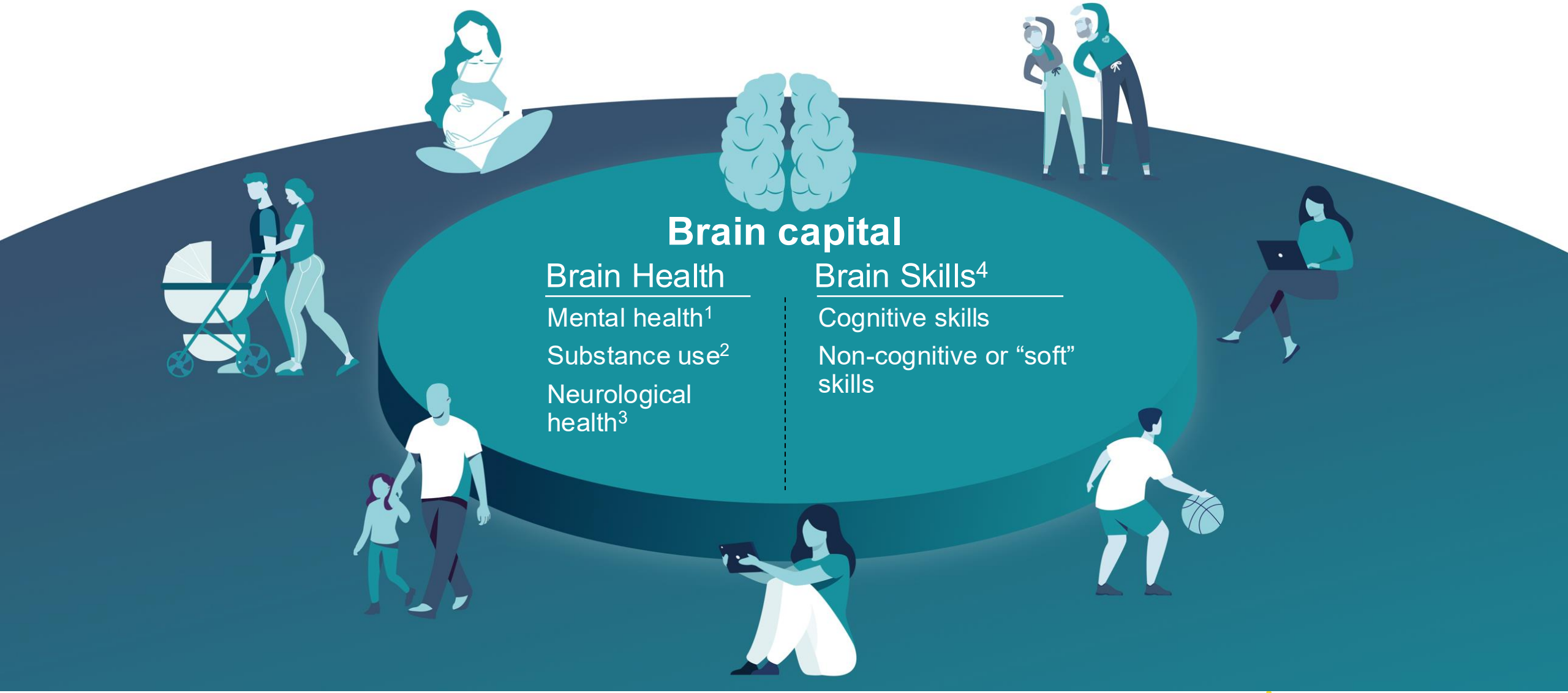
THE KENNEDY FORUM

In collaboration with McKinsey Health Institute

90-90-90 Tactical Guide for States

August 2025

Brain capital is the value generated by optimizing brain health and brain skills



Source: 1. Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community (WHO) 2. Substance use refers to the use of selected substances (e.g., alcohol, tobacco, illicit drugs) that are absorbed into the body with possible dependence and other detrimental effects (CDC) 3. Neurological health is the health of the central and peripheral nervous system (WHO) 4. Eyre, H., et al (2023)

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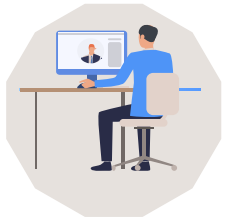
Investing in brain capital is made increasingly important by evolving global trends

Not Exhaustive

Aging population

28% increase in the share of the global population aged 65+ by 2030[1]



Changing nature of work

39% of core jobs skills are expected to change by 2030[3]

Increasing burden of brain disorders

$11T increase in the annual global cost of brain disorders by 2030[2]

Increasing understanding of early brain development

50% uptake of WHO's evidence-based standards for early childhood development since 2018[4]

Source: 1. United Nations / 2. Patel et al (2018) / 3. WEF / 4. WHO

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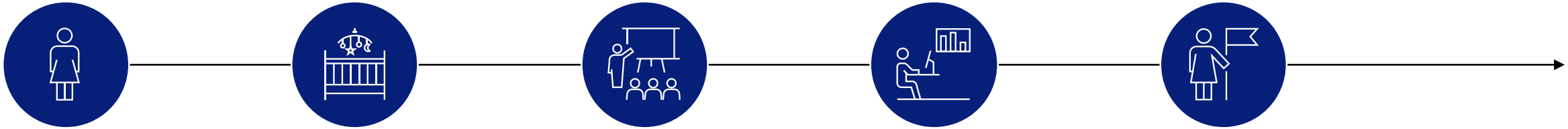
Brain health is an essential driver of brain capital affected by multiple factors across the life course

Not Exhaustive



Perinatal

14%

new parents may experience postnatal depression[1]

Childhood (0-13)

1 in 2

children ages 3 to 4 do not attend preschool[2]

Adolescence (14-24)

1 in 7

young people experiences a substance use disorder[3]

Adulthood (25-64)

52%

employees report having felt symptoms of burnout in the past year[4]

Older adulthood (65+)

1 in 3

older adults has dementia or mild cognitive impairment[5]

and

up to **22%** of working adults are providing care for a parent[6]

Source: 1. Cleveland Clinic 2. National Center for Education Statistics 3. American Addiction Centers 4. NAMI 5. Manly, Jones, & Langa (2022) 6. Guardian Life

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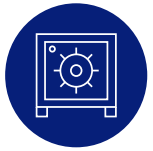
Brain health challenges have direct impact on States

Individuals with behavioral health conditions incur medical costs that are **3-6x** times higher than those without such conditions, placing a financial strain on state healthcare systems

Elements of the BH care continuum (e.g., inpatient and emergency services) are currently overburdened, while other services (e.g., crisis care, promotion, prevention) are consistently underdeveloped

Behavioral health has immense impact on systems outside of healthcare, including emergency response (e.g., through crisis care), education, justice, foster care, welfare, and other state systems



Investing in optimal well-being globally could produce an incremental upside of **$1,100-3,500** per employee annually

The COVID-19 pandemic disproportionately affected the health of communities of color, people with low income or in poor health, exacerbating the existing inequities within the BH ecosystem

Source: McKinsey Health Institute Analysis, The Kennedy Forum Press Releases

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There are significant financial returns from investing in brain capital

Imagine the economic "tax" on Brain Co., a 10,000-employee company, that does not invest in its brain capital

Untreated substance use disorders could result in an annual cost of **$7.3M**, due to increased **healthcare, turnover and replacement costs**

Limited access to early education puts **38%** of the future workforce at increased risk of **lacking essential skills** to succeed in the knowledge economy

Employee burnout could cost **$11.2M** annually due to increased **turnover and productivity losses**

Untreated depression could result in **$2.2M** in **annual productivity losses**

Employees with **eldercare responsibilities** could result in **$1.5M** of additional annual **healthcare costs alone**

Source: NORC, CDC, NIMH, Brookings, National Center for Education, Bureau of Labor Statistics, Gallup, KFF

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States have an opportunity to improve population brain health and build a resilient, productive workforce through the 90-90-90 framework

of individuals are **screened** for brain health conditions

of individuals receive the evidence-based **treatment** and supports they need

of individuals treated are able to manage their symptoms and achieve **recovery**, working at peak performance

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To support 90-90-90 objectives, States have the opportunity to develop a best-in-class brain health strategy

Potential focus areas of a leading brain health strategy include…

Increasing equitable access to services and supports

Co-designing new access points (e.g., digital, telehealth, mobile outreach, school-based services, and community-based interventions) with those with lived experience

Improving crisis care across the continuum, through investing in 988 Lifeline, building mobile crisis capacity, and expanding stabilization services and crisis residential care

Scaling evidence-based and community-defined practices through grants to community-based organizations, statewide and local agencies, schools, etc., and payment innovation to improve sustainability of services

Addressing workforce challenges

Expanding the workforce through innovations and care extenders, including digital tools, peers and "BH coaches" to complement the current clinical workforce

Launching comprehensive initiatives to address workforce barriers, such as earn and learn programs, loan-repayment, increased reimbursement rates

Increasing workforce diversity through changes in incentives, training requirements, and talent pipeline development

Strengthening foundational capabilities and infrastructure

Advancing cross-agency collaboration and data sharing (e.g., Medicaid, Housing, Corrections, Dept of Education) through operating model redesign, data aggregation, and capability-building

Improving performance infrastructure through tools to measure equity, quality, access, sources of value, and other outcomes

Enhancing digital, analytic and technology infrastructure (e.g., HIEs, PDMPs, care coordination tools, predictive analytics)

Strategies for priority sub-populations	Children & youth	Parent & caregiver	Underserved populations	Justice-involved	Rural	65+

There are opportunities across state leadership to meaningfully support 90-90-90 aspirations

Illustrative

Focus for tactical guide

Governor	• Champion a robust cross-agency behavioral health strategy (e.g., key metric targets, systems level-innovation, workforce expansion, inclusion in State of the State address) • Direct funding and champion policy / legislation to support key strategic initiatives • Support employer-led brain health initiatives (e.g., for state employees, through public-private partnerships)

Governor's office (e.g., Chief of Staff, COO, CAO, CIO, etc)

- Establish targets for key 90-90-90 metrics
- Invest in infrastructure necessary for data collection and reporting
- Measure, monitor, and report on key metrics
- Engage local leadership (e.g., counties) for collaboration and co-creation

Cabinet position(s) responsible for Physical and Behavioral Health (e.g., Medicaid)

- Expand underdeveloped / overburdened areas (e.g., mobile crisis teams, integrated screening / care, treatment capacity for individuals with SUD)
- Integrate BH into other programs (e.g., maternal health, child welfare, school-based services) to catch unmet need
- Support innovative payment / treatment models (e.g., CCBHCs, virtual care) to support 90-90-90 objectives

Cabinet position(s) responsible for Housing

- Support housing programs (e.g., through SMHAs, CoC, affordable housing, PSH) to stabilize individuals with BH needs
- Champion initiatives in support of individuals with SUD (e.g., supportive housing)

Cabinet position(s) responsible for Labor and Insurance

- Establish initiatives focused on resolving workforce crisis drivers (e.g., task shifting, incentivizing provider education, reducing barriers to licensure)
- Support BH parity

Cabinet position(s) responsible for Education

- Provide guidance for effective integration of BH supports in academic environments
- Support BH curricula (e.g., promotion and prevention, resiliency and wellbeing) through educational systems

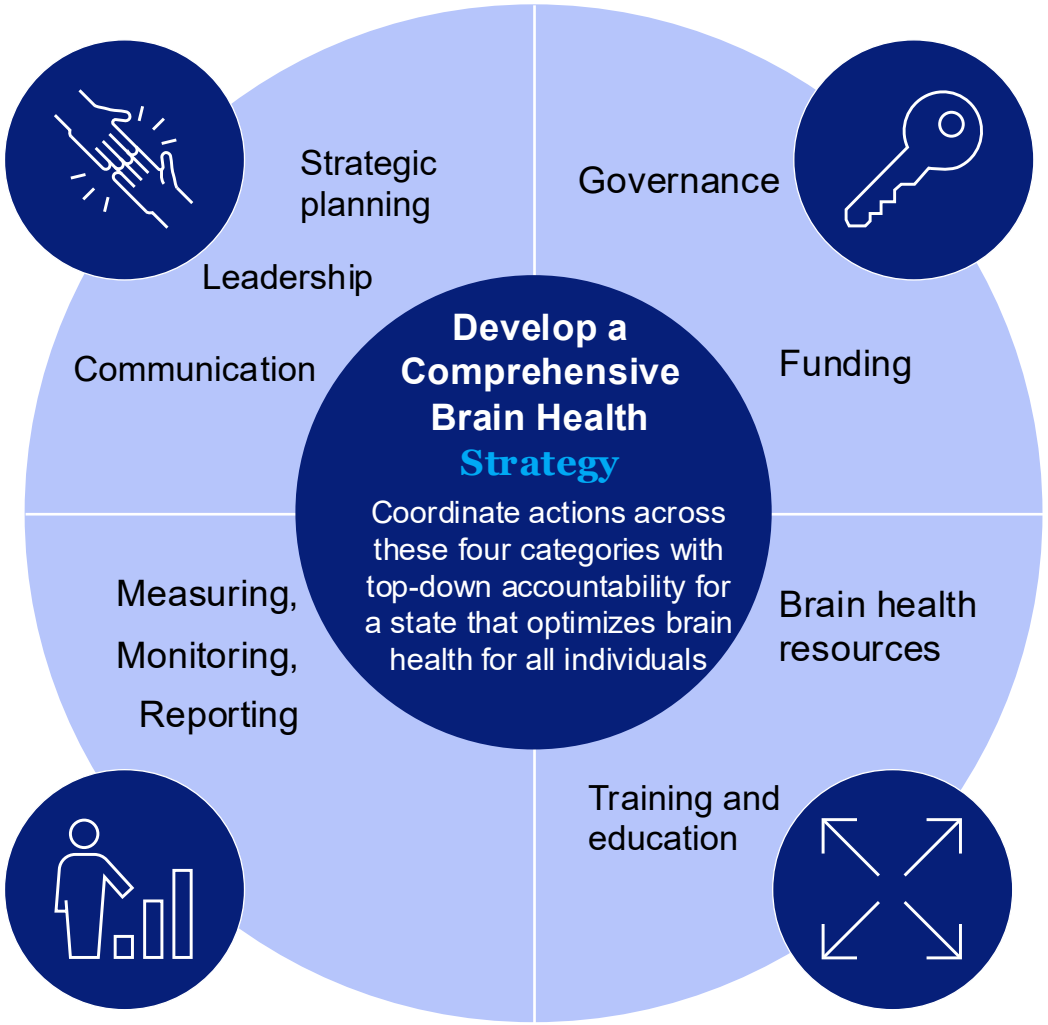
Cabinet position(s) responsible for Public Safety

- Improve integration and collaboration with crisis services
- Train first-responders in behavioral health literacy and crisis de-escalation

Source: Expert Interviews

There are four key categories of potential actions the Governor's leadership team can take to operationalize across 90-90-90 stages

Foster a Brain Health Forward Culture



Implement Policies and legislation Supporting Brain Health

Track Brain Health and Brain Capital Metrics

Expand Access to Brain Health Resources

Source: Informed by One Mind Mental Health at Work Index Categories

Within these four categories, there are tactical actions State leaders could take to support the 90-90-90 objectives

Illustrative

(#) Deep dive follows

Action Category	Goal	Tactical actions
Culture	Embed brain health as a priority throughout the state and foster a stigma free environment	(1) **Strategic planning**: Conduct top-down, cross-agency strategic planning to develop a comprehensive, state-wide brain health strategy including targets tied to 90-90-90 metrics and prioritized strategic initiatives (2) **Leadership**: Explore opportunities to formalize cross-agency collaboration and hold cabinet members accountable to delivering on brain health metric targets • **Communication**: Collaborate with external partners (e.g., private, local government, commercial insurers) to co-create shared objectives and support strategies (e.g., employer-led brain health efforts)
Policies and legislation	Strengthen brain health systems and infrastructure through targeted regulation and incentivization	(3) **Governance:** Adjust brain health governance strategy to balance regulatory needs with operational flexibility to respond to changing BH landscape (e.g., elevating unlicensed workforce / peer support specialists) • **Funding:** Support funding for innovative, evidence-based payment models and strategic initiatives that support key 90-90-90 objectives and resolve key challenges (e.g., tele-medicine)
Resources	Ensure brain health resources and education adequately meet population needs	(4) **Brain health resources:** Empower cabinet members to evaluate gaps in current continuum of care (e.g., crisis systems, Inpatient / step-down treatment capacity) and develop initiatives to address gaps • **Brain health benefits:** Ensure state employees have access to and awareness of appropriate brain health resources and benefits • **Training and education:** Support development of public training and education to increase brain health literacy, promote supportive behavior, and reduce stigma
Metrics	Leverage insights from 90-90-90 metrics to inform strategic decision making	(5) **Measuring, monitoring, and reporting:** Systematically assess the brain health needs of the population and invest in infrastructure needed for tracking and reporting on progress

Source: Informed by One Mind Mental Health at Work Index Categories

1 Example 90-90-90 key metrics

90	Official metric	Baseline measurement(s)
Screening	% of individuals in the US who have been screened for mental and substance use disorders once in the past year	% of adults and adolescents who have been screened once in the past year for depression by a healthcare provider % of adults who have been screened once in the past year for unhealthy alcohol use by a healthcare provider
Treatment	% of individuals with positive screening for a mental or substance use disorder receiving the appropriate evidence-based treatment	% of individuals receiving quality, evidence-based interventions for select MH/SUDs according to HEDIS quality and effectiveness measures[1]
Recovery	% of individuals who have received evidence-based treatment for mental or substance use disorders who consider themselves in recovery or able to adequately manage symptoms	% of adults and adolescents who achieved remission from depression within 4–8 months after the initial elevated PHQ-9 score

Baseline measurements for the 90-90-90 are not optimal or comprehensive but rather provide a perspective on the starting point for each 90 while additional data capabilities are developed.

1. Baseline calculation will be an index of 10 metrics spanning multiple disorders and intervention types.

2 Case examples: Potential levers to promote interagency collaboration

Case studies

Maryland operated under two Behavioral Health Agencies (BHA) until 2014 when they merged into a single state Department of Health (DoH)[1]

Pennsylvania Office of Mental Health and Substance Abuse Services are operated jointly as OMHSAS and program oversight occurs at the county level, rather than the state level[2]

New York Inter-Office Coordinating Council is a collaborative entity (consisting of three mental hygiene-related state agencies) created to improve continuity and coordination of services for people with multiple needs[3]

1. Maryland Manual On-line
2. Pennsylvania Association of Community Health Centers
3. NY State Office of Addiction Services and Supports

Example actions

- Clarify **roles and areas of focus** across each agency through a targeted taskforce, potentially as subfunction of the Health subcabinet, starting with alignment around key governance topics
- Coordinate across agencies to ensure **equitable access/ outreach** (e.g., languages, literacy levels) and **engage community stakeholders**
- Designate an individual/agency lead to **coordinate social determinants of health topics** (e.g., housing, environment) with related agencies
- Consider **organizing service delivery to promote continuity** along the behavioral health continuum

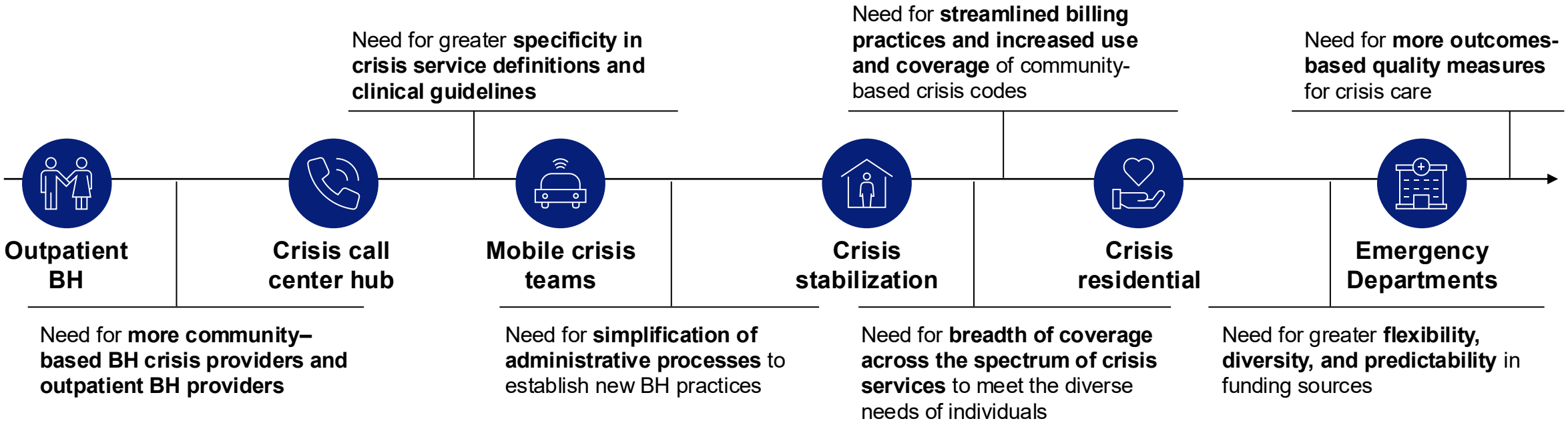
3 States are taking action to expand behavioral health supports through innovative workforce models

Illustrative / PRELIMINARY

	Alaska	California	Georgia	Louisiana	Minnesota	Texas	Washington
Key focus areas	**Task shifting under licensed supervision**	**State certification program for SUD counselors**	**Unlicensed clinicians as first responders**	**Required training modules and counselors-in-training program**	**Continuing education requirements**	**Expanding school-based & crisis services**	**Paid trainee and apprenticeship programs**
Details	In Alaska, unlicensed behavioral health workers are allowed to conduct intake assessments and develop treatment plans under the **supervision of a licensed professional**	California offers a **certification program for unlicensed substance use disorder counselors**. This program provides a standardized curriculum and requires ongoing training to maintain certification	In Georgia, **unlicensed bachelor's-level and master's-level clinicians, handle most duties for the crisis line**; they conduct warm introductions to licensed clinicians when there are more severe crises	Louisiana develops **standardized basic training modules for unlicensed providers** to introduce key concepts and core competencies they must demonstrate prior to rendering specialized behavioral health services Louisiana also **reimburses services provided by counselors-in-training**, under the supervision of a licensed mental health provider	Minnesota requires unlicensed behavioral health workers to complete **six hours of continuing education on cultural** competency every two years, ensuring that workers are able to provide culturally sensitive care to diverse populations	In Texas, **unlicensed behavioral health workers pursuing licensure must work under supervision of a licensed professional** for a set number of hours in order to gain practical experience while ensuring that they are providing safe and effective care	Washington's **Behavioral Health Integration Apprenticeship Program** offers paid apprenticeships to unlicensed BH workers, who receive on-the-job training and mentoring from licensed professionals Washington also **reimburses a chemical dependency professional trainee**, who can provide select services under the supervision of a certified individual

4 Sustainability-related needs exist across the crisis care continuum

ILLUSTRATIVE **NOT EXHAUSTIVE**



Source: SAMHSA, McKinsey Health Institute, NASMHPD

5 Case examples: Potential levers to improve data infrastructure and collaboration capabilities

Case studies

South Dakota, as part of the Familiar Faces Initiative, coordinated agreements between the county jail, two major hospitals, Department of Health, and The Link (a24-hour alternative to jail) to enable data sharing for coordination and tracking progress. This enables health professionals to more quickly meet clients at discharge and better coordinate care[1]

New Jersey promoted interoperability by encouraging SUD providers to establish or enhance their electronic health records systems. New Jersey has since expanded the program for non-SUD providers, based on incentive payments tied to provider milestones[2]

Example actions

- **Standardize and enhance data collection** (e.g., frequency, categories)to **understand inequities** (e.g., racial disparities in access to care) and **inform equity-focused efforts**
- **Bolster coordination on data** to capture more robust data for smaller populations/ subpopulations in order to provide more insight into the range of individual behavioral health experiences
- **Strengthen data management systems** to monitor contracts with service providers and capacity utilization
- Explore financial incentives and support to **encourage greater EHR utilization for BH providers**

1. Familiar Faces Initiative Case Study — NACo
2. State of New Jersey Department of Human Services

State performance across dimensions can be assessed against peer states

Dimension	Description	Example metrics
Health Burden	Reported prevalence of various BH conditions across youth and adult populations	▪ % of adults / youth diagnosed with SUD ▪ % of adults / youth who experienced a major depressive episode in the last year
Access	Ability of residents to access quality BH care (incl. prevention, diagnosis, treatment and management of conditions) when they need it	▪ # of MH / BH providers per 100K ▪ % of MH / BH facilities accepting Medicaid ▪ Community-based MH / BH facilities per 100K
Outcomes	Clinical and social outcome measures to assess impact of care access and delivery	▪ Drug overdose mortalities per 100K ▪ % readmission rate into a State hospital psychiatric unit ▪ % of child entries into out-of-home placement due to parental substance abuse
SDOH	Non-medical / clinical factors that may impact residents' access to care and health outcomes	▪ % of population with high school education attainment or higher ▪ % of population with limited English proficiency (LEP) ▪ % of individuals experiencing homelessness
Funding	Sources and amounts of funding allocated for BH delivery in a State	▪ Total SAMHSA grant amounts per capita ▪ Total State MH expenditures per capita
Business operations	Viability of business operations along key dimensions for BH organizations	▪ Time to licensure for providers credentialed out of state ▪ Parity compliance enforcement policies ▪ Medicaid rates ▪ Time to get Certificate of Need ▪ Workforce availability