11.2. Provider payment rates

Payment for MOSAIC services was multifaceted and complex. The schools and primary care practices bore the costs of conducting universal screenings. This has long been an issue in that screening in primary care offices was always supposed to be in place but frequently was not routinely provided or tracked. Screening was usually completed as a part of another visit, so it was not billable on its own. The schools did not get extra financial incentives to provide social and emotional screening; therefore the school district's decision to screen all students was a testament to their commitment to their students' health and wellness.

SCHOOL SETTINGS/RULE 132 BILLING

As a community mental health center, MBH moved to fee-for-service funding more than a decade ago. For the most part, community mental health services were funded by Medicaid administrative Rule 132, which established the reimbursement rates and the billing requirements. Rule 132 was prescriptive compared to most insurance requirements for the same services. With the exception of crisis services, before we can provide services under Rule 132, we must complete an assessment and treatment plan and the accompanying intake paperwork. After many years of stagnated rates and considerable advocacy, Illinois implemented a "temporary" rate increase. We are still operating with the rate add-on. The table below lists the rates as of FY2017.

Community Mental Health Rule 132 Services and Reimbursement Rates

MENTAL HEALTH ASSESS

QMHP (Master level)

ON	\$23.60/unit (\$ 94.40/hour)
OFF	\$26.57/unit (\$106.28/hour)

MHP (5 per unit rate add-on)

ON	\$22.18/unit (\$88.72/hour)
OFF	\$24.93/unit (\$99.72/hour)

RECOVERY PLAN

QMHP

ON	\$18.60/unit (\$74.40/hour)
OFF	\$21.57/unit (\$86.28/hour)

MHP

ON	\$17.18/unit (\$68.72/hour)
OFF	\$19.23/unit (\$76.92/hour)

THERAPY

QMHP (5 per unit rate add-on)

ON	\$23.60/unit (\$ 94.40/hour)
OFF	\$26.57/unit (\$106.28/hour)

MHP (Counseling)

ON	\$17.18/unit (\$68.72/hour)
OFF	\$19.23/unit (\$76.92/hour)

FAMILY THERAPY

QMHP

ON	\$18.60/unit (\$74.40/hour)
OFF	\$21.57/unit (\$86.28/hour)

COMMUNITY SUPPORT INDIVIDUAL

QMHP

ON	\$18.60/unit (\$74.40/hour)
OFF	\$21.57/unit (\$86.28/hour)

MHP

ON	\$17.18/unit (\$68.72/hour)
OFF	\$19.23/unit (\$76.92/hour)

CRISIS ASSESSMENT

7 per unit rate add-on

ON	\$37.93/unit (\$151.72/hour)
OFF	\$42.88/unit (\$171.52/hour)

SASS Screen

ON	\$299.70
OFF	\$347.70

The benefit of Rule 132 was that non-licensed and bachelor's level staff can provide and get paid for services, unlike services covered by most commercial insurance companies, which must be provided by licensed and master's level staff. The disadvantage of Rule 132 is that it was cumbersome to get individuals enrolled and did not cover the embedded brief wrap-around support that was valued in the MOSAIC model. Neither did it pay for engagement services for people not yet enrolled. With the schools and other sites like SIU Pediatrics, we experimented with different coverage models that maximized our ability to bill Medicaid for services. Medicaid Managed Care Organizations (MCOs) were required to pay no less than these rates. As of February 2018, Illinois was moving all of its Medicaid covered lives to MCOs, and Rule 132 was going through major revisions. Another problem with delivery of mental health services in schools was the mix of insurances. Most of the students enrolled in MOSAIC schools had Medicaid coverage and could be served by non-licensed therapists. However, high school students had a more diverse payor mix, and, therefore, must receive services from a licensed therapist who could bill the full mix of payor sources.

PRIMARY CARE

Therapists embedded in primary care practices can bill insurances for their services most of the time. MBH and the primary care partners set up several arrangements related to billing. For example, we contracted with two of our primary care partners to provide MOSAIC therapists, as well as supervision and administration. The practices used their billing systems to bill for the services. Because one of the practices was an FQHC, licensed therapists could bill for mental health services. And, because FQHC rates were encounter-based, those rates were better suited to the short brief interventions of an integrated care model.

Our primary care therapists now see children and adults. In FY2017, Memorial Physician Services (MPS) staffed their eight clinics with 7.24 FTEs embedded therapists. The cost of the therapists was \$493,955; insurance payments to MPS totaled \$466,583.

All of our MPS clinicians were licensed and credentialed with the various insurances. We were able to cover nearly all costs of the embedded therapists through billing, and we continued to refine our ability to cover the cost of services. Credentialing our therapists was a significant barrier. MPS Medicaid was also difficult to capture, but under the new legislation, we can bill for Medicaid in the primary care setting without having to resort to mental health billing through Rule 132. In addition, some services were inherently difficult to capture billing, including the personal introductions to the therapist, quick on-the-spot interventions, and consultations with the primary care team. However, the primary care teams continued to increase their reliance on the therapists and understood the value a therapist brought to their team in terms of efficiencies.

11.3. Revenue generation and system reinvestment

Although MOSAIC did not generate much revenue, three Springfield-based entities demonstrated their support of MOSAIC through financial reinvestments: Memorial Health System, United Way of Central Illinois, and the Women for Women Giving Circle, a fund administered by the Community Foundation for the Land of Lincoln. The United Way and the Community Foundation both were key partners from the nascent days of MOSAIC.

Memorial Health Systems (MHS), of which Memorial Behavioral Health is an affiliate, committed significant resources in the form of community benefit—unreimbursed services—to support MOSAIC. The community benefit was allocated to health priorities identified in the community health needs assessment. MHS completed its most recent needs assessment in 2015 and developed three-year priorities for each community it serves. Access to care and mental health were the top two priorities for 2016-2018 in Springfield. MHS selected MOSAIC as its community benefit focus for the three-year period. MHS also awarded MOSAIC a three-year grant totaling approximately \$303,000. The funding supported the following: salaries for

the Program Manager, three Behavioral Health Consultants, and multiple Mental Health Clinicians; professional staff training in behavioral health integrated care; and the evaluation component.

Beginning in FY2016, in response to the Community Health Needs Assessment described above, United Way of Central Illinois allocated a portion of its annual Community Fund grants to support mental health services. Memorial Behavioral Health's application for MOSAIC received a two-year grant totaling approximately \$175,000 to expand services in existing MOSAIC schools and to initiate services in another school.

The Women for Women Giving Circle annually distributes grants to programs to improve the lives of local women and children. In 2013, one of the members of the Giving Circle attended a community presentation about the impact MOSAIC was having on children and families. Later that year, the Giving Circle announced that their 2014 grant cycle would focus on programs that address the mental health of women and girls. Memorial Behavioral Health submitted a grant application to the Giving Circle to establish the MOSAIC Moms program (see Section 4.1). The Giving Circle awarded MOSAIC Moms three consecutive years of funding totaling \$45,000.

The 2016 grant to Memorial Behavioral Health is a continuation of the first multi-year grant awarded by Women for Women, which is a reflection of the importance and success of the MOSAIC Moms program.

COMMUNITY FOUNDATION FOR THE LAND OF LINCOLN

11.4. Billing and claims processing

We learned that a clinician based in a primary care office with a mix of payors was, for the most part, sustained through billing. However, a clinician based in a school was not a sustainable model due to the Medicaid billing requirements imposed by the State of Illinois under Rule 132. The primary barrier was that a family must complete intake paperwork prior to receiving services that could be billed to Medicaid. We devised a better model in which the school social worker assisted the family with completing the intake process. We are in the process of implementing a similar process with the community-based organizations where we have embedded staff. Rule 132 allowed for billing by bachelors-level staff, which was more affordable; however, bachelors-level staff cannot provide the same level of service that masters-level (licensed) staff can, which limited the services available to children with Medicaid coverage. Community Mental Health Center Medicaid billing simply did not cover costs for a licensed clinician to staff a MOSAIC school. We found that older students tended to have a more diverse payor mix and needed the services of a licensed clinician. We assigned non-licensed staff to the elementary schools where the younger students tended to require less intensive services than their older peers.

Most models for behavioral health integration in primary care were found in Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) structures, which provided favorable encounter billing rates and a single source for the majority of billing. In fact, FQHCs had an encounter rate that favored the integrated model of brief 15- to 30-minute interventions. Koke Mill Medical Associates was a practice serving primarily patients with private insurance. As such, determining billing practices and potentially negotiating with payors added greater complexity to embedding staff in this practice. We hope that what was learned through MOSAIC's partnership with Koke Mill will pave the way for integrating behavioral health in other practices serving groups with private insurance.

All staff embedded in primary care settings were licensed and were required to be credentialed with all insurers to bill for their services. The lengthy credentialing process by some of these insurers prevented immediate billing and some did not allow back-billing to the time of application. Furthermore, some insurers had either extremely poor rates or closed panels, which also complicated the behavioral health billing in primary care. Despite all of the barriers, nearly all of the costs were covered for services provided by

the behavioral health clinicians embedded at Koke Mill. An added benefit was the value of increased efficiencies in the primary care office.

11.5. Utilization of ILCHF grant funds over time

In general, we used ILCHF grant funds to pay for start-up costs each year, such as onboarding new staff, setting up systems, and promoting the program. As MOSAIC expanded to new schools, we also used grant funding to cover the time the Project Director spent on administrative oversight critical to expansion. We discovered that we did not allocate enough grant funding for the administrative oversight. Building and sustaining a system of care needed significant leadership support. Even though the need for direct services was significant, we guard against allowing administrative funding to migrate to direct care.

In addition to start-up costs, we also used ILCHF funds to offset the cost of services not reimbursable by Medicaid. As discussed in Sections 11.2 and 11.4, the current Medicaid reimbursement model (Rule 132) is inadequate in terms of supporting many services delivered through an innovative integrated school mental health model such as MOSAIC. We can only bill Medicaid for services if we formally open a case for a student through our agency.

Over the years of implementing MOSAIC, we learned that integrated mental health involves much more than providing intensive on-site therapy. Effective integrated mental health required care coordination for families and for children in crisis. We now understand that, given the current restrictions of Rule 132, it was unrealistic to expect that a community mental health agency, such as MBH can rely on Medicaid reimbursement to sustain a system of care. The restrictions prevented us from providing a number of services to youth and families who were not formal MBH clients.

Therefore, ILCHF grant funds proved extremely valuable in supporting many important activities that were unallowable by other funding sources. Examples include the following:

- Outreach to children and families who may have needed support but had not yet completed the intake process;
- Teacher consultation and mini-trainings;
- Engagement—any service that helped families realize the importance of mental wellness;
- Staff time to open client cases and complete the required paperwork;
- Care coordination especially related to a family member; and
- Staff time to respond to students in crisis who were not in the SASS group.

12.0. Information management

MOSAIC influenced changes in the electronic health record that will be used in the major practices in Springfield.

For better or worse, the MOSAIC team elected to extract data from the existing electronic health records (EHR), rather than create a separate system. In Year 1, SIU School of Medicine and Memorial Physician Services—the two major practices involved with MOSAIC—used distinct EHRs. In Year 4, those two practices, as well as Springfield Clinic, converted to a single EHR. This shift to a shared EHR required MBH staff to attend countless meetings and spend an inordinate number of hours to negotiate changes with the developers. It was imperative that MOSAIC clinicians have the ability to track and respond to patient data, a critical component of a fully-functional medical home.

It was still difficult, if not impossible, to collect the following data points: (1) the number of screens provided compared to the number of patients who were screened; (2) the number of referrals made compared to the number that should have been made; (3) the number of patients who engaged in services compared to those referred; and (4) the number of patients who improved and by how much. We

continue to search for a solution for extracting that information from the EHRs. We have made the most progress in tracking depression and anxiety screens, but the data does not yet include child screens.

PRIMARY CARE PRACTICES

Although SIU's Center for Family Medicine has integrated mental health services into its practice since Year 1, we still faced ongoing challenges with data collection by Year 4. SIU's EHR did not include the tools that their primary care physicians used to screen for mental health concerns (see Section 4.6). The only way to collect screening data was to conduct a chart audit—an extremely time-intensive and costly task. The Chief Information Officers (CIOs) of Memorial Health System and SIU School of Medicine collaborated to solve the problem. As a result, the new EHR (owned and managed by Springfield Clinic) integrated the screening tools in a manner that facilitated screening and data collection, including tracking the number of total screens, number of positive screens, and referrals.

In the early years of the project, MOSAIC staff were able to document in the record but faced barriers to sharing that information with the primary care providers. Later, after significant consultation, the information management team developed a better system for sharing information, while not violating HIPAA. In particular, the Mental Health Code allows information sharing to coordinate treatment but does not allow sharing psychotherapy notes without a release of information. Even with the release of information, there was no means to share a patient's chart in the EHR with the primary care provider.

Developing a shared EHR required collaboration from leaders across several departments within Memorial Physician Services: Population Health, Quality Assurance, Legal, Ambulatory Informatics, Compliance, and Privacy. Leaders from each of those departments met several times with Memorial Behavioral Health's President, Clinical Director, Outpatient Behavioral Health Manager, Quality Management Director, and Health Information and Privacy Manager to identify the need for and resolve how to create a shared record. The legal department determined that sharing records was appropriate because the behavioral health consultants and primary care providers were members of interdisciplinary treatment teams. However, shared documentation had to be limited to progress information only, not process information, such as direct patient quotes, highly protected information, or highly descriptive information.

Once the shared record was finalized and the legal department approved the documentation policies and procedures, all behavioral health consultants received training on the new documentation system. New hires received training during employment orientation and on-boarding. The Behavioral Health Consultant Supervisor regularly audited their documentation to ensure compliance with the policies and procedures.

After the staff completed the initial training, the BHC Supervisor worked with the Ambulatory Informatics and Health Information departments for two months to determine which documentation would be outside the firewall and to build templates for the open documentation. We finally completed the process at the end of Year 4. We also shared this process with SIU-CFM.

SCHOOLS

Collecting data in the school setting has been an easier process than in the primary care setting. We started out receiving screening numbers and positive screening results via email inquiry to MOSAIC schools, but there was no standardized data collection and storage process. At first, we used a spreadsheet to collect and track students referred to MOSAIC, especially students with highly elevated screens. The school social workers and the MOSAIC on-site clinicians used the spreadsheet to track which students and families were contacted to engage in services, as well as how often. Without a standardized process, each school modified the spreadsheet to meet its needs and stored the spreadsheet on its own computer. The Project Director requested each school to send its version of the spreadsheets a few times throughout the year.

About mid-way through the project period, MOSAIC schools began saving their data to a shared document saved to the Box.com account owned and managed by the University of Illinois at Springfield. This cloud-based, secure data storage system eliminated the multiple versions of the spreadsheet and eliminated the need for MOSAIC staff to request schools to submit their data, who were then able to access the data at any time. We still encountered problems due to school personnel downloading the document to enter data and then uploading the updated document to the correct folder in the cloud. We eventually transferred the spreadsheet from the UIS box.com account to the school district's secure GoogleDocs/Intranet server. This proved to be the most effective solution, significantly reducing errors in data entry.

Toward the end of the project period, the MOSAIC clinicians and MOSAIC Project Manager were granted access to the school district's database, including individual user credentials. Having access to the database, as well as to school personnel's email addresses, significantly improved the staff's ability to determine meaningful metrics to collect and how to collect them, as well as collect data at more timely intervals, with defined operational definitions, throughout the academic year. This data collection process provided rolling baselines for children entering the MOSAIC system of care, with purposeful follow-up on data points throughout the academic year, or as long as children were receiving behavioral health services.

An additional improvement to the data system involved the school district adding "MOSAIC" as a behavioral intervention option within the "Intervention" tab in the database. We will work to identify a meaningful tool to measure and track progress within the academic system. With this process, we will be able to run reports, quickly identifying students receiving or having received MOSAIC services. This process is new, with the procedure and database going live with the start of the 2017–2018 academic year. We look forward to continuous quality improvement of MOSAIC and using data to meet the needs of the children and families we serve in the school setting.

12.1. Protecting child/family privacy

MOSAIC's Behavioral Health Consultant Supervisor worked with Memorial Physician Services' Ambulatory Informatics leaders to develop documentation templates and privacy restrictions in accordance with the guidance received from the legal department. This information management team decided that the behavioral health consultants would use a memo field to document patient assessments. The memo field was not shared, thereby protecting clients' privacy. Shared fields only provided necessary clinical data and progress notes that documented on-going patient services. Over the years, we have installed increasingly sophisticated firewalls to safeguard highly protected information.

As required by the State of Illinois, we secured formal releases of information with Springfield Public Schools, SIU Center for Family Medicine, and other entities where MOSAIC therapists provided services.

12.2. Sharing information between systems

PRIMARY CARE

Perhaps the most challenging issues related to information sharing that we have encountered was the delay in receiving requested data from partnering entities. Each partner had unique methods of storing and retrieving data, as well as unique timetables for providing requested data. Because many of our data requests involved highly protected information, the entities from whom we sought data posed a considerable number of questions, as they discerned whether or not we should have access to the data. For example, we had a written agreement with one department within the SIU School of Medicine, but if we needed data from a different department, we were subjected to increased levels of scrutiny.

Data requests regarding screens standardized to track patient improvement, such as the Adolescent Patient Health Questionnaire–9 and the Adolescent Generalized Anxiety Disorder–7, from the record were delayed for over a year. Business Informatics, the department responsible for data collection, within Memorial Health Systems was focused on developing reports combining all electronic health record systems in the area to track patients across all health systems.

Another challenge we encountered was the inability for the EHRs to exchange information electronically. Thus, to share client data with our partnering clinicians (and vice versa), we had to transmit documents by fax or e-mail. Then the receiving entity's staff had to manually enter the data into their own system.

Despite the challenges associated with sharing data across multiple entities, we finally reached the point where the appropriate clinicians have access to the correct level of primary care documentation more quickly than in the past and in a usable format.

SCHOOLS

The MOSAIC Manager started working with the Information Technology team at Springfield Public Schools in Year 4 to eliminate barriers that prevented MOSAIC Onsite Clinicians from obtaining a district email address so that they could access students' cumulative folders via the district's Intranet. By Year 5, we established the appropriate agreements and documentation to grant the MOSAIC Manager and Onsite Clinicians access to the Intranet. The data sharing agreement allowed us to access historical data for all students who had ever participated in MOSAIC services. In Year 6, we tested access to student data at participating schools and developed procedures for collecting baseline data (academic, discipline, and attendance) when new students entered the mental health system of care.

Because the clinician and school social worker now use the same data-secure e-mail server, communication about specific students was no longer constrained by data-sharing restrictions. Furthermore, the clinician and school social worker may use the secure server to store data such as the MOSAIC school data tracking form, providing real-time updates to student status entering and engaging in the system of care.

12.3. *Electronic medical records*

When we launched MOSAIC in 2011, program and participant data was stored in three distinct electronic health records—one owned and managed by Springfield Clinic (discussed above), one owned and managed by SIU School of Medicine, and our own at Memorial Behavioral Health. In recent years, nearly all primary care provider offices in Springfield have shifted to one shared EHR; Memorial Behavioral Health retained its own. While each system evolved to comply with privacy standards, they have not evolved at the same pace or to the same degree. Furthermore, once an EHR is established and operational, system upgrades are costly.

Increasingly, EHRs are tools not just for documentation but for improving individual and population health. We face the challenge of securing adequate funding that will allow MOSAIC to continue to work with the CIOs of Memorial and SIU to ensure that children's mental health screening tools are embedded in the EHR now used by all the major practices in Springfield. Making it easier for physicians to screen and to track the status of individual patients, as well as that of their patient population, will lead to **increased screening and more active management of children's mental health care**. Both CIOs are strong proponents of screening. However, without continued attention and input from MOSAIC, children's mental health screening may get lost among competing priorities for thoughtful inclusion in the EHR. In addition, we will continue to work to get screening tools embedded within the patient portal, so patients can get, take, and provide screenings prior to their patient visit.

13.0. *Quality improvement*

13.1. *Monitoring*

The school-based clinicians used a data-tracking spreadsheet to evaluate MOSAIC's impact, especially related to academic success. Over the years, we refined the spreadsheet to improve our ability to monitor project outcomes. As discussed in Section 12.2., the MOSAIC clinicians and MOSAIC Project Manager were granted access in Year 6 to Springfield Public Schools' Intranet, which allowed them to collect student data directly rather than rely on school personnel to provide the data. The school district also assigned e-mail addresses to the school-based clinicians and Project Manager, which improved their

ability to maintain the school data-tracking spreadsheet. Each school's spreadsheet was stored on a password-protected Google drive and shared only with the Project Manager, the district's lead social worker, and the clinician(s) assigned to that school. The Google docs platform allowed users to edit the spreadsheet online to prevent multiple versions. The clinicians also used a Google calendar application to share their appointment schedules, which enabled the school social workers to schedule new client appointments directly and avoid unnecessary back-and-forth communication.

We encourage all of our clinicians to use the key elements of the IMPACT model (<http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment>) which builds in constant monitoring of symptoms and a stepped response based upon whether the patient is improving. In that regard, our clinicians are constantly monitoring and revising their treatment approaches. We also track our programmatic quality through monitoring productivity, staffing and supervision, chart reviews, setting and meeting goals, and identifying trends. This also leads to changes in how we document and deliver services. For instance, if one of our programs or staff have low productivity (low client contact), we determine the barriers and solutions. This process allows us to increase or decrease staff time at different sites of care, based upon need and usage.

13.2. Feedback loops

MOSAIC uses feedback loops in many forms. Our system of care consistently looks at all data coming in, whether in the form of anecdotal discussions, data collected specifically for evaluation reports, volume numbers, client caseloads, screening numbers, positive screening rates, etc. to evaluate the program design, accessibility, buy-in, and sustainability. All these data channels help us determine what should be improved, how it should be improved, where we should make the improvements, who would carry it out, and how to monitor the changes. The following graphic illustrates one feedback loop we use.



Collect information about processes, activities, and outputs/outcomes: Data collection activities included: (1) generating monthly and quarterly reports from electronic health records and school data spreadsheet; and (2) meeting with clinicians, behavioral health consultants, leadership at all MOSAIC sites, and members of the Executive Team and community partners. We used several methods to collect outputs and outcomes data as systematically as possible, given the limitations of our data systems. Much of the information we collected is through frequent meetings and check-ins with all the components of our system of care.

Share information with appropriate groups/partners: MOSAIC leadership shared data and other program information with MOSAIC school clinicians, primary care behavioral health consultants, community partners, various funders, Memorial Health System, MBH leadership, school district leadership, MOSAIC school personnel, and the Executive Team.

Analyze and evaluate the data to determine if SOC expectations are being met: The data team analyzed and evaluated available data to determine if MOSAIC served the population of children with limited access to behavioral health support, conducting social-emotional screening, appropriately referring children to services, if children were using embedded services, if embedded clinicians and behavioral health consultants were being used appropriately, and our impact on academic success and student attendance. The expectations for the system of care varied, depending on the part of the system; therefore, we analyzed and evaluated all data and information based on what that particular setting/site/school needed in terms of integrated behavioral health care.

Work with appropriate groups/partners to develop changes/best practices to meet SOC expectations: In each setting, we convened a group of MOSAIC champions to review the data, evaluation report, and/or feedback and recommend new or improved processes we could develop to achieve desired outcomes. The champions composed the document that explained any changes to be made and the rationale for the changes and distributed it to the people who would be impacted.

Implement changes/best practices in processes and activities to improve SOC: With the help of the MOSAIC Project Manager and the MOSAIC Executive Team, the group that developed the changes or best practices would implement the group's recommendation(s) and modify the data system/process so that we could collect data to measure the impact of the changes to the system of care.

13.3. Problem-solving within the system

MOSAIC's structure incorporated a number of forums that offered a collaborative approach to identify and address problems that arise.

PRIMARY CARE

- The executive team met monthly (or more often as needed); and
- MBH leadership facilitated monthly MOSAIC community team meetings.

Both forums engaged community stakeholders in discussions about how to modify clinical practices to improve service delivery and improve children's health.

SCHOOLS

Each of the following forums offered staff to problem-solve, share information, provide updates, process improvements, and review metrics to track improvements.

- The school teams met quarterly;
- The Project Manager conducted site visits each semester (twice a year) and met with Springfield Public Schools leadership every other month; and
- The school clinicians met with MOSAIC leadership monthly.

14.0. Evaluation

Moving healthcare from volume to value requires a monumental shift in our practices and tracking.

DAVID RACINE, PH.D., *Local MOSAIC Evaluator*

David Racine, Ph.D., led the local evaluation team for The Children’s MOSAIC Project. Racine is the Executive Director for the Center for State Policy & Leadership at the University of Illinois at Springfield. He began meeting with the planning team during the last half of the planning year, which gave the evaluation team the opportunity to develop a good understanding of the initiative. They began formulating the evaluation plan prior to implementation and then built and refined it during the first few months of implementation (see flowchart in Appendix L).

Upon notification of funding to implement project, Racine and the evaluator assigned to MOSAIC met with the Project Director and the Data Manager to design the evaluation plan. Due to delays in executing a contract, the evaluation began midway through Year 1. During Years 1–3, the evaluation team met monthly, and sometimes more frequently. In Years 4 and 5, the evaluation team met every other week. Currently, we are in the process of transitioning the monitoring and evaluation functions to the systems at Memorial Behavioral Health and Springfield Public Schools in which MOSAIC operates.

The primary goal of the MOSAIC project evaluation in Years 1–3 was to describe the management and implementation of the program and identify areas for potential improvement. This aspect of the evaluation, composed of both cross-site and local evaluation elements, were intended to aid future efforts to implement the SART model (see Section 4.4) in Illinois and beyond. Much of the reported data was descriptive in nature, including surveys, short term screening outputs and outcomes, participants’ background factors, participation in assessment and treatment, and the long term changes in the mental health of children who received treatment. All data included in the cross-site evaluation were a part of the local evaluation, but the local evaluation also included a number of additional elements that did not overlap with the cross-site evaluation.

A secondary goal of the evaluation was to produce more rigorous estimates of the effects of particular program elements on service usage and the effects of receiving treatment. Another analysis matched positively screened children who received treatment through MOSAIC with similar positively screened children who entered the behavioral healthcare system in other ways. The purpose of the comparison was to estimate MOSAIC’s impact on children’s mental health symptoms, school behavior, and academic achievement. The evaluation team completed the first comparison in Year 2 using data collected for students attending Matheny-Withrow Elementary School. The evaluators reproduced the comparison with larger groups of children in Years 3 through 5. The ability of the local evaluation to draw firmer conclusions on the effectiveness of program elements was aided by the collection and analysis of more detailed data on family background factors, socioeconomic status, and neighborhood risk factors.

The evaluators produced a series of reports that enabled MOSAIC’s leadership staff to better monitor project activities and determine whether the project was being implemented as expected and achieving its goals. Examples include output data related to screening, care coordination, average screening scores, treatment referrals, access to services, types of services, distribution of diagnoses, family satisfaction, provider satisfaction, and reasons for no-shows.

The evaluation plan for Years 4 and 5 was essentially the same as the evaluation for Years 2 and 3, except that in Year 5, the final evaluation included a practice change study of primary care and school settings (originally planned for Year 4), as well as a summative view of how MOSAIC has changed mental health services for children.

The MOSAIC leadership shares results of the local evaluation with the MOSAIC staff members, partnering organizations, funders, and other stakeholders. We use the results to improve service delivery, recruit new primary care practices and schools, leverage additional funding, and educate the community. For example, we share with prospective medical practices the local data related to sustaining integrated clinicians and the satisfaction of participating physicians. In response to information about the needs of single mothers with young children, we applied for local funding to establish and sustain the MOSAIC Moms program. We also explored a partnership with the Bright Promises Foundation to address the needs of children who have experienced trauma; however, we decided we did not have the capacity to take on another grant and its accompanying expectations at the time. The MOSAIC Steering Committee represents a good cross-section of providers and other stakeholders and, thus, offers a forum for educating providers and community leaders about the needs of children and families living in the target neighborhood. Probably the most significant impact of the evaluation on the project to date is the increased visibility in the community. The Sangamon County Continuum of Learning Coordinating Council published a report that highlighted MOSAIC as showing early promising results related to “improving the identification and treatment of children with social-emotional problems” (*Sangamon Success*, August 2015).

The cross-site evaluation has provided only modest benefit to our community. Conducting the chart audits at the primary care practices did shed light on inconsistencies within and among primary care practices in how screening results are scored, recorded, and acted upon. Furthermore, at NTI’s suggestion, we developed a valid instrument to survey participating physicians. The structure of the evaluation, however, did not correspond well to the work that was being done, and, therefore, did not adequately measure the project’s breadth or depth. Additionally, during early implementation, we lacked feedback from the cross-site evaluators at NTI Upstream. Toward the end of the project period, however, the NTI evaluator sent us the cross-site reports more frequently. Dr. Racine pointed out that “the cross-site [evaluation] harms our efforts in that providing the cross-site data requires significant resources. For example, to obtain the rate of positive screens and the positive domains among screens administered at SIU Center for Family Medicine requires chart audits conducted by graduate assistants.” Dr. Racine added that some of the data required for the cross-site evaluation had little or no value: “For example, if a consistent rate for positive screens is found in one setting for several quarters, is there value to be gained by continuing to collect that data? In our community, the clinician in the school setting conducts the mental health assessment and provides treatment. Thus, the data points related to the time between assessment and treatment and the usefulness of assessment for treatment are of no value.”

15.0. Impact for children/families from the care system improvements

The real success of MOSAIC isn’t reflected solely in the number of screenings completed, but in each child, who is better equipped to lead a healthy and happy life because of the mental health services provided and partnerships built within our community.

HEATHER SWEET, MOSAIC Project Manager

ACCESS TO SERVICES

Based on data available from six of the 12 participating schools, almost 1,800 students were screened in Year 6.

- 59% of 192 children with highly elevated screens were referred for treatment services.
- 78% of 114 children received for treatment services either began or continued participating in treatment.
- Overall, 46% of 192 children with highly elevated screens (95th percentile and above) engaged in treatment.

- 45% of 351 children with elevated screens (80th to 94th percentile) were referred to a Tier II intervention.

While school engagement has been relatively consistent and expanding, a few schools have been less consistent because they lacked sufficient resources to support the embedded mental health clinicians needed to follow up on positive screens. In some cases, the onsite clinician position remained vacant for extended periods of time. Now that we cross-train SASS staff members (see Section 4.9), the gap in services during a vacancy was minimized.

Due to data limitations in the three participating primary care practices, the evaluators were unable to calculate comparable referral and service engagement rates based on positive screens. However, based on Year 4 data (first two quarters only) available from SIU Center for Family Medicine, physicians referred 140 children (24% were younger than 6) for treatment services. Calculating a referral rate based on positive screens is not relevant in primary care settings, because, even when a screen is negative, physicians may perceive a need and refer the child for behavioral health services.

We first met Stacey, a high-performing and extremely likable student, at a routine screening at her school. Her mother was shocked to learn that Stacey was experiencing significant mental health symptoms such as crying spells, suicidal ideation, feelings of hopelessness, and pervasive sad moods on a weekly basis. Stacey's father had committed suicide, so her mom agreed to take her to counseling to prevent Stacey from repeating her dad's fate. At first, Stacey had difficulty communicating her feelings. She soon learned to identify her faulty beliefs about herself and how they contributed to her depression. She also started taking an antidepressant to prevent her symptoms from interfering with her ability to function at school, in social situations, and at home. Stacey said, "I feel like I am a totally different person. I'm not crying all the time." And, in response to the therapist's question about what is different for her now versus last year, Stacey said, "I think I have really grown."

CHILD WELL-BEING

The principal measure for assessing the effects of MOSAIC on child well-being in the cross-site evaluation was the Child Behavior Checklist. However, because these data have not been available in easily-accessed electronic records from primary care sites, and because only one of the participating schools has conducted more than one screening to date, it is not yet feasible to conduct an outcome analysis using screening results. As an alternative strategy to evaluate the effects of MOSAIC on school-age children, the most recent local evaluation included a comparative analysis of data routinely collected by Memorial Behavioral Health on all children receiving their services. Therapists used the Daily Living Activities 20 instrument to measure a child's baseline functioning, as well as subsequent changes in functioning throughout the treatment period. Thus, the evaluators were able to compare children who accessed care through MOSAIC with children who accessed care outside of MOSAIC to determine if MOSAIC were more successful in improving child well-being. The data set spans all five years of MOSAIC implementation prior to the analysis, which was completed in Year 6.

Despite perennial challenges to engaging MOSAIC families in treatment (see Section 4.1), the data clearly indicates that school-age children who enter the behavioral healthcare system through MOSAIC experienced a higher degree of increased social-emotional functioning compared to children receiving behavioral health services outside of the MOSAIC system of care. MOSAIC's effect on functioning was mainly the result of higher treatment intensity (i.e. the number of therapy/counseling sessions per 30 days).

Alex is a 10-year-old boy who attends elementary school in Springfield and began receiving MOSAIC services in January 2017. Alex's mother reported that he behaved well at home, but she noticed that his grades had started to go down, and the school called more frequently about Alex's behavior at school. The teachers explained that Alex had inappropriate behavior outbursts, screaming in class and ripping up papers. The school social worker introduced Alex and his mom to the MOSAIC clinician at this school. The clinician met frequently with Alex for the next four months until the school year ended. The clinician used Cognitive Behavioral Therapy and Play Therapy to help Alex learn to process his emotions and find positive ways to cope when he felt frustrated. The clinician also consulted with Alex's teachers and helped them identify strategies they could use in their classrooms to help him cope. For example, one teacher noticed that Alex seemed distracted by noise coming from a nearby classroom, so the clinician suggested that Alex wear headphones during testing. This simple accommodation enabled him to concentrate, which eliminated his need to act out in anger due to being overly stimulated. Near the end of the school year, Alex's teacher reported she had seen positive results: "Alex has been doing so well . . . I think meeting with [his therapist] is helping him a lot." She reported Alex has had fewer outbursts and seems to be more in control of his anger and seems happier overall. His grades improved over the course of the semester. One day Alex even approached his teacher and asked excitedly, "What are we learning today?"

PARENT WELL-BEING

The array of MOSAIC services expanded in Year 3 to include MOSAIC Moms, a program that addressed the social-emotional needs of low-income mothers (see Section 4.1). As of December 2016, 203 individuals participated in the MOSAIC Moms program. Nearly all (99%) participants were female. About half (49%) were African American; 43% were White. About two-thirds (65%) of participants had a high school diploma or less. The majority (74%) reported being single; 15% married. Nearly half (44%) had one child; 24% had two; 27% had three or more children.

Providing services to this target group offered the opportunity to evaluate the impact of MOSAIC on parents. Parents attending group sessions were asked to complete a survey used to measure feelings of stress, social support, and depression. One-third of the participants completed the survey at least twice, allowing evaluators to assess preliminary outcomes. The data showed steady modest improvement over time, indicating that the MOSAIC Moms program was making a positive impact on participants' well-being. The underlying assumption of the program was that improving a parent's social-emotional health would positively impact the social-emotional development of the child.

Sandra didn't realize how much she needed the support of MOSAIC Moms until she stopped attending the group sessions. She joined the group when she and her children were living in M.E.R.C.Y. Communities' transitional housing. Over the past four months, Sandra had gotten a job, was enrolled at the community college, and had moved her family to their own apartment. Even though her life had stabilized considerably, she was grieving the recent death of a close friend and has been feeling stressed over negative dynamics in her neighborhood. Because of her previous experience with the support group, Sandra recognized the negative stressors and decided to re-engage in the MOSAIC Moms program. Sandra said she "miss[ed] the support from the group and missed having the skills that help me process things, stay positive, and keep focused on my goals."

16.0. External technical assistance and consultation

MOSAIC staff members received a great deal of technical assistance from the cross-site evaluation team at NTI Upstream.

The Illinois Children’s Mental Health Partnership provided a consultant to support the staff involved with providing services in early childhood settings.

17.0. Cultural competence

Memorial Behavioral Health conducts an annual organizational assessment of linguistic and cultural competence, as required to maintain our certification with the Illinois Department of Human Services. We use the assessment results to modify our master plan for Linguistic and Cultural Competence, which includes short- and long-term goals as well as strategies for providing language assistance to clients, hiring bilingual staff, and training staff.

As an on-boarding requirement, all new staff members complete an initial person-centered training to increase their sensitivity to the needs of special populations we serve who have mental health and intellectual disabilities. Additionally, every staff person—clinical and non-clinical—is required to complete an annual computer-based learning module on cultural competency to remain mindful of issues related to serving clients. The agency’s policies and procedures related to cultural competence apply to all program staff and activities, including MOSAIC.

Moving from the general to the specific, MOSAIC’s partnership with The Springfield Project (TSP) augmented the MOSAIC staff’s cultural competence. From conducting focus groups during the planning phase to deploying the Neighborhood Outreach Workers during implementation, TSP gave voice to the residents of the Neighborhood of Hope. Through their involvement with economic development and neighborhood revitalization, TSP has demonstrated their ability to engage a difficult-to-reach population. They also leveraged existing relationships with trusted faith- and community-based organizations, such as neighborhood churches and the Boys & Girls Club, to host MOSAIC services.

18.0. Sustainability/longevity of the leadership

The incremental process is the best way to embed the changes MOSAIC has called for. Rather than screen every child in Springfield, the initiative has limited screening to children for whom services can be provided if they have a positive screen . . . And this process of gradual embedding is showing signs of the desired pay-offs.

DAVID RACINE, PH.D, *Center for State Policy and Leadership, University of Illinois at Springfield*

Since 2010, two individuals have led MOSAIC’s day-to-day program management. The first manager held the position full time for three years. Because she was hired during the planning phase, her responsibilities included logistics and operations related to program start-up. In subsequent years, she continued to start new sites, but her responsibilities extended to managing existing sites, meeting funding requirements, generating and maintaining community support, budgeting, communicating with stakeholders, and staff supervision. When she advanced to another position in the agency, she continued to manage the program for one year concurrently with her new duties. Over time, the nature of the position evolved as the program expanded. At the beginning of Year 4, the second manager transitioned to the position and remained until the end of Year 7, when grant funding ended. She spent the majority of her time integrating the program into the community and schools, strengthening partnerships, and reporting accomplishments to stakeholders. Staff supervision duties were re-assigned to other staff, freeing up the MOSAIC Manager to focus on implementing a Mental Health First Aid program (see Section 4.10) and other tasks related to community benefits and community care, as a whole.

The clinical supervisor is on staff at Memorial Behavioral Health. The Springfield Project now employs the Neighborhood Outreach Workers. The Outpatient Behavioral Health Manager supervises the primary care staff. District 186's Student Services Coordinator supervises the school staff.

One of the advantages of expanding the position beyond MOSAIC is the opportunity to apply to the health system for funding to support community benefit activities, including a portion of the manager's salary. In Years 6 and 7, the MOSAIC Manager devoted 60% of her time, on average, to the program.

19.0. Plans for preparing the next generation of system leaders

In 2013, Memorial Behavioral Health's executive team realized that many of the agency's key leadership positions were filled by individuals who were approaching retirement age. To avoid a gap in human capital as our seasoned employees retire, we devised a plan to develop leadership among our less experienced staff. We hired an organizational development consultant and formed a steering committee in 2014. The following year, we convened the first cohort of emerging leaders four times throughout the year and used the appreciative inquiry approach to interview participants at the end of the year. In 2016, we formally chartered the Memorial Behavioral Health Emerging Leaders Group.

Each year, the steering committee solicits supervisors to nominate staff members who have demonstrated leadership potential. We invite the nominees to join the next cohort of participants and assign each person a member of the steering committee to guide her/him through the process of developing an individual learning plan. The guide provides an overview of the program, invites the participant to discuss his or her leadership path, and offers encouragement to identify activities that will help define or clarify a leadership path. Activities may include, but not be limited to the following:

- Formal mentoring with a steering committee member or program graduate;
- Expansion of knowledge (e.g. attending a workshop or visiting an inspirational program or agency); or
- A targeted experience (e.g. shadowing specific leaders that interest them, chairing a project outside one's particular area of responsibility).

All cohort members are required to:

- Complete the Character Strengths and Virtues survey and discuss the results and possible applications with the other cohort members;
- Review the organizational development resources available through the Memorial Center for Learning and Innovation; and
- Participate in cohort meetings held three to four times a year.

Each cohort meeting features two key activities:

- Interviewing seasoned leaders to understand and celebrate their leadership journey; and
- Participating in small group discussions facilitated by graduates of the Emerging Leader initiative. The discussions focus on mutual support and skill development.

Each cohort continues to meet until all its members have graduated from the program. Graduation occurs when a participant transitions to a leadership position or has a clear understanding of her/his leadership path and the next step in the journey.

The MOSAIC staff members are employed by Memorial Behavioral Health and, therefore, are included in all issues that impact other agency staff. Several MOSAIC staff members participate in the Emerging Leaders initiative, including the Project Manager. In some cases, MBH employees completed their master's degrees in counseling through the Emerging Leadership program and transitioned to MOSAIC positions.

LESSONS LEARNED

APPLYING A GRADUAL APPROACH TO SCALING THE PROJECT

- Starting with the highest-need areas of the city and gradually scaling the capacity of the project—based on staffing capacity rather than screening results—has proven to be an effective strategy. Because of the project’s complexity, scaling up more quickly would be difficult to manage.
- We have found that integration of behavioral health in schools and physician practices is a school-by-school, physician-by-physician effort.
- We have been deliberate about framing MOSAIC as a grassroots, bottom-up approach. Based on our experience, real systems change cannot take place if the individuals responsible for implementing the model in their setting perceive the changes are being imposed from an outside entity or in a top-down manner.

MANAGING EXPECTATIONS AND AVOIDING SCOPE CREEP

- During the planning phase, we recognized the need to manage expectations and to prevent scope creep. As we conducted the key informant interviews, people began spreading the word about MOSAIC, which generated great excitement and hope about how the project could help children and families. In some cases, however, community leaders viewed MOSAIC as the vehicle for solving problems that fell outside MOSAIC’s scope. We realized we must strike a balance between encouraging people to imagine the possibilities and communicating the project’s limited scope.
- We discovered that we had to guard against scope creep even among our Steering Committee members, who, one would assume, had a clear understanding of the project’s parameters. However, each person brought a set of expectations and a list of mandates they wanted to fulfill. Each person viewed the project through a lens that specified the best way to work with children and families.
- We were surprised to encounter complaints from parents and social service providers who felt their children or clients were excluded from participating in MOSAIC services. In most cases, the objections subsided once we explained that we wanted to ensure we could serve the children who were identified as needing mental health services rather than screen every child and place them on a waiting list.

ACCOMMODATING THE GATEKEEPERS

- Successful implementation of a system of care required the implicit and explicit approval of many gatekeepers, individuals who hold positions of power—either real or assumed. The gatekeepers determined if and when and to what extent they would adopt the changes required to implement the system of care, or, in some cases, grant access to the true decision-makers. We encountered two levels of gatekeepers—administrators and front-line staff. For example, we had to secure administrative approval in every department within one partner organization prior to accessing MOSAIC participants’ electronic health records. The process was cumbersome and time consuming.
- While buy-in at top levels was necessary, it was not sufficient. Buy-in and support on the front lines—at the point of contact with children and families—was crucial. We believed that securing local ownership among the front-line staff would ensure the work of MOSAIC would continue because they understood the concept and saw the benefits first-hand.
- Expanding MOSAIC’s capacity in school settings required intentional efforts to build support among school personnel. Unlike primary care practices, which provide individualized clinical services, schools are oriented toward teacher-led group instruction. And, although schools have systems to meet the needs of individual students, the primary focus is on the group. Therefore, for successful implementation within any given school, each teacher in that school must understand and support the model.

- Our efforts to obtain stakeholder support have been thwarted on several occasions, due to external factors. For example, over the past seven years of implementing MOSAIC, Springfield Public Schools has replaced its Superintendent of Schools four times. Over the years the school district has experienced contentious relationships among its Board members and the Superintendent, scandals related to the Board/Superintendent, accusations of leaked test data, and school closures. MOSAIC has also been impacted by leadership turnover among other partner organizations including The Hope Institute for Children and Families, United Way of Central Illinois, and the Greater Springfield Chamber of Commerce, all three of which were integral to establishing MOSAIC. Furthermore, Central Counties Health Centers dismissed their CEO shortly before he executed a contract for embedding a MOSAIC clinician in their practice.
- Internally, Memorial Behavioral Health also experienced significant turnover in leadership, including the Program Director and several executive-level personnel. We needed to attend to relationship-building during the transitions to ensure our stakeholders that the personnel changes would not negatively impact MOSAIC.
- The Behavioral Interventionist/Health Specialist position at the school sites was problematic from the beginning. We discovered early in the project period that embedding a full-time staff person who lacked specific training in behavior management simply did not produce the return on investment in terms of impact on student outcomes, especially in an environment of shrinking school funding. Furthermore, we discovered that the position required two distinct skills sets that would be delivered more effectively by two separate positions—one position to coach school personnel and one position to address student crises. In addition, there was too much overlap in the job descriptions for three of the school-based positions—the MOSAIC on-site clinician, the school social worker, and the MOSAIC behavioral health specialist. Ultimately, the school district created a hybrid position (see Section 4–Evolution of Services).

FIDELITY

- MOSAIC is a relatively new system of care, which has been evaluated on a limited scale. As MOSAIC produces more usable data over time, we will use the evaluation process to identify aspects of the model that are critical to success, and, therefore, imperative that we continue to implement with fidelity.
- As with any change in practice, component processes tend to drift over time from what was originally intended. Some of this drift is adaptive. That is, initially proposed processes do not work as expected and those who are implementing the process find better, more effective strategies.
- Drift also can be problematic. As MOSAIC continues to scale up over time, ensuring that each school and primary care office implements the model with fidelity is important to achieving desired outcomes. This involves a great deal of up-front staff time meeting with leadership at each new site, explaining the model, securing their buy-in, and educating each teacher and physician how to integrate MOSAIC into their existing services.

CONSISTENCY

- Screening children on a regular basis for potential social-emotional problems has been a valuable and necessary addition to the standard repertoire of clinical practice. But, it should not be assumed that every professional administering or scoring screening understands it in the same way. For example, some children screen positive but may not receive needed assessment or treatment. When Springfield Public School District 186 implemented a policy to conduct universal screenings in all schools at all grade levels (effective the last year of the project period), they found anomalies in screenings that stemmed from individual teachers' perspectives that will require further education and refinement. It is important that the gateway into mental healthcare for children be uniform to ensure that all children are being served fairly. Therefore, we need to communicate our expectation of how

the screenings should be scored, monitor the process for consistency across all MOSAIC sites, and provide feedback to the individual professionals.

- Because a child's diagnosis drives treatment decisions, informs parental expectations, and determines eligibility for educational services, it is essential that the diagnosis (or lack of diagnosis) be as accurate as possible. Forming multidisciplinary assessment teams is one strategy for ensuring each child receives a comprehensive assessment. This approach requires significant resources in terms of recruitment and training professionals.

COLLABORATION

- Local stakeholders, across the spectrum, have been extraordinarily supportive of MOSAIC. This support is a function of decisions made at the outset to create plenty of room for participation by those who wanted or needed to be involved. As MOSAIC has matured, the role of the Steering Committee shifted from short-term planning and implementation to long-term strategic planning and sustainability. Some stakeholders have resisted this shift, due in part because sustaining a system of care is less enthralling than forming one.
- Typically, collaboration is achieved at the macro level when the leadership of each partnering organization agrees to the terms of the collaboration and executes a memorandum of understanding that outlines the terms of the agreement. But collaboration can also leverage existing relationships on the micro level. Integrated care involves more than simply occupying the same building. The families need to see that there is a relationship between the provider they already know and trust (the physician, school social worker, teacher) and the mental health provider they are being referred to. Ideally, a referral to the mental health provider includes a personal introduction.
- Integrated care also requires responsiveness and flexibility on the part of the mental health clinician embedded at the MOSAIC site. For example, being available to assist a physician or teacher in a crisis situation generates good will and appreciation for integrated mental health services.

ENGAGEMENT IN MENTAL HEALTH SERVICES

- Despite the progress MOSAIC has made in the community in terms of universal screening and early intervention, engaging families in treatment in clinic-based settings continues to be problematic. Most families are willing to permit their children to receive mental health services at the school but are less likely to take their children to the clinic for more intensive treatment. When the Outreach Workers conducted home visits, the residents were friendly and engaged in conversation, but they were extremely reluctant or unable to receive formal mental health services—even when the services were offered in the home—due to stigma, mistrust, the amount of paperwork required, and other barriers.
- We have struggled with engaging families in neighborhood settings, primarily because we did not have the resources to address the families' basic needs (see Section 4—Evolution of Services). A more recent initiative in Springfield, called the Enos Park Access to Care Collaborative, has experienced better engagement outcomes in its first two years than MOSAIC has achieved in seven years. Following the Enos Park model, we now use Community Health Workers who are accountable to a Neighborhood Advisory Board and who have a larger mandate to address a family's and community needs, with no restrictions.

STAFFING FOR IMPLEMENTATION VS. STAFFING FOR SUSTAINABILITY

- During the planning phase, we anticipated that we would subcontract with partnering organizations for key personnel. Further discussions resulted in the decision for the lead agency to hire all key MOSAIC positions to provide greater control and consistency.
- Beginning with the planning phase, the Executive Team has always been very mindful of sustainability in terms of staffing. We did not include positions unless they met one or more of the following criteria: the position could be eliminated when the implementation phase ended; the position could be

significantly reduced and transferred to a partner organization; or the position could be sustained through billing or local funding. To date, the clinicians embedded in primary care sites are proving sustainable. We increased the school-to-clinician ratio to reduce overall staff costs and sustain the school-based sites.

- The focus on sustainable positions worked against us in terms of the Project Director's position. Initially MOSAIC focused most of its funding from ILCHF on establishing the systems and process needed for the primary care sites. The budget supported very few positions devoted to functions related to organization and structure. The Project Director's organizational responsibilities prohibited her from conducting day-to-day oversight of implementation. Supervising staff in multiple off-site locations would have justified a separate position. The Project Director spends considerable time cultivating and launching new sites, but, once the sites are operational, the focus shifts to supervision and monitoring.
- We discovered that the high staff turnover rate in Year 7 at the school-based sites negatively impacted child outcomes.
- As originally conceived, we would sustain the Outreach Worker positions by billing for services under Medicaid Rule 132. When families declined to engage in home-based mental health services, the Outreach Workers were unable to bill their time because outreach efforts are not covered by Rule 132. We later found other avenues for reaching and supporting neighborhood children, such as embedding a MOSAIC staff person to facilitate a social/emotional curriculum in after school programs. This approach was more effective and acceptable to families than home-based services.

DATA COLLECTION

- While we are able to report on the number of screens and number of children receiving services, electronic health records have hindered our ability to report on positive screen rates in medical settings. Spending more time during the planning phase to examine the data capabilities of primary care practices would inform a more realistic timeframe for implementation. Furthermore, creating a supplemental data collection system that we could control directly would facilitate the evaluation process, while the partnering sites improve their EHR systems, institute EHR-based data collection, and train their staff.

EVALUATION

- Developing a system of care occurs over the course of several years. Evaluating its impact on systems change cannot be evaluated adequately in a period of two or three years. Further resources are needed to extend and enhance the evaluation. We anticipate that the results over time will be even more compelling than the initial findings, offering the opportunity to seek funding from local, regional, and national funders to sustain the MOSAIC model.

SUSTAINABILITY

- We have partnered with our local United Way and Community Foundation from the initial discussions that became MOSAIC. Their involvement has helped us secure local funding for components that were not supported by ILCHF funding. In fact, MOSAIC's relationship with the Community Foundation led to a shift in funding focus for one of their donor-advised funds, resulting in multi-year grants to support the MOSAIC Moms program.
- We have not capitalized yet on federal funding opportunities, such as the Agency for Healthcare Research and Quality, for dissemination of promising practices, utilizing a community collaborative.

ADVICE TO OTHER COMMUNITIES

- **Be mission driven.** Develop the system of care that meets the long-term need of the community with the eye to sustainability upfront. The best grant-funded programs outlast the initial funding due to careful planning and commitment to providing those services.
- **Be determined.** Much of the time, system of care development does not occur in a linear fashion. As such, there are times when seeing progress is difficult. Remaining determined in such times and focusing on the end goal is helpful.
- **Be flexible.** There are many forces that impact the development of a system of care. Many of these forces are not predictable and some of them are entirely unknown! Those involved must maintain a degree of flexibility to manage the unexpected.
- **Don't do it alone.** Discussion with other sites and other project directors has been very valuable. Beyond sharing resources and information, there are opportunities to share support. Leading the development of a system of care can be isolating (no one else in your agency has a similar job) and challenging (it's a large undertaking). Reaching out to and maintaining regular contact with others who are in similar positions is helpful.

CONCLUSION

The Illinois Children's Healthcare Foundation grant was given to four communities to transform children's mental health. The Springfield community is on that path by proactively identifying kids and families in trouble and providing that immediate assistance in schools, physician offices, and community settings. It is a fundamentally different approach than the traditional community mental health system of care. In that system, services are limited to children already diagnosed with serious emotional disturbances. In that system, children usually engage in services only after experiencing a significant crisis event. We are grateful to the Foundation for this opportunity and look forward to increasing our community's ability to identify and provide early intervention so that all children have the opportunity to grow up happy, healthy, and successful. We look forward to quieting the "ghosts" of children past who have suffered in isolation.

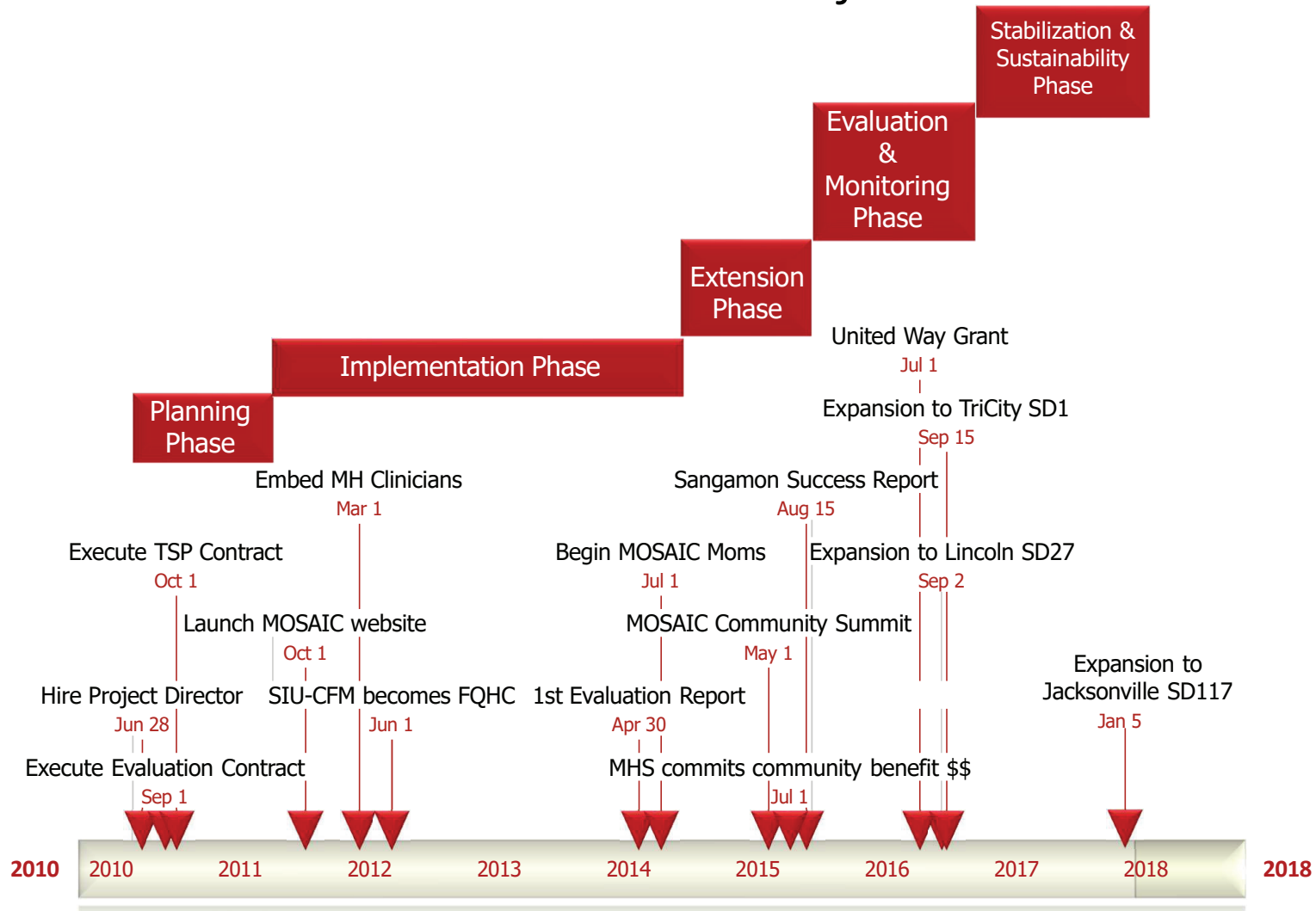
JAN GAMBACH, *President, Memorial Behavioral Health*

Children's MOSAIC Project

System of Care Development and Implementation Manual

Appendices

The Children's MOSAIC Project Timeline



Appendix A.2. Expansion timeline

Children's MOSAIC Project - Expansion Timeline														
School Sites	2012		2013		2014		2015		2016		2017		2018	
	Spring	Fall	Spring	Fall	Spring	Fall	Spring	Fall	Spring	Fall	Spring	Fall	Spring	Fall
Matheny-Withrow Elem														
Capitol College Prep Acad					closed May 2013									
Head Start														
St. Patrick Cath.														
Washington Middle														
Southeast High														
Graham Elem.														
Harvard Park Elem.														
Fairview Elem.														
McClermand Elem.														
Douglas Alt.														
Black Hawk Elem.														
Springfield Learning Academy														
Enos Elem.														
Lincoln Jr. High														
Tri City Elem.														
Tri City Jr. High														
Garrison														
Primary Care Sites														
SIU-CFM														
KMMA														
SIU-Ped														

Service Network Gaps

1. **Infant Mental Health:** There are few providers in the area who have any formal infant mental health training. The MOSAIC is working to develop a central chapter of the Illinois Association of Infant Mental Health to increase access to training in the region. In addition, we are exploring options for training local providers in an infant mental health model.
2. **Comprehensive Assessment:** Most children who receive mental health services in Springfield do not receive a multidisciplinary assessment. One of the hurdles is the availability of relevant professionals. Opportunities to develop and/or support post-doc positions in partnership with local organizations are being examined. Springfield is well-positioned for the development of a multi-disciplinary assessment clinic. Through the Children's Healthcare Partnership, a variety of agencies are located in a single building. SIU Center for Family Medicine began seeing patients at the Noll Pavilion in late 2010. Also located at Noll are MHCCI's Children's Center, The Autism Program, and the Noll Dental Clinic (which specializes in desensitization techniques). The Children's Healthcare Partnership is moving toward full-integration of services centered around the medical home.
3. **Psychiatry:** Access to child psychiatrists is limited, although perhaps not to the degree that it is in other areas of the state. We are exploring options for maximizing the impact of available psychiatric resources including consultation, training of primary care providers, etc.
4. **Mental health services for children with a developmental disability:** Current billing rules make it challenging to meet the mental health needs of children with developmental disabilities. We are exploring potential solutions to this issue.

Appendix A.4. Community partners

Letter of Commitment (LOC), Letter of Support (LOS), &/or Linkage Agreement (LA)		WEBSITE	TYPE OF ORGANIZATION/PRIMARY ACTIVITIES
Partners: COL, CHP, SSHS			
LOC, LA	Boys & Girls Club of Springfield	www.bgccil.org	Provides mentoring and leadership specifically designed to change the lives of youth who face daily challenges such as poverty, broken homes, crime, unemployment, prejudice and difficulties in school.
LOC	City of Springfield, Mayor Tim Davlin		
LOC	Continuum of Learning, Steering Committee	www.continuumoflearning.com	Partnership between SCCF, The Chamber, & UW whose purpose is to ensure that all Sangamon County residents are Ready to Work, Ready to Learn, and Ready to Succeed
LOC	Mental Health Centers of Central IL, Memorial Health System Affiliate	http://www.mhcci.org/	refer to narrative
LOC, LA	SIU Department of Psychiatry	http://www.siumed.edu/psych/	The mission of the SIU School of Medicine, Department of Psychiatry, is to engage in excellence in psychiatric education and research while providing high quality, effective, state-of-the-art clinical care.
LOC, LA	SIU Center for Family Medicine (formerly Physicians & Surgeons)	http://www.siumed.edu/physurg/	Committed to providing the people of central and southern Illinois with the best possible medical care and treatment
LOC	Sangamon County Community Foundation	http://www.sccf.us/	Serves as a bridge between donors in the community and the institutions whose collective mission is to improve quality of life.
LOC	Springfield School District #186	http://www.springfield.k12.il.us/	Springfield Public Schools
LOC	Springfield School District #186: Family & Community Engagement Office	http://www.springfield.k12.il.us/familyengagement/	Building Partnerships and Relationships to Support Student Achievement
LOC, LA	Springfield Urban League (Head Start)	www.springfieldul.org	Head Start is a comprehensive, inter- disciplinary, national child development program designed to meet the educational, nutritional, health, social service and mental health needs of low income preschool children and their families, free of charge.
LOC, LA	The Chamber: Greater Springfield Chamber of Commerce	www.gssc.org	Voluntary organization of business and professional men and women joined together for the purpose of promoting the civic and commercial progress of our community.
LOC, LA	The Hope Institute	www.thehopeinstitute.us	To support children and families to reach optimum growth, independence, and joy. Provides evidence-based, empirically-supported residential, educational and health services to children and families; trains professionals in the provision of services
LOC	The Autism Program (TAP) at The Hope Institute	http://www.theautismprogram.org/aboutus.asp	A systems initiative, network of resources for Autism Spectrum Disorders. Provides the strategy and framework for the State of Illinois to address the complex issues involved in diagnosis, treatment and research.
LOC, LA	United Way of Central Illinois	http://www.springfieldunitedway.org/	Offers a number of programs to mobilize resources to meet community needs
Supporting Agencies			
LA	American Red Cross, IL Capital Area Chapter	www.il-redcross.org	Non-governmental provider of emergency services, including disaster relief, comfort for victims, necessary food, clothing, temporary shelter, first-aid and mental-health counseling. Also has educational programs in first aid, CPR, babysitting, AED use, etc.
LOS, LA	Big Brother/Big Sister	www.bbbsCapitalregion.org	To provide a mentor to every child who needs and wants one, contributing to better schools, brighter futures and stronger communities.
LOS	Capital Community Health Center	www.capitolcommunityhealthcenter.org	Family Practice, Internal Medicine, Pediatrics, and General Dentistry. Medicaid, Medicare and other health insurance is accepted. Discounted sliding fee for those without health insurance.
LOS, LA	Catholic Charities	www.cc.dio.org	Services include adoption; counseling programs; day care; senior services and guardianship; health care; residential care, foster care, independent living; special education, emergency shelter care; family preservation services; food and clothing
LOS	Central Baptist Church		Faith Community
LA	Central Illinois Foodbank	www.centralilfoodbank.org	Does not serve individuals, but distributes food to pantries, soup kitchens, after-school programs, and residential centers - 160 partner agencies in 21 central and southern IL counties which hold not-for-profit status and serve the food at no cost.
LOS	Community Child Care Connection, Inc.	www.cccconnect.org	A Child Care Resource and Referral agency linking parents, providers, employers and the community with resources. CCCC is part of the Illinois Network of Child Care Resource and Referral Agencies and is funded in part by the Illinois Department of Human Services. CCCC serves Christian, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Sangamon and Scott counties.
LOS	Computer Banc	www.computerbanc.info	Provides children who are academically at risk with computer access at home. Also provides technology for other not-for-profits and schools. Refurbishes donated equipment for reuse in the community - seeks to expand volunteer staff and clientele.
LOS	Contact Ministries	www.contactministries.net	Homeless shelter for women and children, employment assistance, budgeting, family literacy, parenting classes, tutoring, and case management with a goal of finding and maintaining permanent housing. Referrals are made for other mainstream resources through partnerships with other local service agencies.
LOS, LA	Family Service Center	www.service2families.org	Strengthen families through services including adoptions, counseling, adoption preservation, parenting classes, and programs for pregnant/parenting teens.
LA	Fifth Street Renaissance/Sara Center	www.fsr-sara.org	Transitional housing for homeless and those who have HIV; provide food, youth & family support services, and comprehensive case management programs.
LOS, LA	Gateway Foundation & Youth Care Foundation	gatewayfoundation.org	For teen males age 13-18 and adult males and females with substance abuse issues. Provides group and individual counseling; basic outpatient for teens and adults; intensive outpatient for teens and adults, short-term and long-term residential treatment for teens.

Appendix A.4. Community partners, *continued*

LOS	Heartland Continuum of Care; c/o Helping Hands of Springfield		Help to plan and coordinate services to the Springfield homeless community. Local Affiliate of HUD's Continuum of Care network
LOS, LA	Helping Hands of Springfield, Inc.	http://www.helpinghandsofspringfield.org/	A non-profit organization to shelter the homeless, provide support, promote independence and work with others in the prevention of homelessness in the community.
LOS	IL DHS	www.dhs.state.il.us	Office of Mental Health helps maximize community supports and develop skills for persons with serious mental illness and children with serious emotional disturbance. Community Health & Prevention improves the health and well-being of families and individuals through partnerships and services that build community competence.
LOS	Kids Hope United	www.kidshopeunited.org	We provide advocacy, support and treatment to vulnerable children and families. Offer the diverse array of intervention, prevention, child development, counseling, family preservation, youth services and placement services.
LOS, LA	Land of Lincoln Goodwill Industries	http://www.llgi.org/	Programs include: Supported employment, Developmental Training, and Workforce Development
LOS	Lincoln Prairie Behavioral Health	http://www.lincolnpairiebhc.com/index.htm	Provide treatment to children and adolescents that present with a broad range of psychiatric and behavioral disorders. 80 inpatient psychiatric beds for youth ages 3-17; array of outpatient programs including partial hospitalization and intensive outpatient to complement and supplement the community needs of Springfield; physicians to monitor medications and treat childhood behavioral and mental health needs; inpatient\ outpatient treatment options
LA	Lutheran Child & Family Services	http://www.lcfs.org/Page.aspx?pid=388	Programs/Services: Adoption; Foster Care; Individual, Marital and Family Counseling; Pregnancy Counseling; Family Life Education
LOS, LA	M.E.R.C.Y. Communities	http://www.mercycommunities.com/	Provide Housing and Supportive Services to Foster the Independence of Homeless and At-Risk Families.
LA	Mini O'Beirne Crisis Nursery	http://www.miniobeirne.org/	Prevent child abuse and neglect by providing emergency, temporary care, 24 hours a day, 365 days a year, for children who may be at risk or whose parents are experiencing some type of crisis.
LOS	Memorial Health System	https://www.memorialhealthsystem.org/	Leading healthcare organization in Illinois dedicated to patient care, education, and research. All six Memorial System affiliates participate in health screenings and educational events to further provide for the healthcare needs of our community.
LOS	Memorial Home Services	http://memorialhomeservices.com/	Home health services include skilled high-tech nursing, home health aids, maternal-child program, specialized wound care and telehealth, nutritional services, private-duty services, social services and rehabilitation.
LOS	Prevention First	https://www.prevention.org/	Committed to building and supporting healthy drug-free communities through public education, professional training and effective tools for those working to prevent drug use and related issues such as violence, teen pregnancy and academic failure.
LOS, LA	Rutledge Youth Foundation	http://www.rutledgeyouthfoundation.com/	Where Abused and neglected youth become productive, independent citizens. Services: Case Management/Youth Counseling, Group Home/Transitional Living Residency, Transition to Independent Living, Foster Care, Psychological Support Svcs, & Systems of Care
LOS, LA	Sangamon County Court Services Dept./ Juvenile Probation Dept.		Administrative, Adult, Juvenile, and Detention Services
LOS, LA	Sangamon Co Dept. of Community Resources	http://www.co.sangamon.il.us/departments/resources.asp	Strives to raise the health, education, and economic standards of Sangamon County residents living at the lower social and economic margins
LOS, LA	Sangamon Co Sheriff's Office	http://sheriff.co.sangamon.il.us/	Sheriff's Dept.
LOS	Sojourn Shelter & Services	http://www.sojournshelter.org/	Free and confidential services include: shelters, children's program, court advocacy, SAFER program, non-residential, & prevention and education
LA	SPARC	http://www.spfldsparc.org/gw1/	Helps individuals with developmental disabilities improve the quality of their lives; Spare programs include 24-Hour Residential Support, Developmental Training, Supported Living, Respite, Supported Employment, Family Support and the Epilepsy Resource Center
LOS	Springfield Community Federation	http://www.springfieldfederation.org/	Provider's Council, ENCORE care donation program, Youth education and workforce program (NBA), and Neighborhood transformation initiatives such as "Sprucing up Springfield" and "Miracles on 13th Street".
LA	Springfield Housing Authority	http://www.springfieldhousingauthority.org/	Provides quality affordable housing to individuals and families, while encouraging partnerships necessary for residents to develop self-sufficiency and to be productive members of the community
LOS, LA	Springfield Jewish Federation	http://www.shalomspringfield.org/	Programs include: Chaverim and Social Services, Adult Education, Youth and Family, Jewish Community Relations Council, and Maimonides.
LOS, LA	Springfield Police Department	http://www.springfield.il.us/police/default.htm	Working in partnership with the community to promote open communication, education, cooperation, and fair and equal treatment to improve the quality of life, promote unity, encourage respect and make Springfield a safe community.
LA	Springfield Public School Dist. #186 Special Ed	http://www.springfield.k12.il.us/specialeducation/	Offers a full continuum of services for students with disabilities, ages 3-21 years old
LA	Springfield/Sangamon Co. Schools (ROE #51)	http://www.springfield.k12.il.us/	Regional Office of Education, Area #51
LA	St. John's Hospital	http://www.st-johns.org/	Hospital
LOS, LA	The Parent Place	http://www.tppos.org/	Teach local parents and professionals who work with children effective parenting skills.
LOS, LA	The Salvation Army	http://www.tsaspringfield.org	Mission is to preach the gospel of Jesus Christ and to meet human needs in His name without discrimination
LOS, LA	Triangle Center	http://www.trianglecenter.org/	Offers a full array of inpatient and outpatient chemical dependency programs for adults, outpatient services for youth, and workplace programs for employers as well as DUI services
LOS	United Cerebral Palsy	http://www.ucp.org/ucp_local.cfm?72	Provides comprehensive services to over 1,000 infants, children and adults with disabilities in 27 counties in Central Illinois.
LOS, LA	Youth Service Bureau	http://www.ysbi.com/	The mission of the Youth Service Bureau is to divert youth from the juvenile justice and/or child welfare systems by providing access to needed comprehensive community based services aimed at prevention, diversion or treatment.

MOSAIC Framework for the School Setting

Tie in MOSIAC mission to everything--make this visible.

What is MOSAIC?

MOSAIC is a system of care that braids together community resources to provide embedded behavioral health services in the school setting.

What are MOSAIC services?

- Embedded clinician to:
 - Provide onsite individual and family therapy
 - Provide behavioral health education as it relates to classroom management
 - Provide professional development around behavioral health education
 - Integrate within school systems to advocate for MOSAIC students
- Identification of and access for students to appropriate school interventions

How to pick a MOSAIC school

Assessed by school readiness and/or percentage of students with Tier III needs

Principal and school staff must have an understanding of MOSAIC and the commitment to appropriately integrate behavioral health in the school setting

Making MOSAIC a priority for the school and the students to ensure success of social-emotional learning

Long-term commitment to continuously advocate for the success of MOSAIC at individual school site

Willingness to embracing MOSAIC clinician as a part of the school team

Needs access to private space as an office and therapy room

Having braided behavior support teams in place, making decisions at all three tiers

Having systems and processes in place that help facilitate school behavioral health integration

Once MOSAIC is in the school, what needs to be in place

- Continual collaboration between social worker and MOSAIC clinician
- Continual collaboration within larger MOSAIC team, as outlined below
- Consistent use of universal SEL screener (suggested twice a year screening)
- Ensure fidelity of the referral process, i.e. MOSAIC warm hand-off, school as first contact for students and families regarding behavioral health needs
- Communicate concerns to Lead Social Worker and/or MOSAIC Project Manager
- Celebrate successes with staff, families, and communities
- Frequently analyzing behavior data for the purpose of progress monitoring students and MOSAIC SOC
 - System in place to share data, as appropriate, with MOSAIC team

Who needs to be at the table

Specific roles at site-level

School social worker

- Presentation to staff on MOSAIC and benefits of an annual universal screener
- Send out screening letter to parents
- Organize universal screener and facilitate the administration to teachers/staff/students
- Analyze results school-wide, class-wide
- Input necessary tracking data into spreadsheet for program evaluation purposes and program impact purposes
- Make initial contact with families of students identified as eligible for MOSAIC services (script provided as guide for discussion of program)
- Schedule initial appointment for student with MOSAIC clinician
- In charge of facilitation of teacher referral forms
- Remains touch base person for all social-emotional things at the school site
- Continual coordination with site-based clinician
- Coordinate BBSS interventions for identified students that do not qualify for MOSAIC
- Coordinate appropriate BBSS interventions for students eligible for MOSAIC but not in services yet, students in MOSAIC, and families that have declined services
- Continue to reach out to families to engage in MOSAIC services
- Attend MOSAIC school teams meetings
- Assisting the integration of the MOSAIC clinician into the school setting

Building principal

- Assist the integration of the MOSAIC clinician into the school setting
 - Advocate for MOSAIC clinician in the building
 - Supporting logistical elements, i.e. space, scheduling, acquiring district electronic access
 - Participate in development of MOSAIC clinician training/observation schedule at the school site
- Advocate for MOSAIC program at the building-, district-, and community-level
- Celebrate program achievements and impact
- Attend MOSAIC school teams meetings
- Keep open communication between district and behavioral health systems
- Maintain strengths-based perspective in solving programs ("stay at the table")
- Facilitate the fidelity of MOSAIC implementation
 - Ensure the completion of the universal screener
 - Ensure students are referred to appropriate program interventions
 - Ensure appropriate role boundaries

School psychologist

- Coordinate with school social worker to analyze results and potentially assist with referral process.
- Referral to any appropriate intervention

MOSAIC clinician

- Attend weekly supervision at MBH site

Appendix A.5. School framework, *continued*

- Attend bi-weekly MOSAIC clinician meetings
- Attend MOSAIC school teams meetings
- Maintain schedule on Google Calendar
- Input necessary tracking data into spreadsheet for program evaluation purposes and program impact purposes
- Attend appropriate school meetings, e.g., IEP meetings for MOSAIC clients, any professional development pertaining to social-emotional learning, and as appropriate participate in braided behavior support services
- Coordinate with school social worker on:
 - Presentation to staff on MOSAIC and benefits of a universal screener on an annual basis
 -
- Facilitate weekly touch bases around schedule, students engaged in MOSAIC, identifying families difficult to engage, etc.
- Provide professional development to designated school staff, e.g. strategies for anxiety in the classroom
- Participate in integrated training through MBH and school district
- Meet direct client care hours per week (20 hours)
- Provide home visits as necessary, especially on school breaks and during the summer, to continue MOSAIC engagement
- Participate in annual school registration prior to the start of the school year

Parent educator

- *If available*
- Coordinate with social worker to support families
 - Connect families to needed services in the community
- Coordinate with MOSAIC Clinician
 - Assist families with addressing barriers to engage in services available at the school
 - Provide transportation for families to appointments
 - Accompany clinician on home visits as needed and as appropriate

Lead social worker (MOSAIC Leadership)

- Act as liaison for MOSAIC between school setting and mental health
- Collaborate with MOSAIC Project Manager to:
 - Plan professional development
 - Facilitate site-based meetings
 - quarterly
 - Develop protocols, referral streams, data tracking systems, MOSAIC communication to school sites
 - Participate in monthly check-in meetings
 - Facilitate MOSAIC Schools Team Meetings
- Serve on MOSAIC Executive Team
- Provide technical assistance to site-based social workers
- Schedule MOSAIC Schools Team Meeting
- Provide professional development to MOSAIC clinicians around school systems

Lead psychologist (MOSAIC Leadership)

- Provide support and technical assistance as needed
 - Help with school data collection for MOSAIC students

Director of Student Support Services (MOSAIC Leadership)

- Oversee implementation and integration of MOSAIC district-wide
- Act as liaison between MOSAIC and Superintendent
- Act as liaison between MOSAIC and Cabinet members
- Act as liaison between MOSAIC and leaders across student support departments
- Serve on MOSAIC Executive Team
- Participate in quarterly collaboration meetings with Lead Social Worker and MOSAIC Project Manager
- Guide in the selection process for bring on new MOSAIC schools
- Advise and assist in the evaluation of program and staff located in the schools

Superintendent

- Advocate for project throughout school district and in the community
- Advocate on the importance of social/emotional well-being
- Provide access to decision makers in the District at multiple levels, parents of students, and key community stakeholders
- Commit to innovative approaches to school/mental health integration
- Have and share knowledge of state and federal funding levels and opportunities
- Have knowledge of needs of children and families including the underserved
- Effectively communicate the needs of schools and children within the community
- Provide support (manpower and financial) to incorporate universal screening, behavioral health interventions within the school setting
- Support training of school personnel on MOSAIC programs and cross-training of mental health staff to educational issues
- Consult to other principals and schools on behavioral health integration within the school setting

MOSAIC Project Manager (MOSAIC Leadership)

- Participate in BBSS Team meetings
- Collaborate with Lead Social Worker to:
 - Plan professional development
 - Facilitate site-based meetings
 - On a semester basis
 - Develop, improve, and maintain protocols, referral streams, data tracking systems, MOSAIC communication to school sites
 - Participate in monthly check-in meetings
 - Facilitate MOSAIC Schools Team Meetings

MBH-Springfield Children's Center Manager (MOSAIC Leadership)

- Provides clinical supervision to MOSAIC Onsite Clinicians
- Acts as direct supervisor for MOSAIC Onsite Clinicians

Appendix A.5. School framework, *continued*

Engaging site administration

From the beginning, consistently
Need to be a champion/advocate
solution-focused

Dual training--mental health and school systems

Preparation for school staff
Clinician needs to be trained in MH
Hiring quality people for lower compensation; high competition in this area
Teachers need to understand MH framework
How to access the role of the social worker/how to access MH services
"Staying at the table"-core belief of integrated behavioral health in the schools
Philosophy

Tier III expectations

Recommendation

- MOSAIC leadership team (Director of Student Support Services, MOSAIC Project Manager, Lead Social Worker, MBH President)
- Application/interview to apply to be a MOSAIC school (readiness check)
 - Core team meeting (parent educator, school social worker, a few teachers, principal, school psychologist)-->questions to assess school readiness
 - Best practices for MOSAIC to be sustainable in the building (list given prior to discussion)
 - What does your MTSS/BBSS look like in your building?
 - How do you provide interventions based on the results of your universal screener? How often do you screen?
 - Therapy sessions will be scheduled around what time is best for the family, which may be during instructional times. As the leader of the building, how will you support this work?
 - One of the essential elements for MOSAIC is integrating behavioral health into the school setting, working across systems as one partnership. What challenges do you foresee in braiding together these two systems/organizations?
 - The social worker will be the point person for MOSAIC, how will you restructure the role of the social worker to accommodate for this work?
 - MOSAIC sessions require confidentiality and a private room. How will you provide this?
 - What questions or concerns do you have about MOSAIC?
 - Stigma is often associated with mental wellness. How will you engage families throughout MOSAIC therapeutic process?

Appendix A.6. Staffing plan—years 2 and 3

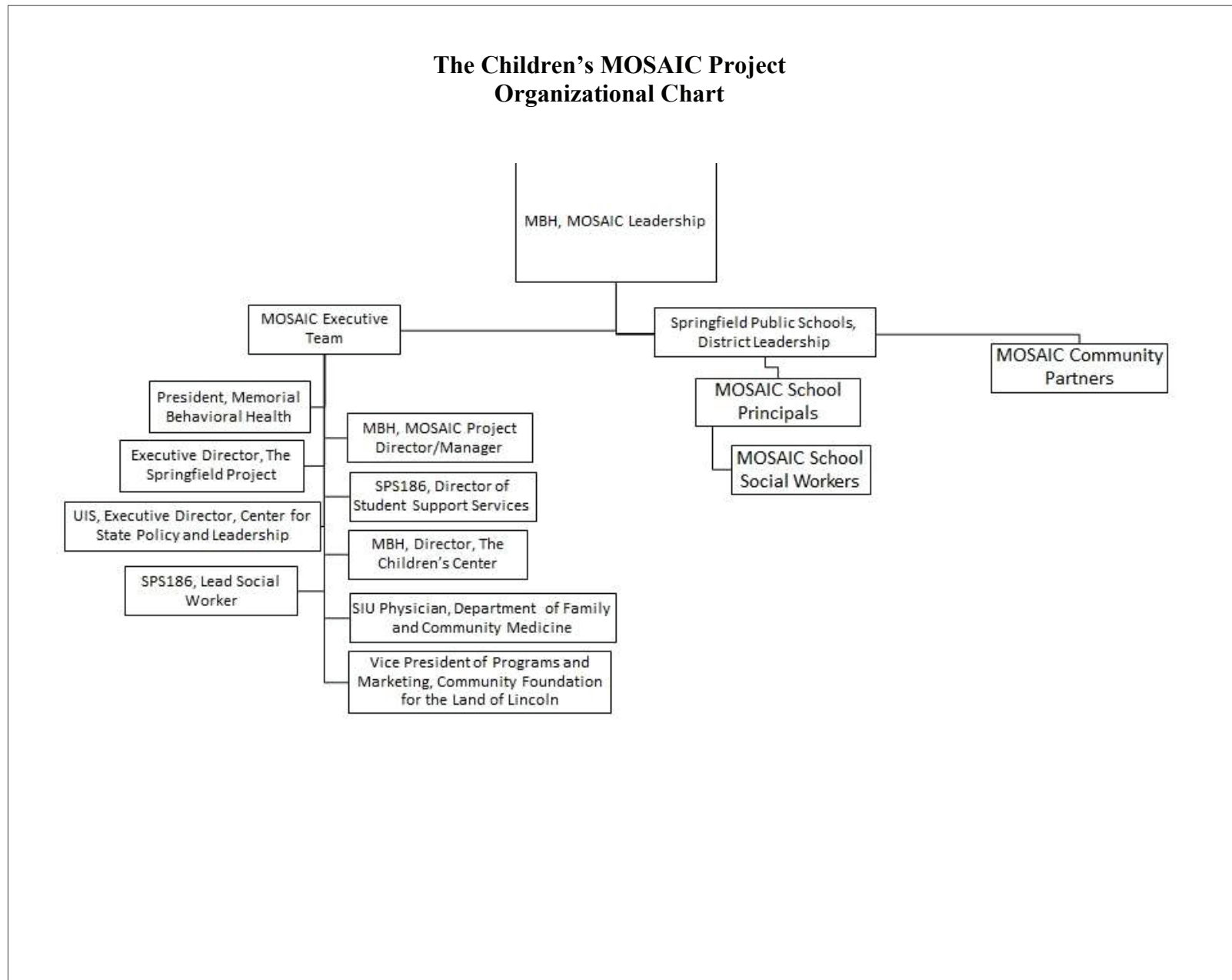
Children's MOSAIC Project Staffing Plan – Year 2 and 3

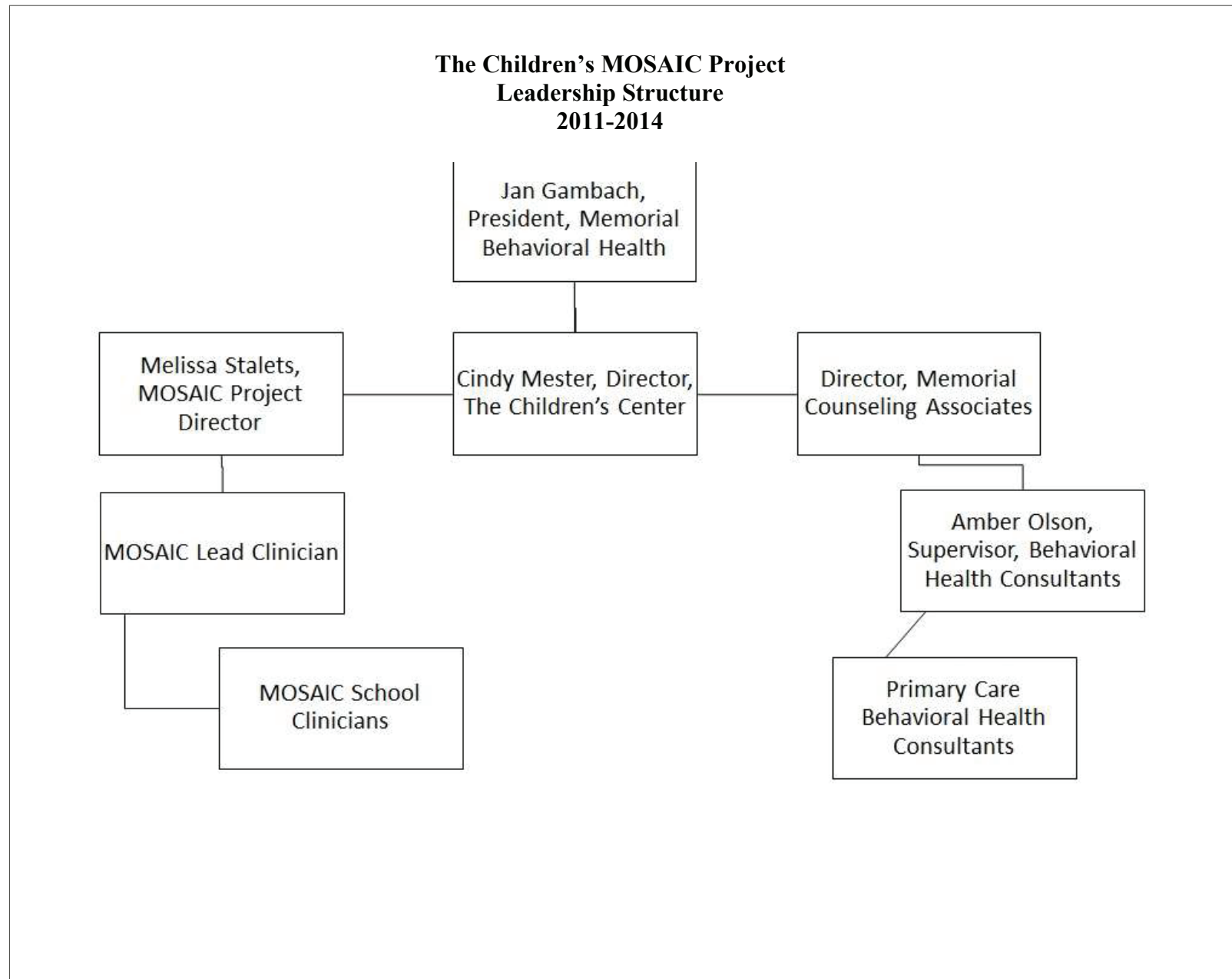
Position	FTE	Start Date	Location	Employer	Reports to	Y2-funded by:	Y3-funded by:	Beyond
Project Director	1.0	6/10	MHCCI—8 th St.	MHCCI	Brenda Diedrich, MHCCI Admin.	ILCHF	ILCHF	MHCCI and Community
Project Liaison	.50	ASAP	MHCCI—8 th St.	MHCCI	Melissa Stalets,	ILCHF	ILCHF	NA
On-site clinician (Primary Care)	1.0	3/12	SIU-CFM	MHCCI	Melissa Stalets	.50 ILCHF .50 via contract with SIU	SIU/MHCCI contract	SIU/MHCCI contract
On-site clinician (Primary Care)	1.0	ASAP	Koke Mill Medical Assoc	MHCCI	Melissa Stalets	ILCHF	KMMA	KMMA
On-site clinician (Primary Care)	1.0	1/13	CCHC	MHCCI	Melissa Stalets	.50 ILCHF .50 via contract with CCHC	CCHC/MHCCI contract	CCHC/MHCCI contract
On-site clinician (Serving NofH, Matheny Withrow, CCPA, and Lawrence Head Start)	1.0	3/12	Feitshans School	MHCCI	Melissa Stalets	Request for full support for the position from ILCHF. Expect the position to generate revenue to support .50 of position.	.3 ILCHF Remainder through MHCCI billing	MHCCI (billing)
On-site clinician (Serving middle and high school)	1.0	8/13	Feitshans office & assigned sch	MHCCI	Melissa Stalets	ILCHF (position begins August 2013)	.3 ILCHF Remainder through MHCCI billing	MHCCI (billing)
On-site clinician (serving additional schools)	1.0	8/14	Feitshans office & assigned sch	MHCCI	Melissa Stalets	NA	ILCHF	MHCCI (billing)
Behavioral Specialist	1.0	8/12	Matheny-Withrow School	District 186	Diane Motley and Cindy Knight	.50 ILCHF .50 Dist 186	.5 ILCHF .5 Dist 186	Dist 186
Psychologist	.60	8/12	MHCCI—Children's Center	MHCCI	Melissa Stalets	Request full support for the position from ILCHF. Expect the position to generate revenue to support .20 of position.	.5 ILCHF Remainder through MHCCI billing	MHCCI (billing)
Neighborhood Outreach Worker	1.0	3/12	Feitshans School	MHCCI	Melissa Stalets	Request full support for the position from ILCHF. Expect the position to generate revenue to support .30 of position.	.3 ILCHF Remainder through MHCCI billing	MHCCI (billing) and possibly grants to support outreach activities that are not billable
Neighborhood Outreach Worker	1.0	5/12	Feitshans School	MHCCI	Melissa Stalets	Request full support for the position from ILCHF. Expect the position to generate revenue to support .30 of position.	.3 ILCHF Remainder through MHCCI billing	MHCCI (billing) and possibly grants to support outreach activities that are not billable
Data Manager	.80	7/12	MHCCI—8 th St.	MHCCI	Jim Wilkerson	ILCHF	ILCHF	MHCCI
Marketing/Training Professional	.37	2/12	MHCCI—8 th St.	MHCCI	Cindy Kiriakos, Marketing Dir	ILCHF	ILCHF	NA
MHCCI Director of Quality Control	.10		MHCCI—8 th St.	MHCCI	Cindy Butler, Dir of Clinical Operations	In-kind by MHCCI	MHCCI	MHCCI

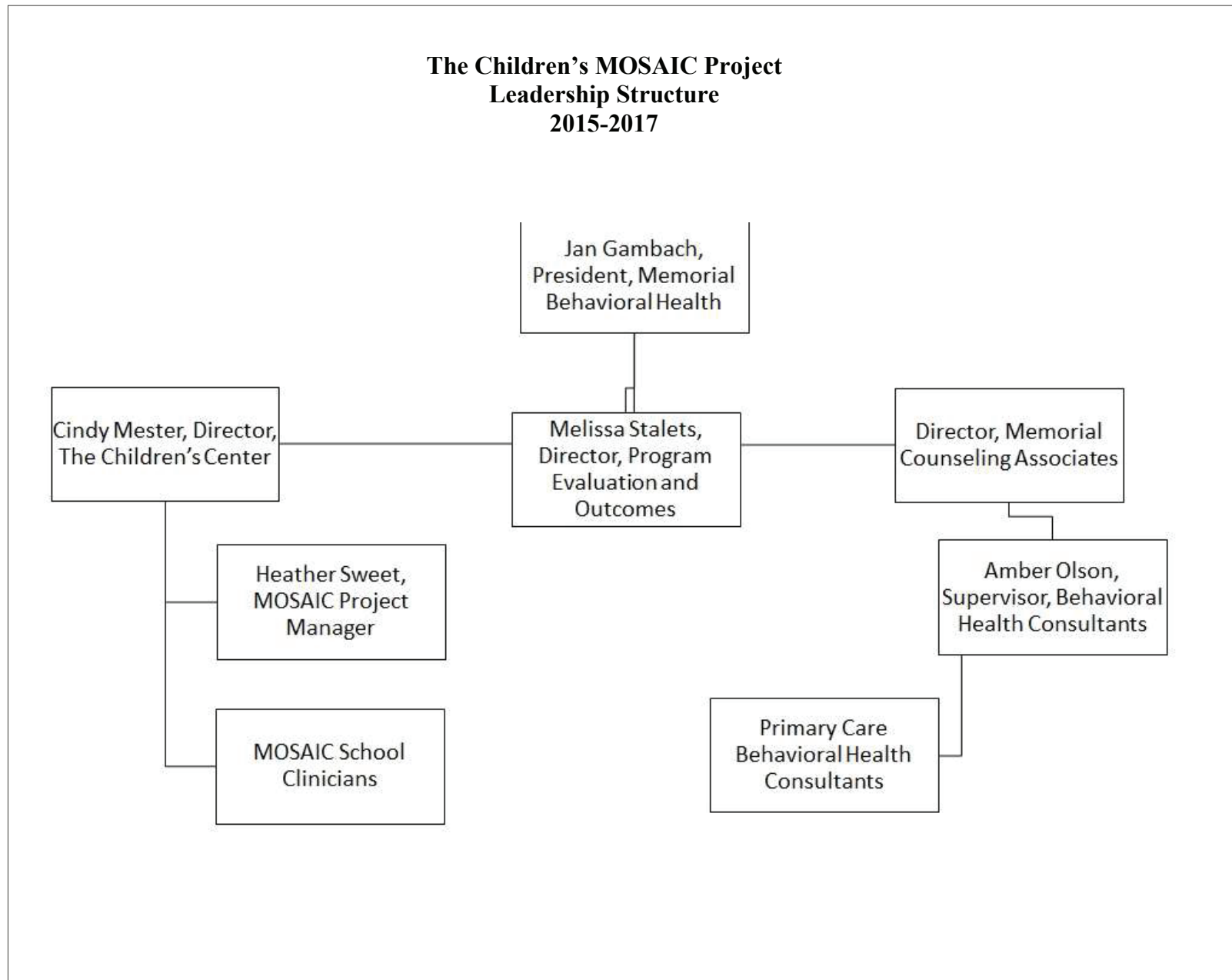
Appendix A.6. Staffing plan—years 2 and 3, continued

MHCCI Children's Center Director	.05		MHCCI Children's Cent	MHCCI	Brenda Diedrich	In-kind by MHCCI	MHCCI	MHCCI
MHCCI Children's Center Lead Clinician	.05		MHCCI—Children's Cent	MHCCI	Cindy Mester	In-kind by MHCCI	MHCCI	MHCCI
School Social Worker			Matheny Withrow School	Dist 186	Diane Motley (Principal) and Cindy Knight	Dist 186	Dist 186	Dist 186
School Social Worker		1/13	Capitol College Preparatory Academy	Dist 186	Chris Colgren (Principal) and Cindy Knight	Dist 186	Dist 186	Dist 186
Head Start Coordinator			Urban League Head Start—Lawrence Site	Urban League	Deb Lahey, Head Start Director	Urban League	Urban League	Urban League

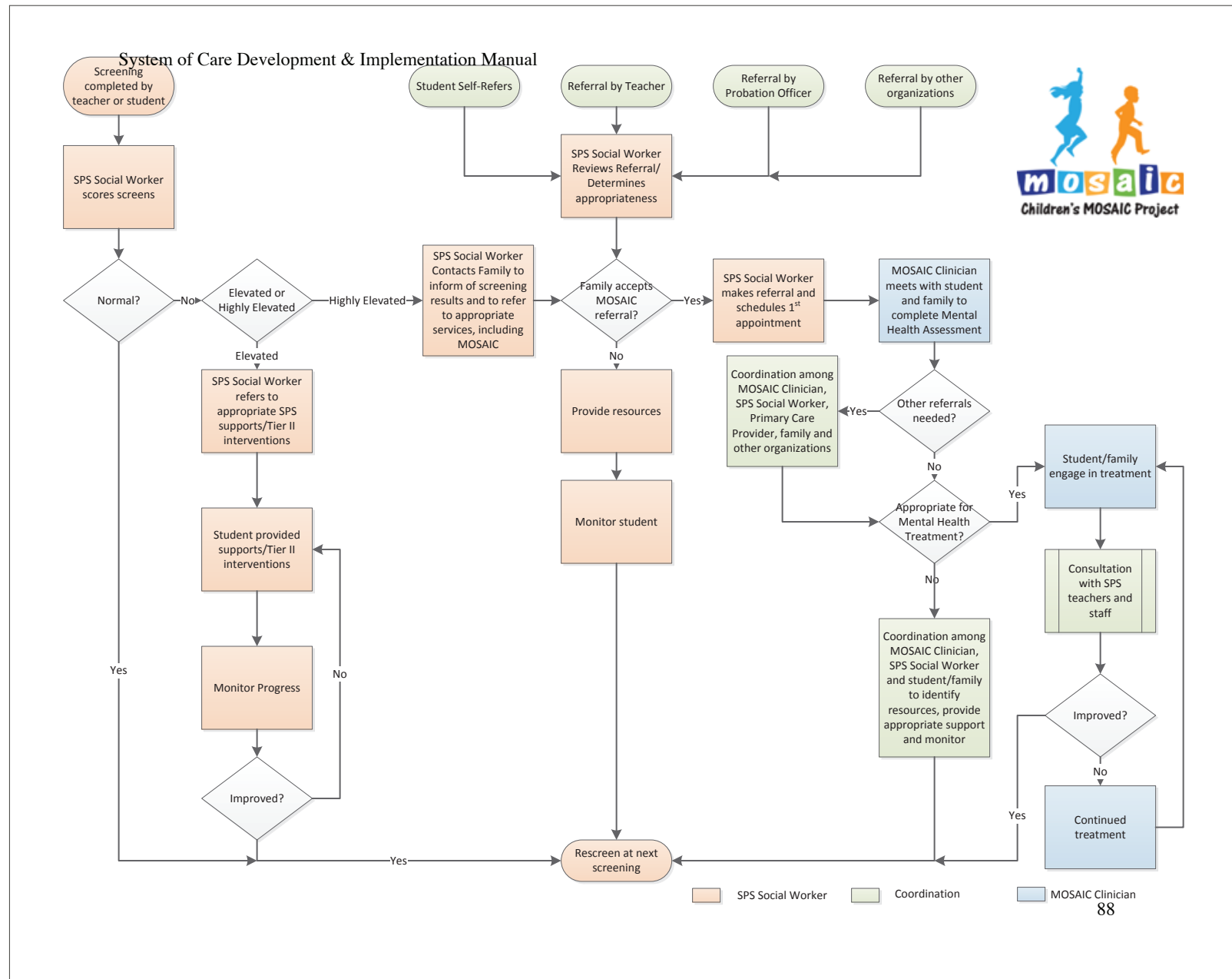
Appendix A.7. Organizational chart



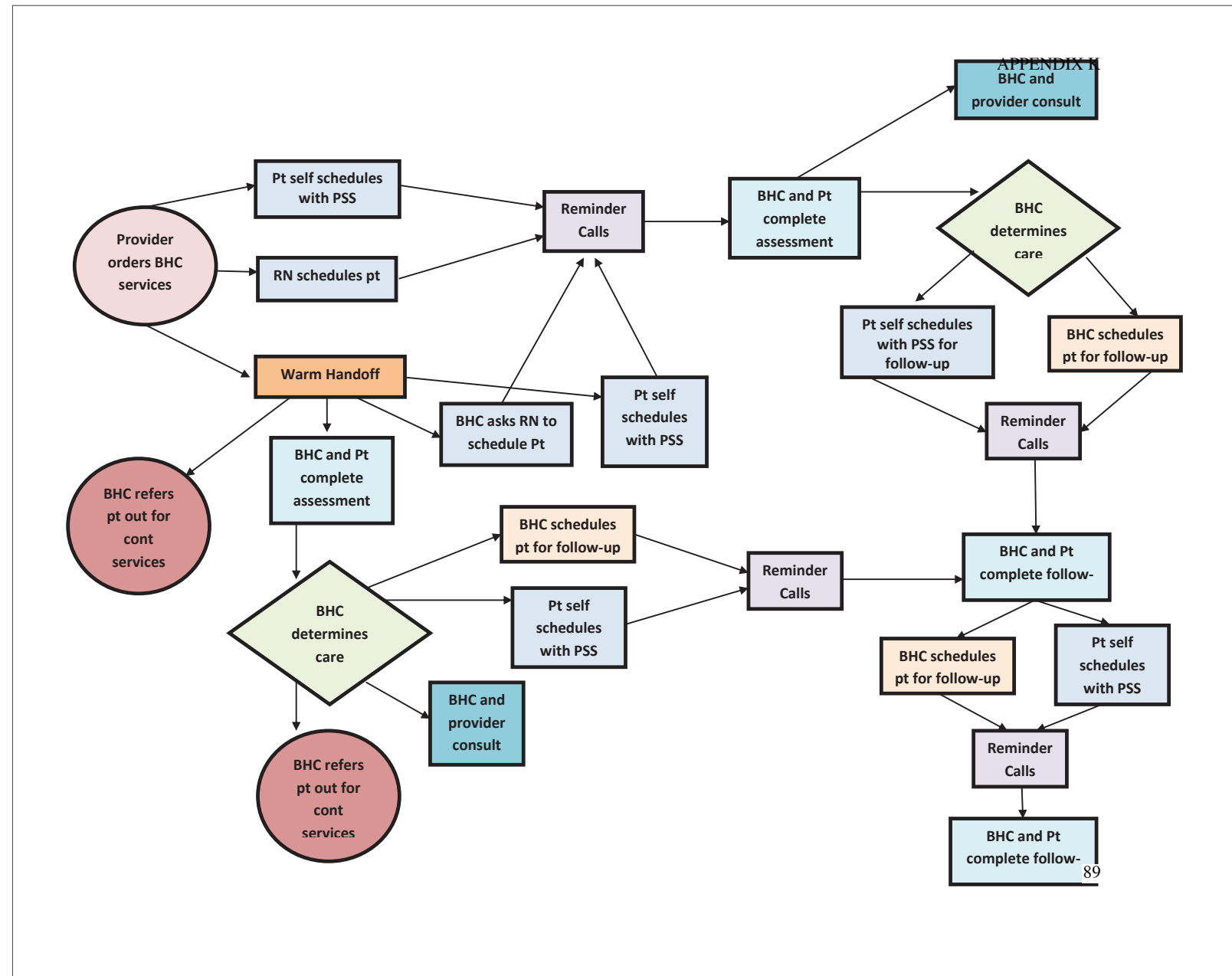




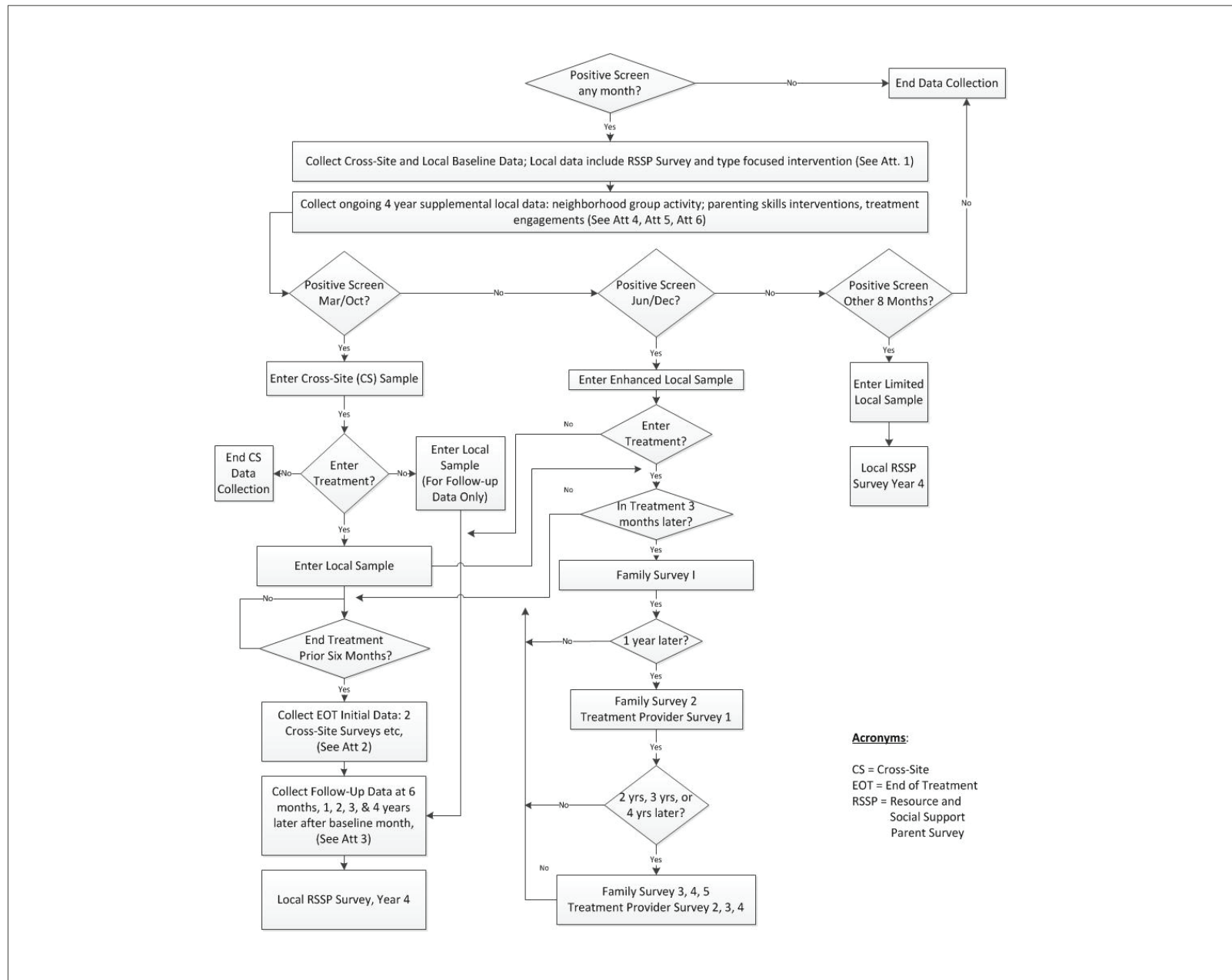
Appendix A.10. Participant flowchart—school



Appendix A.11. Participant flowchart—primary care



Appendix A.12. Evaluation flowchart



FOR MORE INFORMATION

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MOSAIC

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