

Casa de Salud Connection to Coordinated Care (CCC) for Immigrant Health

Staff Recommendation: Deny Funding Request of \$381,002

INITIATIVE STRENGTHS

A key strength of the Connection to Coordinated Care (CCC) collaborative is the complementary expertise and trusted community relationships that each partner brings to the initiative. Casa de Salud provides leadership, coordination, and infrastructure for the network; Monarch Immigrant Services contributes deep experience in immigrant and refugee outreach, navigation, and case management; St. Francis Community Services offers expertise in serving children, youth, and families; and NAMI St. Louis expands access to behavioral health education, peer support, and family-centered resources. The planning grant allowed each organization to explore new ways to strengthen their referral relationships. The partners demonstrated meaningful progress during the planning phase, including the development of a shared data dictionary and a stronger understanding of the needs of immigrants and refugees through a family-centered approach. The collaborative has identified important gaps in behavioral health services and has built partnerships that could support future system improvements.

STAFF CONCERNS & QUESTIONS

Significant feasibility concerns limit confidence in the project's ability to achieve the proposed outcomes. The implementation plan remains highly conceptual, with nearly three years of additional planning anticipated before full implementation. Key components of the project lack sufficient detail, making it difficult to assess how proposed changes will be carried out, how partner organizations will operationalize new processes, and whether the timeline and deliverables are realistic. In several instances, the application describes a coordinated system that appears more advanced than what was documented during the planning phase, raising questions about readiness and the feasibility of implementation.

The sustainability strategy further weakens the proposal. The project relies on the creation of new intake positions across partner agencies, yet there is no clear plan for maintaining these positions after grant funding expires. In addition, the proposed shared intake and referral processes may create additional workload for partner organizations without demonstrating that sufficient resources and infrastructure exist to support these changes long term.

While the proposed activities may improve coordination, referrals, and information sharing among participating agencies, the application does not provide adequate evidence that the collaborative is prepared to implement and sustain these changes at the scale proposed. The collaborative may be better positioned for future consideration after further development of its implementation strategy and establishment of a more credible sustainability plan.

MHB staff submitted 37 follow-up questions to Casa de Salud after reviewing their application material and hearing their presentation. A summary of questions and responses for relevant evaluation criteria is provided below.

POPULATION OF FOCUS

Q: Is the planning year baseline data of 49 individuals too small to build a model upon?

A: In FY26, Casa's Mental Health Collaborative (MHC) served approximately 200 individual clients. When pediatric cases are removed, that leaves 108 adult MHC clients. This means our 49-person planning-year pilot captured an extraordinary 45% representative sample of our active adult mental health population, making it a statistically rigorous baseline from which to scale the current proposal. This baseline data revealed that of those with impaired

daily functioning, 44% acknowledged financial barriers to care as the most common challenge after controlling for language and insurance. Legal support and transportation were also commonly acknowledged barriers to care. This baseline scope allows us to prioritize first points of contact for scaling up services and partnerships within the CCC. These barriers to care can exacerbate the specific debilitating mental health conditions of our population of focus. Debilitating mental health conditions—specifically severe PTSD, acculturation trauma, and acute anxiety—occur at far higher rates among immigrants than the general population. This leads to impaired daily functioning, mismanagement of intense legal and political stress, confusion in navigating resources, and being overwhelmed with intergenerational family struggles. This need is set to accelerate rapidly as we anticipate the upcoming loss of Medicaid for certain visa holders later this year, which will drive a massive wave of newly uninsured individuals into our community safety net.

SUSTAINABILITY

Q: Is sustainability achieved too late in Year 5, risking service disruptions? How will you address this beginning in Year 1?

A: Sustainability is integrated into the project design from the outset rather than reserved for Year 5. One example is that rather than creating new positions, we strategically allocate existing staff capacity and FTEs across partner agencies to drive implementation. This structural approach ensures operational continuity and long-term viability. Outside of fiscal sustainability, we are creating sustainable systems change by piloting a new structure for case management that involves true collaboration and communication between organizations. This practice can be scaled or sustained beyond the needs of this proposal or this population. Some examples of how we are changing organizational policies that are sustainable over time are the incorporation of data sharing agreements, application of a shared data dictionary for clarity on inter-agency communications and integrating ethical data practices into our data collection methods and analysis, all starting in year 1.

COLLABORATION

Q: Does the clinical and evaluation expertise exist among the collaborative partners? Do the partners have the capacity to implement these coordinated changes?

A: The driver of this initiative is that it solidifies the communication between our partner agencies but does not require agencies to abandon their current workflows for intake and data collection. The change is the shared data tracking and collective responsibility for different aspects of case management. Each agency benefits because all of us have been in a situation where a client has a higher level of need than our one agency is able to provide, but when there is a solution for that client through CCC, it can bring greater long-term benefit for the client population as a whole.

While Casa de Salud, NAMI, Monarch, and St. Francis participate in many of the same regional collaboratives (e.g., BHN, ISPN, CHCM), this proposal is not a subset of those initiatives. Those platforms primarily address broad gaps in access, whereas our collaboration is specifically tailored to address unique barriers faced by our target population—namely language capacity, cultural competence, and ineligibility for traditional health insurance. We will leverage the governance models established by these regional agencies to guide our work, without replicating their broad scope. For instance, our planning year led to a significant shift in program focus: while we initially prioritized in-patient psychiatric care for severely mentally ill clients, partner feedback and community needs assessments redirected our focus toward preventative case management. This approach allows participating agencies to deliver care in tandem, ensuring a more cohesive, efficient, and palatable experience for our clients. By isolating clients

within this “window of prevention” we remain adaptable to community needs and can advocate with a unified voice in larger regional forums.

BUDGET

Q: Why is Casa allocated \$198,422 while partners receive only \$35,000 to \$50,000 each? Are partner allocations sufficient to support the staff capacity required?

A: Partner allocations were discussed and agreed upon by each of the partners prior to submitting the grant request. Casa de Salud does not plan to hire new staff to administer and implement this program. However, over the five-year implementation period, we may develop new position descriptions if the partnership and community needs continue to grow. Similarly, our partner agencies plan to allocate a portion of their existing care coordination staff's time toward this collaborative effort, which offers a more cost-effective and sustainable approach at this stage. Monarch and St. Francis are each to receive \$50,000 to support designated staff to work on CCC. Each agency has the autonomy to allocate this to one staff member or multiple to accomplish their responsibility for intake, coordinate case management, and submit data requests. NAMI will receive \$35,000 each as they do not currently have as robust of a case management structure and will be receiving referrals for family members more than coordinating resources directly with clients.

PROJECT DESIGN & EVALUATION

Q: What evidence will show that coordinated care is becoming standard practice?

A: To prove that coordinated care is becoming a standard practice among CCC agencies, we will track: (1) the percentage of cross-agency referrals fulfilled (2) the completeness and timeliness of shared data entry, (3) partner attendance at monthly interdisciplinary case conferences, and (4) self-reflection/partner survey results. Using our planning year's shared data dictionary, we will establish a common language to analyze present symptoms, severity, and barriers, ensuring data consistency across all organizations.

Q: How effectively will partner organizations coordinate referrals and warm handoffs?

Agency capacity can clearly be assessed through platform communication and visibility of caseloads. Because Monarch, St. Francis and Casa specialize in serving immigrant populations, we know the language capabilities are present. Our data sharing agreements will allow us to share intake screenings with the referral so a client does not have to repeat their intake but focus on the service-oriented information only.