Eastern Region
Public Mental Health Planning Project

April – December 2006
Eastern Region Public Mental Health Planning Project

The Eastern Region of Missouri has a long-standing commitment to provide services and programs to individuals and families affected by mental health and substance abuse issues (referred to as behavioral health). In order to strengthen the current behavioral health safety net system, stakeholders joined together to create recommendations for a more responsive and coordinated system for acute adult behavioral health care.

During this first phase of work, stakeholders were interviewed to identify challenges and opportunities in the behavioral health safety net system, the current processes for patient flow and coordinating care across behavioral health system providers were assessed, best practices and alternative models were identified, and detailed recommendations for improving the safety net behavioral health system were developed. This document includes a summary and written record of all of the efforts noted above.

Who is involved in the process?
Organizations and individual stakeholders from around the region are involved in the planning efforts. The project includes mental health and alcohol/drug abuse service providers, the Missouri Department of Mental Health, physical health providers, consumers, consumer advocates, community leaders, law enforcement representatives, drug/mental health courts and community organizations. Please see the following pages for a list of individuals and organizations involved in this project.

The Eastern Region includes St. Charles County, Franklin County, Jefferson County, Lincoln County, St. Louis City, St. Louis County, and Warren County.

The following chart illustrates the committees who are working on the project. The Regional Mental Health Steering Committee sets strategic direction and guides the project. The Mental Health Advisory Board provides direct input to the workgroup and steering committee. The Workgroup assesses the current patient flow, referral and triage processes. The St. Louis Regional Health Commission reviews and approves the final recommendations.
The St. Louis Regional Health Commission (RHC) is facilitating the community-wide planning process. The RHC is a collaborative partnership of health service providers, government and community leaders, community organizations and consumers. Since its formation in 2001, the RHC has served as a lead body for regional planning and implementation of initiatives to strengthen the health care safety net system, and to improve health literacy, prevention and wellness services.

What is the project timeline?
The planning partners worked from April – December 2006 to develop the strategic plan. Future phases of the project will involve implementing the recommendations from phase one, and specifically addressing the needs of the children’s behavioral health system.

What recommendations will result from the project?
Recommendations for system transformation fall into the following categories:

- Coordinate and Plan on a Regional Level,
- Integrate Behavioral Health and Physical Health Systems,
- Enhance and Streamline Funding,
- Increase Capacity for Behavioral Health Services,
- Improve Service Delivery,
- Improve Crisis Services,
- Reduce Access Barriers,
- Redesign Assessment and Screening Process, and
- Develop a Master Patient Index.

What lessons have you learned from the project?
We have learned several lessons as a result of this work that may be helpful for other regions considering similar efforts:

- **Keep the client at the center of all efforts** – Keeping the focus on the client is the first priority. Clients must be engaged in two ways: 1) to provide input in the changes being discussed and 2) any changes being discussed must be centered on the success of the client.

- **Involve a broad group of organizations** – To be successful, a broad spectrum of organizations and individuals must be involved, including local and state governments, large and small providers, advocacy organizations, etc. Additionally, the stakeholders must move beyond “involvement” to real decision-making authority of the project and the recommendations.

- **Clarify the project vision early and often** – Stakeholders need to narrow and clarify a vision for the work early in the project so that the project remains focused. The vision should be reviewed and clarified throughout the project because 1) new people will be engaged as the work progresses, and 2) the vision may change slightly as more information is gathered.

- **Engage executive sponsors for the project** – To ensure success, a diverse group of individuals should be identified who can champion the project to external audiences, provide input about the project direction and encourage stakeholders to keep moving toward the goal. The executive sponsors are not usually involved in the daily management of the project, but they should be regularly updated about the project status. To identify executive sponsors, consider “Whose support do we need to implement any recommendations resulting from this project?”

- **Assess before you recommend** – Stakeholders should ensure they have collected and reviewed data about the issue before moving to recommendations. Time spent on data
collection ensures decisions are made on facts – not just gut feelings, helps build trust and rapport among group members, and provides a solid, fact-based case for change before beginning the hard work of agreeing on recommendations.

∞ **Continue to assess external environment for factors that impact project outcomes** – It is important to be proactive in staying aware of and navigating through changes in the external environment that can impact project outcomes. For example, the new Missouri Transformation Initiative, a state-wide effort to transform the behavioral health system, and current Medicaid reform efforts have influence on both the creation and implementation of recommendations.

**What is included in this document?**
As noted above, this document includes:

∞ **Vision** – summary of stakeholder interviews to identify challenges and opportunities in the behavioral health safety net system.

∞ **Current State Assessment** – summary of the Eastern Region behavioral health system, including: how individuals access and utilize the behavioral health system, how the behavioral health system is financed, and barriers to accessing and utilizing the behavioral health system.

∞ **Alternative Models Analysis** – summary of best practices and alternative models for behavioral health service delivery from across the country.

∞ **Recommendations** – detailed recommendations, developed by all stakeholders involved in this project, for improving access to and delivery of services in the safety net behavioral health system.

**How do I get involved or who do I contact for more information?**
The Mental Health Advisory Board provides input to the steering committee and workgroups and is open to all who would like to be engaged in the planning process. To be involved in the Advisory Board, contact Bethany Johnson (see below).

For more information, contact Bethany Johnson, Project Director, at bjohnson@stlrhc.org or 314.446.6454, extension 1011.
Eastern Region Public Mental Health Planning Project
Steering Committee Membership

Ms. Francie Broderick
Executive Director
Places for People

Mr. John Eiler
Executive Vice President, Behavioral Health Services
SSM Healthcare St. Louis

Dr. Dolores Gunn
Director of Health
St. Louis County

Ms. Mary Ann Hampton
Chief Nursing Officer
Forest Park Hospital

Mr. Jim House
Executive Director
Mental Health Association of Greater St. Louis

Dr. Steve Huss
President/CEO
COMTREA, Inc.

Mr. Laurent Javois
CEO, Eastern MO Hospital Psychiatric System
Missouri Department of Mental Health

Ms. Barbara Keehn
District Administrator, Division of Alcohol and Drug Abuse
Missouri Department of Mental Health

Ms. Betty Kerr
CEO
People's Health Centers, Inc.

Ms. Jackie Lukitsch
Executive Director
NAMI St. Louis

Dr. Amanda Murphy
President/CEO
Hopewell Center

Ms. Connie Neumann
Executive Director
Queen of Peace Center

Mr. Mark Stansberry
Executive Director
BJC Behavioral Health

Ms. Regina Trotter
Vice President of Services
Hopewell Center

Dr. Karl Wilson, Committee Chair
President/CEO
Crider Center for Mental Health

Ms. Janet Woodburn
President/CEO
Bridgeway Counseling Services

Mr. Joe Yancey
Community Mental Health Manager
Missouri Department of Mental Health
Eastern Region Public Mental Health Planning Project
Workgroup Membership

Mr. John Bendick
Director of Central Intake, Behavioral Health Services
SSM Health Care

Mr. Tony Cuneo
Chief Operating Officer
Metropolitan St. Louis Psychiatric Care

Ms. Wendy Dudek
Family Support Specialist
NAMI St. Louis

Mr. Bob Fant
Regional Liaison
Missouri Family Support Division

Ms. Kim Feaman
Program Director
Preferred Family Healthcare

Mr. Al Fressola
Vice President of Operations
Behavioral Health Response

Ms. Terri Gilbert
Director of Clinical Operations
BJC Behavioral Health

Ms. Nancy Gongaware
Vice President
Crider Center

Dr. Mary Hoke
Assistant Executive Director
Jewish Family and Children's Services

Ms. Doris King
Clinical Social Worker Supervisor
St. Louis County Health

Mr. Matt Morrison
ER Nurse Manager
Metropolitan St. Louis Psychiatric Center

Ms. April Newland
Probation and Parole
Missouri Department of Corrections

Ms. Rosemary Pates
Gracehill Neighborhood Health

Dr. Marva Redd
Director of Co-Occurring Substance Abuse Program
Hopewell Center

Ms. Regina Trotter
Vice President of Services
Hopewell Center
Eastern Region Public Mental Health Planning Project
Mental Health Advisory Board Membership

Ms. Connie Neumann, Chair
Executive Director
Queen of Peace Center

Ms. Judy Dungan
Community Liaison
U.S. Senator Talent

Ms. Peggy Barnhart
Community Liaison
U.S. Senator Talent

Ms. Carol Evans
Research Associate Professor
Missouri Institute of Mental Health

Ms. Joan Bialczak
Administrator, Health Services
St. Louis County Dept. of Health

Ms. Angela Herman
Clinical Program Manager
Missouri Primary Care Association

Ms. Sharon Bowland
Fahs-Beck Scholar
Olin Fellow
Washington University

Dr. Mary Hoke
Assistant Executive Director
Jewish Family and Children's Services

Ms. Anita Contreras
District Administrator East Region/
St. Louis Regional Center
Director
Missouri Department of Mental Health,
Mental Retardation and Developmental
Disability Division

Ms. Rosetta Keeton
Patient Advocate
St. Louis ConnectCare

Mr. Don Cuvo
Executive Director
St. Louis Mental Health Board

Mr. Mike Keller
Executive Director
Independence Center

Ms. Debbie Cochran
Area Director
Congressman Todd Aiken

Dr. Hilary Klein
Vice Chair of Psychiatry
Saint Louis University

Ms. Mary Ann Cook
Manager
JVC Radiology

Mr. Bill Leritz
Executive Director
Adapt of Missouri

Ms. Lesley Levin
President/CEO
Behavioral Health Response

Mr. Rick Majzun
Vice President, Strategic Planning
BJC HealthCare

Mr. Dick Dillon
Senior VP of Plan. & Development
Preferred Family Healthcare

Mr. Gary Morse
Executive Director
Community Alternatives
Ms. Julia Ostropolsky
President/CEO
Bi-Lingual International Assistant Services

Dr. Enola Proctor
Professor and Director Center for Mental Health Research
*School of Social Work*
*Washington University*

Ms. Valerie Russell
Executive Assistant
*Dept. of Human Services*

Dr. Vetta Sanders-Thompson
Assoc. Professor
*St. Louis University School of Public Health*

Ms. Denise R. Thurmond
Psychotherapist

Mr. Greg Vogelweid
Chief Operating Officer
*St. Patrick Center*

Ms. Marilyn Wilson
Psychiatric Social Worker
*Barnes-Jewish Hospital*
EASTERN REGION PUBLIC MENTAL HEALTH PLANNING PROJECT

VISION
MAY 2006
Overview

The Eastern Region of Missouri\(^1\) has a long-standing commitment to provide services to individuals and families affected by mental illness, with particular attention paid to those who are medically underserved. The 2003 publication of the St. Louis Regional Health Commission’s recommendations for improving the mental health services safety net included “improving coordination between mental and physical health systems.”

To this end, regional stakeholders representing state government, mental, physical, and substance abuse service providers, clients and their advocates have convened to improve the responsiveness of the public mental health safety net system. During this first phase of work, recommendations and an implementation plan will be developed to address triage processes, case management functions, and treatment options within the public system for acute adult mental health safety net services. The intent is that the implementation of the plan will commence in 2007. The scope of phase two, to begin in early 2007, will be determined by stakeholders as a continuation of phase one’s work. Issues that may be addressed in phase two include, but are not limited to, integration of physical and mental health services, long term funding, prevention, and children’s services.

During April 2006, the Regional Health Commission (RHC) conducted 21 visioning interviews on improving the responsiveness of the acute adult public mental health safety net system in the Eastern Region of Missouri. Participants in the interviews were recommended by the steering committee and community stakeholders. The purpose of these interviews was to:

- Collect viewpoints from various stakeholders as related to the scope of this project.
- Evaluate current strengths and unmet needs concerning triage processes, case management functions, and treatment options.
- Evaluate concerns and/or barriers to the development of a more responsive system.
- Identify best practices in other communities to explore in the creation of the Eastern Region’s recommendations and implementation plan.

Vision for the Future

Interviewees envision creating a regional public health system that is focused on the client, providing the optimal level of mental and physical health services and support for clients and their families/support systems. To accomplish this, several themes were repeated throughout the interviews that can serve as guiding principles for improved service delivery.

Guiding Principles

Collaboration – An environment of collaboration will form the foundation for any improvement in service delivery. “Territorialism” and “silo” approaches to funding and decision making have increased competition, draining resources which might have provided the best outcomes for clients. Collaboration between the public and private sectors, physical and mental healthcare systems, and among the three divisions in the Missouri Department of Mental Health are macro level goals. However, two immediate priorities emerged: 1) increasing collaboration among service providers within Comprehensive Psychiatric Services in partnership with Alcohol and Drug Abuse, and 2) improving communication between providers, funders and clients.

\(^1\) The Eastern Region is defined by the Missouri Department of Mental Health Administrative Agents’ service delivery areas: St. Charles, Franklin, Jefferson, Lincoln, St. Louis and Warren Counties and St. Louis City.
Vision – To improve service delivery, the network of service providers will look beyond “how things have always been done” to engage in long term, innovative problem solving and strategic planning that is client focused. Examples of visionary approaches to care mentioned during interviews include:

- Integrating services, both in practice and in principle, so that there is an inherent understanding that using the term “physical health” assumes mental health needs. Therefore, primary care providers address both mental and physical health needs in everyday practice.
- Services are utilized efficiently using an integrated, holistic approach that is strength based and promotes resiliency. The health care delivery model must be evidence-based.
- The health care system prioritizes funding to support early intervention and services that prevent crises from occurring.

Client Centered – Improved service delivery will be client-centered so that individuals can achieve a productive and fulfilling life regardless of the level of health assumed attainable. Client-centeredness is viewed as the approach that should be “the guiding and unifying principle and practice across the public and private mental health/health system.” The system of care will focus on the client – from the first entry into the system to the referral process to service delivery. The focus will be on understanding a client’s unique needs and connecting that person to community resources to attain the very best quality of life possible.

Advocacy – Advocacy will continue to be a key role for service providers, clients and concerned others as well as for the identified advocacy organizations. Education and awareness are essential for overcoming the stigma of and the complacency about mental illness and substance abuse. Health service providers, legislators, policy makers, families with loved ones who live with mental illness, insurance and managed care companies, and the greater community were identified as target audiences.

Awareness – In order to improve the health care encounter, the quality of care and the overall responsiveness of the public mental health system, discriminatory, systemic, and structural barriers will be removed. Barriers which can impede provider, client, and the community’s understanding and awareness include the stigma associated with mental illness, racial, ethnic, economic, geographical (i.e. city and rural), and cognitive differences.

Accountability - Expected results, goals and outcomes will be clearly articulated and agreed upon in partnership between the client and the network of community providers that support the client and family on an ongoing basis. Data will be regularly collected and shared to address questions of whether outcomes have been met for the individual client, for the organization, and for the health care system as a whole. Technical assistance should be made available to providers to ensure that desired outcomes will be reached and a standard level of care will be administered throughout the health care system. On-going feedback and continuous quality improvement will be encouraged and expected at all levels of the system.

Proposed Criteria:
In order to achieve this vision, stakeholders have outlined criteria that future recommendations must address:

Streamlined Care Coordination and Delivery
- Ease of Entry – Individuals in need of immediate care can access services efficiently regardless of their point of entry or ability to pay. Stakeholders identified current barriers to entry that include the lack of capacity for community mental health centers to provide the triage function and the lack of immediate availability of services due to providers experiencing the strain of increasing demand for services using diminishing resources. Stakeholders were concerned that clients with co-occurring disorders, high acuity levels, and
those without insurance or Medicaid, experience the most difficulty entering into the current safety net system.

∞ **Streamlined Referral Processes** – A simplified referral process is responsive to the needs of clients; the revised process accounts for providers’ availability to accept referrals based on their mission, scope of services, and criteria for admission. Stakeholders viewed that current referral processes were inefficient and point to these processes as a component of the system where clients fall through the cracks of service delivery. Lack of a formalized communication structure, and the lack of awareness of referral sources by service providers and the community are viewed as major barriers.

∞ **Effective Case Management** – Case management is a critical component to ensure effective navigation and continuity of care in the healthcare system. However, in the current system, the delivery of case management functions varies by definition and extent from provider to provider. Breakdowns stem from the lack of “real follow-up and wrap-around services.” Client advocates described the need for providers to “aggressively engage people with severe mental illness...going to the people who won’t come to the [provider]” in order to build trust and relationships. The ACT model was mentioned consistently as an approach to consider.

∞ **Array of Treatment Options** – An array of treatment options and increased community based resources are available in order to prevent individuals from entering into crisis. “The current system creates crisis,” is the conclusion drawn by workgroup members after creating a map of the way clients currently move through the system. Stakeholders identified a need for a blend of long term care, acute care and a community component; however, the focus should be on providing care within the least restrictive setting possible for clients.

Recognizing the need for and appropriate usage of acute care beds in the region, interviewees were concerned about the perceived dependence on inpatient services and lack of referral sources for services. The future healthcare system should increase the array of treatment options by including lower acuity access points. Options most frequently mentioned are: outpatient services, medication services, day hospital/day programs, supported employment, supported housing, intensive crisis residential, and independent living services. Stakeholders also envision the inclusion of non-conventional treatment options, i.e. partnerships with churches, faith-based programs, nursing homes, and state and community agencies that provide access to affordable housing.

∞ **Managed Exit Point** – The system is moved from the current “disease based” model to a recovery based model. The “pressure for discharge planning vs. treatment” was viewed as a breakdown in the current system. A managed exit point where clients are able to integrate into the larger community – provided that ongoing case management is included – is critical.

**Funding**

∞ **Flexible Funding** – Funding follows the client through blended and flexible funding streams that will stretch dollars to garner the most benefit for clients. Current barriers stakeholders have experienced are: 1) limitations to funding for the state Department of Mental Health, 2) restrictions placed on how funding can be used by providers, and 3) frequent rejection of funding proposals that include integration of funding streams. This sentiment was echoed throughout individual and community meetings.

∞ **Cost Efficiency** – Fragmented systems are integrated to gain cost efficiencies. Collaboration reinforced by more effective communication, regional problem solving, pooling of resources, and instituting best practices will yield increased service provision without the need for additional funding.
Maximize Funding into the Eastern Region – Given the scarcity of funding resources, federal and national funding streams in the region are maximized.

System Structure

Integration of Physical and Mental Health Services – Where appropriate, linkages and coordination between communities and health providers such as private and state hospitals, Federally Qualified Health Centers and Community Mental Health Centers are explored.

Provision of Care in Optimal Setting – Patients should be treated with the appropriate amount of care, at the right time, in the least restrictive clinical setting, so as to provide optimal care with the available resources.

On-going Regional Planning – Regional planning is the foundation for continuing the collaboration begun by this initial project.

Project Expectations

The Eastern Region expects to create a regional multi-phased plan that establishes the regional vision, sets strategic direction, and includes concrete action steps with funding solutions to provide better outcomes for clients. This regional multi-phased plan should be informed by an assessment of the current safety net system. The current state assessment will include strengths, gaps and barriers in service delivery and funding disconnects. Key findings from the assessment will inform recommendations made based upon the proposed criteria as outlined in this document.

Stakeholders desire for this project to include a recommendation for a pilot project that will improve system responsiveness in the short term while creating a clearly defined vision for the region’s healthcare delivery system within the next five years. Clients’ perceptions of needs, barriers, and vision for the system are key to the completion of the plan.
EASTERN REGION PUBLIC MENTAL HEALTH PLANNING PROJECT

ALTERNATIVE MODELS ANALYSIS

AUGUST 2006
INTRODUCTION

The Eastern Region of Missouri\(^1\) has a long-standing commitment to provide healthcare services to individuals and families affected by substance abuse and mental illness. In April 2006, the Eastern Region Community Mental Health Centers, Missouri Department of Mental Health Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse and the St. Louis Regional Health Commission partnered and began a first phase of strategic planning to improve access to and service delivery of behavioral health services.\(^2\)

Regional stakeholders representing state government, mental, physical, and substance abuse service providers, clients and their advocates convened April through December 2006 to develop recommendations and an implementation plan that will guide the efforts of improving triage and case management functions and identifying best practice collaborative care models of physical and behavioral health integration.

The Eastern Region Public Mental Health Planning Project is being coordinated by the St. Louis Regional Health Commission (RHC), whose mission is to improve access to care for the medically underserved, reduce health disparities, and improve health outcomes for citizens in the region. The RHC is a collaborative partnership of health service providers, government and community leaders, community organizations and consumers.

This Alternative Models Analysis is an effort to analyze “best practice” models of behavioral health service delivery, including effective crisis management and integrated delivery of physical and behavioral health care. A group of providers, advisors and related stakeholders helped research various organizational structures and conduct site visits to study different operational systems. The site visits provided an overview of a variety of implementation strategies that are appropriate for stakeholders to consider in the Eastern Region’s strategic plan for improving access to and delivery of behavioral health services is developed.

First, background information is provided which helped guide the site visits. Second, specific information about each site visit is summarized.

---

1 The Eastern Region is defined by the Missouri Department of Mental Health Administrative Agents’ service delivery areas: St. Charles, Franklin, Jefferson, Lincoln, St. Louis and Warren Counties and St. Louis City.
2 See Appendix 1 for committee structure and steering committee composition.
3 Throughout this document, the term “behavioral health” is used to indicate both mental health and substance abuse care. “Mental health” is defined as individuals with mental illness that is not necessarily substance abuse related. “Co-occurring” is used when speaking of the intersecting needs of mental health and substance abuse.
**Organizational Structures**

Organizational structures used to deliver primary and behavioral health care services vary from place to place and program to program. However, most programs can be grouped into one of four categories which roughly define their *organizational infrastructure*. These include:

1. **Facility or Hospital-based** – This structure is typical in large organizations such as hospitals or comprehensive health centers where primary care and behavioral health departments are owned and operated by one corporate structure. Health systems made up of multiple hospital sites often have arrangements for behavioral health in one or two of their operating locations.

2. **Co-Location** – Health and mental health facilities may be in adjoining geographic locations or even in the same building. However, they are owned and operated by two different corporate owners.

3. **Networked or Purchased Services** – The integration of primary care and behavioral health care may be accomplished through the purchase of care in private for-profit or non-profit settings. Typically, a large integrated health system might outsource specialty mental health interventions by creating a provider network or contracting with a local Community Mental Health Center and/or Alcohol and Drug Abuse provider organization.

4. **Hybrid System** – In this system, a staffed and networked agency is created to broker contracts, deliver direct care and manage area-wide utilization of public, safety net services. The blending of internal staff provided and external purchased services is created to conserve resources while expanding the locations and array of available care.

**Operational Structures**

Variations in structural arrangements used to deliver healthcare must also be examined from an *operational* viewpoint to correctly understand how a system functions in the real world. In other words, physical locations do not necessarily produce integration; we must examine integration and its impact from the clients’ experience. Kirk Strosahl (2004) is a researcher from Moxee, Washington, who has identified operational dimensions of working healthcare systems with a focus on care integration. He describes seven parameters, as “Integration Readiness Criteria,” which are useful to our analysis of service delivery models. The areas for evaluation include:

- Political and organizational
- Core program philosophy
- Financing strategy
- Program mission, scope, and tactics
- Administrative infrastructure
- Staff training
- Performance indicators
In addition to the above criteria, stakeholders in the Eastern Region project determined that an effective crisis management system and a “collaborative care” approach to service delivery was important when considering program effectiveness. Stakeholders defined “collaborative care” as:

“...an integrated health care model in which client needs take priority. Health care services are organized to functionally link behavioral health and primary medical care providers so they may act as partners in the treatment and/or management of substance abuse and mental illness.”

Together, the Strosahl criteria, effective crisis management system and collaborative care definition were used to help identify and evaluate best practice sites. Based on this background, a questionnaire was developed to guide information gathering at the site visits (see below for more information and Appendix 1 for the questionnaire.)

SITE VISITS

In-person visits to behavioral health organizations in other communities were conducted during July and August 2006 to examine first-hand the operational aspects of other systems. Visits provided an opportunity to ask questions about the philosophy of care and the operating systems that are used to produce and monitor services.

All behavioral health organizations in the public sector must address a standard set of issues related to improving access, ensuring quality and containing the cost of health care provided. In addition, these dimensions must also consider client acceptance and ideally with client input. Failure to address any of these issues will probably damage or destroy the program in question. Exemplary programs, by comparison, handle all of these issues well.

Programs to visit were selected based on their ability to deliver effective behavioral health crisis management services and improve integration between physical and behavioral health care service delivery. Each site shared their successes and their limitations. Each site visit included members from the Steering Committee and/or organizations they represent. An effort was made to include representatives from behavioral health agencies as well as hospitals and health centers in our region.

A site visit summary (see Appendix 2) was developed by stakeholders to structure information gathering during the site visits. The summary form focused on five key areas:

- Crisis intervention and case management functions,
- Access to an array of behavioral health and health services,
- Integration between a) mental health and substance abuse services, and b) health and behavioral health care,
- Integrated funding streams to increase resources, and
- Integrate information systems to improve service coordination.

Stakeholders visited Burrell Behavioral Health in Springfield, Missouri; Detroit-Wayne County Community Mental Health Agency in Detroit, Michigan; Johnson County Mental
Health Center in Mission, Kansas; Swope Health Services in Kansas City, Missouri; Waccamaw Mental Health Center in Conway, South Carolina; and, Washtenaw Community Health Organization in Ypsilanti, Michigan. Based on the interview guide, information from each site visit is summarized in this document.

**Burrell Behavioral Health, Springfield, Missouri**

The Burrell Center was established nearly 30 years ago as a federally funded CMHC. The Center joined with Cox Medical Center a decade ago to provide a comprehensive array of behavioral and health services to a seven county region of more than 483,000 people. The Center employs 570 FTE and is known for its leadership in providing inpatient, crisis respite, prevention and many other community based services in 21 locations. It operates with a budget of $27 million and cares for 5,800 people each year.

Burrell Center and the Cox Health system together have been creative and successful in providing a broad array of services in the absence of any state operated inpatient facility or state funding for inpatient care. The system is also noted for its integration of primary care and behavioral health. Unique features of the Burrell Center program include:

- A highly integrated behavioral health system with significant linkages to primary care and acute hospital services,
- Crisis respite, residential, and assertive community interventions used as alternatives to acute inpatient treatment,
- Well developed and highly integrative funding streams, including commercial insurance, to support a growing population within the region,
- A new child and adolescent treatment center recently constructed on the agency campus.

**Addressing Eastern Region Goals:**

1. **Crisis intervention and case management functions:** Burrell assigns case managers to all seriously mentally ill clients in treatment. These staff coordinate all service needs with the client. The agency crisis system includes rapid assessment and a free-standing 10-bed “stabilization” unit which prevents unnecessary hospitalization. The “crisis intervention team” reported more than 4,700 contacts in 2005. Patients may be seen for initial screening at office locations and the hospital emergency departments. Less than half of the patients seen for crisis intake require hospitalization.

2. **Access to an array of behavioral health & health services:** The agency offers a broad continuum of behavioral health interventions including prevention, outpatient, residential, community based and inpatient care services. The client can enter “any door” to the system as dictated by initial screening results. Once in the system, they may move easily between services with guidance from case managers, as needed. Staff provide on-site services at 21 school district locations, Division of Family Services offices and at juvenile courts.
3. Integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care: The full array of behavioral health services are managed under the single administration of the Burrell program. This structure minimizes barriers to care for clients with dual disorders associated with mental illness and substance abuse. The program is also an integral part of the Cox Health system, which affords easy access to medical interventions. The system includes a 40 bed adult inpatient unit as well as a geriatric unit. Burrell staff also provide behavioral health services in the local Federally Qualified Health Center offices.

4. Integrated funding streams to increase resources: Burrell has diversified its program income to include private and public resources. While 19 percent of its operating budget comes from the Department of Mental health, an additional 16 percent is received from private pay, including commercial insurance.

DETROIT - WAYNE COUNTY COMMUNITY MENTAL HEALTH AGENCY

This mental health system is an extensive, well-funded organization, spending $500 million to assist a population of 2 million citizens in a major urban center. Wayne County operates one of the 46 regional community mental health service programs (CMHSPs) in Michigan. The agency provides care to 40,000 people each year. The Detroit Receiving Hospital is an integral part of the health and behavioral health system which includes free standing crisis beds, 23-hour observation units and a continuum of community based services. Services for substance abuse and developmentally disabled clients are included. Unique features of the Detroit – Wayne County program include:

- A large, multi-level service system combining MH/SA and MR/DD client needs under one structure,
- A system which combines the capacity to enter service through “any door” and also operates a standardized, widely known entry point,
- Use of a management information system to track clients across services,
- Shared medical records, and
- Integration of SA/MH services in spite of dual funding streams.

Addressing Eastern Region Goals:

1. Triage, crisis intervention and case management functions: The Wayne County area benefits from the operations of a crisis screening unit, crisis residential facilities, 24-hour mobile crisis response and 23-hour crisis respite beds. Multiple treatment sites and co-location of services with law enforcement, and social service settings are available. Case management service is clearly defined and widely available.

2. Access to an array of behavioral health & health services: The system affords easy access to care because it operates with links to medical and psychiatric emergency settings that are responsive to centralized assessment and triage. Programs are joined by a “common vision” to serve the client by working under the Gateway Community Health
collaboration. An administrative service organization (ASO) model is used effectively to allow sharing of client information as client is seeking care.

3. **Integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care:** Integration with medical services is still problematic, “but is improving.” Five area hospitals participate in the service system.

4. **Integrated funding stream and increased resources:** The multiple fund sources include state and county support. The Common Ground program is a critical resource for integrated funding. This non-profit program operates 24/7 and helps youth, families and adults in crisis. It is funded through the local mental health authority. Many of the services in the area are purchased from contract providers who function as part of the safety net system. This region operates using a hybrid network model.

5. **Integrate information systems to improve service coordination:** A common information platform is used for outpatient mental health services – all participating agencies have access to the client database. The record keeping agreements in place are HIPPA compliant and endorsed by all system providers. Services are pre-authorized to allow monitoring of the quality of care.

**Johnson County Mental Health Center, Mission, Kansas**

This Center was founded in 1962 and is located across the state line from Kansas City, Missouri, making up a portion of the greater Kansas City metro area. Johnson County has a rapidly growing population of more than 500,000 citizens in a prosperous suburban area. Demand for mental health services has increased 35 percent since 2000. The Center has made efforts to keep up with area needs by expanding its array of services and developing new locations as funding allowed. Seven locations are now operating to deliver a broad array of outpatient and community based behavioral health interventions. Most recently, the Center opened six crisis beds co-located with six substance abuse detox beds.

Like other Kansas centers, this agency is a county-based organization governed by a local board with staff employed by the county. The operating budget of $25.4 million is a mix of state, federal and county dollars serving any county resident who meets the income guidelines. The majority of its 8,700 clients (seen in 2005) are at or below 200 percent of the federal poverty guidelines. Special features at Johnson County include:

- A highly integrated behavioral health system that has promoted the use of community alternatives to state hospital care, achieving the lowest utilization of state beds in Kansas,
- A system that delivers a high level of both adult and child services across all diagnostic categories, including SED youngsters who are “most at risk” of out-of-home placements,
An array of integrated mental health and substance abuse services, including outpatient, residential, group home and crisis response capacity,

Blended funding streams which maximize local, state and federal resources to support healthcare,

An agency that continues to operate an active prevention program delivering more than 1,770 hours of community education and prevention.

Addressing Eastern Region Goals:
1. Triage, crisis intervention and case management functions: This agency serves as the point of entry for all behavioral health care in the county. Since state mental health reform was passed in 1990, the Center acts as the gatekeeper for any state facility services in the area. Ten staff are dedicated full-time to crisis intervention, including mobile response. The 24 hour availability is shared across Johnson and Wyandotte counties. Staff also works with police Crisis Intervention Teams to screen individuals who come in contact with law enforcement personnel. The center employs case managers to intervene and liaison with any hospital emergency room receiving clients. The state-funded Rainbow unit is a local facility used by Johnson County for brief hospital care. Crisis residential beds are also available and operated by the Center.

2. Access to an array of behavioral health & health services: The agency has developed a comprehensive array of interventions across the full spectrum of outpatient, inpatient, residential and community based substance abuse and mental health programs. Substantial programs at all levels are in place. The continuum of direct care is also complemented with an actively staffed prevention program known as the “Regional Prevention Center.” The RPC delivered nearly 1,800 hours of prevention services in 2005. Most recently, the Center has also developed an in-house primary care services to assist the clients needing medical care.

3. Integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care: Johnson County has adopted an integrated dual-disorder model of treatment that was developed at Dartmouth University. The “IDDT” model is considered especially effective with clients who are seriously ill. Kansas programs were used as pilot sites for the development of this national model. Screening tools across programs address issues of substance use as well as mental illness.

4. An integrated funding stream to increase resources: The agency has centralized billing and accounting functions which serve all programs operated directly. State, county and federal funds are segregated and applied to clients meeting funding criteria. However, the support for agency services is generally received on a “performance grant” basis (except federal Medicaid which is fee-for-service) which allows some flexibility in use. Case rates and other mechanisms are in place to ensure that public funds are spent efficiently and in an accountable fashion.

5. Integrate information systems to improve service coordination for the client: Information systems at Johnson County are integrated and allow data-sharing with the state facilities. Legislation was created as a result of mental health reform to legally
permit necessary clinical data to follow the patient, even in the absence of a signed release. The agency also is working to fully develop an electronic medical record. Progress notes and admitting information are now available in the electronic medical record format.

Swope Health Services, Kansas City, Missouri

Swope Health Center was established in 1969 to serve the health needs of citizens in the Jackson County area, which includes metropolitan Kansas City, Missouri. Since startup, the agency has expanded to include several satellite locations in two additional counties. With a budget of $16 million, the behavioral health program employs 247 FTE across a full array of substance abuse and mental health interventions. The agency has a strong focus on services to clients with serious mental illness, mobilizing 12 community treatment teams. Addiction and prevention services include the operation of a 30-bed ADA residential program.

Swope has long been a leadership organization in the creation of Swope Community Enterprises and Swope Community Builders, organizations that address community housing and health needs of citizens. The agency has been successful in obtaining large federal and local grants to support its mission. Special features of the Swope Health Center program include:

∞ A highly integrated health system that has also successfully promoted community development efforts to improve housing, create jobs and generally enhance the quality of life for residents of the area,
∞ A behavioral health system that relies on state operated beds for the bulk of its inpatient services,
∞ An expansive array of integrated mental health and substance abuse services, including outpatient, residential, group home and crisis response capacity,
∞ Blended funding streams which maximize local, state and federal resources to support healthcare,
∞ A facility with close linkages to managed care options provided through First Guard (previously owned by Swope), a managed care organization that provides managed Medicaid and fee-for-service contracts.

Addressing Eastern Region Goals:
1. Triage, crisis intervention and case management functions: This agency places priority on its service to clients with serious mental illness and/or substance abuse. A large portion of its operating budget is devoted to support 12 community intervention teams which provide mobile crisis response, assessment, case management and ensure continuity of care. Swope is a member agency of CommCare which coordinates after hours crisis response and linkages with area hospital beds when inpatient treatment is needed.

2. Access to an array of behavioral health & health services: Swope Health Services is a comprehensive health and mental health center which spends more than 40 percent of its
operating budget on behavioral health care. The center operates a 30-bed residential drug abuse facility (Imani House) on the campus and relies on community and state hospital beds for acute inpatient needs. The agency also developed a comprehensive unique outreach program serving large homeless populations in Kansas City.

3. Integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care: Swope Health provides an excellent example of an agency that easily moves any client between behavioral health, dental and medical care services. The patient may enter any door of the Center and receive multiple services at a single site or even during a single visit. Primary care physicians routinely refer to or consult with behavioral health staff in a reciprocal manner to deliver whatever services help the client. The link between services is described as “seamless.”

4. An integrated funding stream to increase resources: The health center has a centralized billing and accounting function which serves all programs within the agency. Swope was highly successful in attracting federal and local grants to support facility construction and program operations. Virtually all of its facilities were constructed with grant or donated funds received over the past 30 years. Funding sources for behavioral health include a local “Combat Tax” for substance abuse and a county mental health levy assessed on property valuations. These local taxes add significantly to the support for behavioral health in Jackson County.

5. Integrate information systems to improve service coordination for the client: The agency information system is centralized and includes electronic access to admitting data system-wide. The administration is currently pursuing electronic data management functions for clinical information as well. An electronic medical record system is being planned with the intent to speed access to clinical data across services.

**Waccamaw Mental Health Center, Conway, South Carolina**

The Center is a state owned and operated facility with several satellite locations that serves 4,500 clients annually. It employs 226 FTE staff and has a $12 million budget. It is part of the larger, primarily rural, state system in South Carolina which has a total population of 2.1 million residents. It shares financial, admitting and treatment protocols with the larger state system.

Since 2001, the Center has been part of a project that united the Center for Mental Health, the Georgetown County Drug & Alcohol Commission, Georgetown Diabetes CORE group and the St. James-Santee Family Health Center and created a “one-stop-shop” community health and behavioral health facility. Grant funding is being used to renovate an old school facility for use as a multi-service complex. Special features of the Waccamaw Center programs include:

- A county/state based system which relies on multiple fund streams to support a full array of health and behavioral health interventions,
Effective inter-agency collaborative agreements which allow each respective agency to operate independently, but in a coordinated approach to enhance client access,

A strong commitment and history of serving minority populations,

Established contracts with local hospitals that provide purchase agreements for inpatient care,

Solutions to unique service demands created by a rural setting.

**Addressing Eastern Region Goals:**
1. *Triage, crisis intervention and case management functions:* The center uses the local hospitals to provide an entry point for crisis management. After the client is medically stabilized, they are referred to a crisis unit and may be moved to another setting within 23 hours. The agency is currently developing a 23-hour observation program to enhance crisis response.

2. *Access to an array of behavioral health & health services:* With very limited resources, the Waccamaw Center created memos of understanding between and among a variety of social service agency partners. The Center has also improved access to care by aggressive outreach at area homeless shelters, parks and through relationships focused on the provision of housing alternatives.

3. *Increase integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care:* This site presents a good example of what can be accomplished with very limited resources toward the goal of integration. The efforts of state and grass roots collaboration have allowed the Waccamaw Center give leadership in the operations of the Choppee Health Complex. The combined programs create a “one stop shop” for clients who require an array of safety net care. Waccamaw stakeholders report that “It is all about relationships…”

4. *Create an integrated funding stream and increase resources:* Service partners assist the agency to maximize state and local dollars for the clients needing health and behavioral health interventions.

5. *Integrate information systems to improve service coordination:* The current information system integrates screening, assessment and intake information for the clients at the agency. Waccamaw is working with its partners on the development of an automated screening tool to be used by the group. Electronic records are not available statewide in South Carolina.

**Washtenaw Community Health Organization, Ypsilanti, MI.**

With a budget of $100 million for an integrated health care delivery system, $44 million is designated for mental health and substance abuse services. The organization contracts with qualified providers, providing consistent, high-quality health care for the 331,000 citizens of Washtenaw County. Approximately 80,000 patients are seen annually.

WCHO is a member of the Community Health Partnership of Southeastern Michigan, a collaborative effort between four Michigan counties established in 2002.
WCHO also benefits from a strong working relationship with the University Medical Center at Ann Arbor. The linkage with the psychiatric emergency services at the center and the related training opportunities with the University of Michigan help create a broad service platform for the area. Special features of the Washtenaw County program include:

- Creative model of behavioral and physical health integration done at the primary care site.
- A model medical record system, using electronic medical record functionality.
- Ability to braid funding.
- Ability to evaluate successes and “save money” through efficiencies in care while increasing the quality of care for the client.

Addressing Eastern Region Goals
1. Strengthen triage, crisis intervention and case management functions: Case management services are clearly defined, and form the basis for staff training for clinicians in addictions and mental health programs. Emergency room services at the medical center offer quick access for crisis management and referral. The system includes contract service providers to expand capacity.

2. Improve access to an array of behavioral health & health services: Washtenaw County collaborates with Oakland and Macomb counties to deliver a comprehensive array of services. Clients are included on the system advisory board to ensure attention to access issues. The area is well funded with $40 million being spent last year for the population being served.

3. Increase integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care: The system operates with a concept of providing a “medical home” for all patients seeking care. This concept fosters close cooperation between providers in the area, including primary care. A “single team” approach is used for each patient. The university health plan is included in the delivery approach. Behavioral health staff members are “imbedded in health care facilities.”

4. Create an integrated funding stream and increase resources: The partnering agencies in this area have considerable “clout” to ensure that a variety of fund sources are available. Major health plans, state, federal and local funds all contribute to the support of behavioral health and integrated health services. System coordination is the key to making the funding work. Agency leadership has worked with the state legislators to create a funding base which allows support for substance abuse, mental health and health services in a process that is “seamless to the client.”

5. Integrate information systems to improve service coordination: The local agency has developed, and is using, electronic medical records. The ENCOMPASS system is considered easy to use by providers and is being made available to other systems around
the country. The record format and content is designed to meet the needs of area stakeholders/providers.

SITE VISIT SUMMARY

The site visit summary on the next page was developed to assist the reader to review the programs visited “at a glance.” The ratings are subjective and are not intended to evaluate good or bad features of the site. Ratings simply reflect the available information as understood and reported by site visitors. A rating of “0” was used to indicate lack of information. The programs provided copies of service manuals, PowerPoint presentations and actual service data, which were used to evaluate their performance.
## Site Visit Summary

<table>
<thead>
<tr>
<th>Integration Principles</th>
<th>Burrell Center</th>
<th>Johnson County MH</th>
<th>Swope Health Center</th>
<th>Washtenaw Center</th>
<th>Washtenaw County</th>
<th>Detroit-Wayne County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Philosophy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Any door&quot; entry</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Collaborative planning &amp; service delivery</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Serves target populations</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Clinical practice combines behavioral health and primary care</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Resources focus on community interventions</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Uses helping networks outside system</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Financial Strategy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective use of multiple funding streams</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sustainable budget</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mechanisms in place for risk sharing among partners</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Mechanisms in place for distribution of cost savings among partners</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Program Scope and Tactics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope of service clearly defined</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Employs clear triage and referral criteria</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>System focused on alternatives to hospitalization</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Administrative Functions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal staff training a key component</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Integrated information system operational</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Performance Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs and outcomes of integrated services documented</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Access and penetration rates documented</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
**SITE VISIT CONCLUSIONS**

- Service delivery challenges differ across programs for many reasons. Clearly, a successful program in Detroit, Kansas City or Springfield may not exactly fit the needs of people in the St. Louis region. The context of the program sites differs and definitely affects approaches to service. The size of the city, available transportation, demographics of the region, funding levels and cultural differences of the population are just a few examples of “contextual variables” that alter what and how services are delivered. These differences were noted as we visited sites and explored solutions. Although dissimilarity cannot be ignored, it should not limit discussions of how programs handle **access, quality and cost** parameters.

- The site visits also included discussion of best practice and evidence-based practice (EBP). Because these concepts are often applied in medical practice settings, they are more difficult to apply in behavioral health and social service agency structures where philosophies of care and intervention strategies vary widely. However, it is incumbent upon us to learn about treatment or recovery protocols which consistently produce good results as documented by replicated research findings. Site visits included some discussions of the EBP approach, the agency’s experience with it, and whether it could be successfully replicated in St. Louis.

- It is apparent that programs visited for this review represent high levels of coordination and integration that is largely the result of single entity administrative structures. When one agency (or a single county) is “in charge” of many functions, the burden of integration may be lighter. However, the St. Louis regional providers may never be united under one county, regional or state administrative entity. This suggests that promoting service coordination, integration and collaboration in the region will require a fresh approach to create a “networked” structure which can standardize key functions across all partner organizations. This might be accomplished using a common electronic data platform for entering clients into the system and tracking their service needs.
APPENDIX 1

Site Visit Questionnaire

I. Core Program Philosophy
   □ Briefly describe the agency mission and values:

   ______________________________________________________
   ______________________________________________________

   □ Is the system “seamless,” allowing the consumer to enter “any
door?”

   □ How does the agency promote integrated or collaborative services?
     i. Between physical and behavioral health
     ii. Between mental health and substance abuse

   □ Does the agency have a well-documented administrative process
     and structure? Describe:

   ______________________________________________________
   ______________________________________________________

   □ How does the agency support cultural competence among services
      & providers?

   □ How does the system offer core services to specified population
      with evidenced-base approach?

   □ Does the agency follow a defined clinical practice model for
      behavioral health (BH) and primary care (PC)?

   □ How does the system focus resources on community interventions
      taking place in helping networks outside of traditional behavioral
      health settings (examples – schools, churches, legal system, etc.)?

   □ How does the system track:
     i. Where individuals are receiving services
     ii. Whatever state the individual is in e.g. crisis situation?
II. Financing Strategy

- What are the agency’s payment mechanisms for behavioral and health services?
  
  ______________________________________________________

- Does the agency have a sustainable budget? How is this achieved?

- How does the agency maximize private insurance revenues?

- Does the agency have mechanisms for risk sharing with partners? What are they?

- Does the agency have agreements for distribution of cost savings (to partners)? How do they operate?

III. Program Scope and Tactics

- Is there a single case manager actively tracking the individual across all services?

- Is the scope of service clearly defined? Identify types of services provided:
  
  ______________________________________________________
  ______________________________________________________

- Describe clinical and team role expectations:
  
  ______________________________________________________
  ______________________________________________________

- Who are the target population(s) served?

- What are the triage and referral criteria for outside services? Examples?

- Is the system focused on alternatives to hospitalization? What are they?
IV. Staff Training

- What kind of skills-based training for BH & PC is provided?
- Is a best practice approach used in training? What is it?
- What kind of service manuals are used as the basis for training?
- How does the agency ensure consistent performance across providers?

V. Performance Indicators

- How does the agency track cost & outcomes of integrated services?
- How does the agency measure whether population targets are met?
- Is there an analysis of program accessibility and penetration rates?
- How does the agency measure consumer and provider satisfaction with services?
- How does the agency collect practice profiles for individual providers and PC teams?
- Are there performance indicators which serve as a core management tool? What are they?
- Is continuous quality improvement built into the system? Are outcomes continuously used to improve the system?

Other comments or observations:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

________________________________________ Date: _________________________
RESOURCES


McCombs, Harriet, DHHS Bureau of Primary Care

Strosahl, Kirk (2004) Health Integration Readiness Survey; Moxee, WA

Sampson, Neil at US DHHS Bureau of Primary Care
APPENDIX 2

Site Visit Summary Form

Site ____________________________  Team Member ____________________________

How does this agency address the GOALS of our St. Louis regional project?

1. Strengthen triage, crisis intervention and case management functions:

2. Improve access to an array of behavioral health and health services:

3. Increase integration between:
   a) mental health and substance abuse services:
   b) increase integration between health and behavioral health care:

4. Create an integrated funding stream and increase resources:

5. Integration information systems to improve service coordination for the consumer:
GENERAL COMMENTS

Advantages of this system:

Disadvantages of this system:

Concepts/System Components we should apply to our CRISIS system:

Concepts/System Components we should apply to our system in general:

Other Key Observations/Takeaways"
EASTERN REGION PUBLIC MENTAL HEALTH PLANNING PROJECT

BEHAVIORAL HEALTH CURRENT STATE ASSESSMENT

DECEMBER 2006
# TABLE OF CONTENTS

1.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: EXECUTIVE SUMMARY AND KEY FINDINGS  
2.0 PUBLIC BEHAVIORAL HEALTH SYSTEMS: BACKGROUND  
3.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: ACCESS TO CARE  
4.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: UTILIZATION OF SERVICES  
5.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: FINANCING THE SYSTEM  
6.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: BARRIERS TO CARE  
APPENDICES
1.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: EXECUTIVE SUMMARY AND KEY FINDINGS

EXECUTIVE SUMMARY

The Eastern Region of Missouri\(^1\) has a long-standing commitment to provide healthcare services to individuals and families affected by substance abuse and mental illness. In April 2006, the Eastern Region Community Mental Health Centers, Missouri Department of Mental Health Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse and the St. Louis Regional Health Commission partnered and began a first phase of strategic planning to improve access to and service delivery of behavioral health services.\(^2\)\(^3\)

Regional stakeholders representing state government, mental, physical, and substance abuse service providers, clients and their advocates convened April through December 2006 to develop recommendations and an implementation plan that will guide the efforts of improving triage and case management functions and identifying best practice collaborative care models of physical and behavioral health integration.

The Eastern Region Public Mental Health Planning Project is being coordinated by the St. Louis Regional Health Commission (RHC), whose mission is to improve access to care for the medically underserved, reduce health disparities, and improve health outcomes for citizens in the region. The RHC is a collaborative partnership of health service providers, government and community leaders, community organizations and consumers.

Since its formation in 2001, the RHC has served as a lead body for regional planning and implementation of initiatives to strengthen the health care safety net system, and to improve health literacy, prevention and wellness services.\(^4\) In 2003, the RHC issued recommendations calling for “improving coordination between mental and physical health systems.”

The implementation of the Eastern Region Public Mental Health Planning Project plan is scheduled to begin in 2007. The scope of phase two, to begin in early 2007, will be determined by stakeholders as a continuation of phase one’s work. Issues that may be addressed in phase two may include, but are not limited to, further collaboration of the Missouri Department of Mental Health Divisions of Alcohol and Drug Abuse,

---

\(^1\) The Eastern Region is defined by the Missouri Department of Mental Health Administrative Agents’ service delivery areas: St. Charles, Franklin, Jefferson, Lincoln, St. Louis and Warren Counties and St. Louis City.

\(^2\) See Appendix 1 for committee structure and steering committee composition.

\(^3\) Throughout this document, the term “behavioral health” is used to indicate both mental health and substance abuse care. “Mental health” is defined as individuals with mental illness that is not necessarily substance abuse related. “Co-occurring” is used when speaking of the intersecting needs of mental health and substance abuse.

\(^4\) For this document and project, safety net includes individuals on Medicaid and individuals who are uninsured.
Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities; long term funding; prevention/early intervention; and, children’s services.

This analysis is the result of several months of activities, including:

- A review and description of the public behavioral health care system at the national, state and local level,
- An in-depth analysis of the continuum of care available in the Eastern region,
- A collection of provider service data information for 2005, and
- An analysis of behavioral health care funding for the Eastern region.

KEY FINDINGS

As a result of the above activities and analysis, the following key findings emerged.

1. The behavioral health system in the Eastern Missouri region is fragmented and has gaps on many levels:

   a. **Limited coordination of health care** – Stakeholders emphasized that the behavioral and physical health needs of an individual should not be separated – they are inextricably linked to the individual’s overall health and well-being. However, there is limited coordination between the behavioral health care system and the physical health care system. The behavioral health system is separated from the physical health system in many ways.

   b. **Limited coordination within the behavioral health system** – Within the behavioral health system, there is limited coordination between providers. For example, clients receive redundant assessments from each different provider/organization. Mental health and substance abuse providers have limited communication with each other and limited knowledge of each others’ programs. And, although more than half of the adults with severe mental illness in the public mental health system are further impaired by co-occurring substance use disorders, there is limited coordination of mental health and alcohol and drug abuse treatment.

   c. **Limited coordination of community based behavioral health services with inpatient psychiatric services** – Stakeholders report that individuals often enter into inpatient psychiatric services without appropriate screening for community alternatives and come out of inpatient services without a seamless handoff to ongoing community treatment.

2. It is difficult for some people in need of behavioral health services to find adequate information regarding who can access services and what services are available. A large number and wide variety of formal and informal entry points are available for

---

^5 Substance Abuse and Mental Health Services Administration, National Mental Health Information Center, Evidence-Based Practices, Co-Occurring Disorders: Integrated Dual Disorders Treatment, Implementation Resource Kit.
individuals to make an initial point of contact into the behavioral health system; however, stakeholders believe the general public does not understand the types or breadth of services provided, or the areas served by specific providers.

3. Clients and family members identify a combination of practical barriers and limited social supports that prevent them from accessing quality behavioral health services. Examples of practical barriers include limited transportation and limited ability to receive appropriate medications. Examples of limited social supports include the limited stable housing and employment, the stigma of mental illness and substance abuse, and the lack of respect from professionals, family and friends.

4. Accounting for dollars spent for behavioral health services in the region is challenging. Several measures highlight the limited funding for safety net behavioral health services in the Eastern region:

   a. *Waiting Lists* – Because of limited funding and restrictions on how funding can be used, individuals with behavioral health needs in the safety net system are often unable to access care unless they are in a crisis situation. Existing capacity for community based mental health and alcohol and drug abuse services is not meeting service demand; many behavioral health organizations have a wait list for services. The current mental health system responds primarily to individuals in crisis, and has less emphasis on prevention and early intervention efforts.

   b. *Serving a lower percentage of the population than other regions* – The money invested in the Eastern region public behavioral health system served a much lower percentage of the population than the percentage of people served in other regions of the state. For example, the state Comprehensive Psychiatric Services 2005 expenditures in the region served 7.5 citizens per 1,000 population (reported by the CPS Division) which is less than half the penetration rate of 15.9 per 1,000 observed in the Northwest Region (Kansas City region) and a statewide average of 12.4 people per 1,000. This finding may suggest the need for increasing community-based treatment options in the region.

   c. *Decreasing state and federal funds* – Changes in the federal and state level have resulted in proportionately less funds available for behavioral health services; this has caused a noticeable erosion in services in safety net behavioral health services across the country.
2.0 PUBLIC BEHAVIORAL HEALTH SYSTEMS: BACKGROUND

NATIONAL PUBLIC BEHAVIORAL HEALTH SYSTEM

The National Mental Health Act (P.L. 79-487) was passed by Congress in 1946, signaling the willingness of the federal government to address the plight of people with serious mental illness. This act eventually led to the creation of the National Institutes of Mental Health (NIMH) and promoted a lasting partnership between the states and the federal government.

In 1963, the Community Mental Health Centers Act was passed and laid the groundwork to establish more than 750 federally funded community mental health programs across the country. The first operating center funded under this act opened in 1966 as Mid-Missouri Mental Health Center in Columbia, Missouri. Mid-Missouri and the rest of the nation shared the goal of moving people out of state hospitals and into community care systems.6

The 1980s marked the end of an era of direct federal funding to community mental health center (CMHC) programs in America. Provisions of SB1122 created to expand the array of community based options for people with mental illness and/or substance addictions were rescinded. Federal support was re-directed to state governments in the form of “block grants” for behavioral health, working under the assumption that states could better coordinate care, meet the local needs of citizens, and operate more economically than the federal government. States in turn created their own administrative structures to pay these funds to community programs. Although these “block grants” were administered to the states, national funds for mental health were cut by 25 percent in the early 1980s.7

Missouri created an “administrative agent” structure within the Department of Mental Health (DMH) to ensure that every community in the state had access to a community program focused on the delivery of a continuum of care in each service area. The mental health centers were named as agents of the state DMH to provide locally managed and coordinated services for the safety net populations across the state. The integrated care systems were mandated and supported through a purchase-of-service (POS) contract system for psychiatric services.

In April 2002, President George W. Bush announced the “President’s New Freedom Commission on Mental Health Initiatives.” President Bush said in his address, “Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care.”8 The New Freedom Commission identified stigma, unfair treatment limitations and financial requirements, and

8 President’s New Freedom Commission Report, 2003
fragmentation of the delivery system as areas of weakness in the current mental health care system. The New Freedom Commission recommended “complete transformation” of the mental health system in America. Six goals were identified to serve as the foundation for this transformation:

1. America understands that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

One of the main problems with the system was the observed fragmentation of mental health services. Many of these problems were traced to the process of deinstitutionalization that shifted care for people with mental illness from a hospital-based to a community-based system. According to the World Health Organization, deinstitutionalization was complex and should have led to “the implementation of a network of alternatives outside psychiatric institutions.” The report goes on to lament that these networks never developed due to a lack of appropriate community services and funding.9 In addition to fragmentation, service delivery is also difficult because of changes to and limitations in funding for behavioral health services.

**FEDERAL CUTBACK IMPLICATIONS FOR LOW-INCOME PEOPLE WITH SERIOUS MENTAL ILLNESSES**

The Eastern Region Public Mental Health Planning Project seeks to address the specific needs of adult clients who are in crisis, who are unable to attain private insurance or do not qualify for Medicaid benefits. In the article, *The Struggle to Provide Community-Based Care To Low-Income People With Serious Mental Illness*,10 the authors outline the challenges of service delivery to low-income people with serious mental illness as reported by mental health professionals, general medical care providers and policymakers in 12 U.S. communities.11 Key findings from this report are:

- Medicaid has become the single largest payer of mental health services for low-income people accounting for about 40 percent of all public-sector spending on mental health services in 2001 compared with 21 percent in 1971.
- Due to tight state budgets and Medicaid cost increases, many states have attempted to contain costs through reductions in reimbursements and eligibility, greater restriction on prescription drug use, and increased cost sharing.
- State budgets for non-Medicaid mental health services have been cut or growth has not kept up with levels of inflation.

---

10 Cunningham, Peter; McKenzie, Kelly; Taylor, Fries Erin. “The Struggle To Provide Community-Based Care To Low-Income People With Serious Mental Illnesses.” Health Affairs 25.3 (May/June 2006) 694-705.
11 The 12 nationally representative markets are Boston, Cleveland, Greenville (South Carolina), Indianapolis, Lansing, Little Rock, Miami, northern New Jersey, Orange County (California), Phoenix, Seattle, and Syracuse.
With states shifting an increasing proportion of their mental health budgets onto Medicaid, fewer state funds are available to provide services to lower-income uninsured people with serious mental illnesses who are not eligible for Medicaid. The impact of service gaps on the community includes homelessness, incarceration, and emergency department usage increase.

A noticeable erosion of services for the uninsured with serious mental illnesses was noted across the 12 U.S. communities including:

- Residential services are in short supply including transitional shelters, housing, and other support services.
- Lack of psychiatric inpatient beds for acute care.
- Shortage of key outpatient care staff, especially psychiatrists, resulting in longer waiting times. As with other physicians, psychiatrists are much more likely to limit Medicaid and uninsured patients in their practices than to limit privately insured or Medicare patients.
- Gaps in outpatient capacity for mental health services were most frequently attributed to low reimbursement from Medicaid.

The Eastern region differs from the trends listed above as related to the lack of psychiatric inpatient beds for acute care. The Eastern Region has a higher concentration of acute psychiatric hospital beds than other regions in Missouri.  

**Federal Implications for Clients with Co-occurring Disorders**

Federal funding streams and structures also influence the ability for clients with co-occurring disorders to receive care. In the article *Substance Abuse with Mental Disorders: Specialized Public Systems and Integrated Care*, Audrey Burnam and Katherine Watkins indicate that although a separate administrative substance abuse structure preserves the distinctive treatment approaches and protects treatment priorities for the population with substance abuse disorders, administrative and funding divisions between mental health and substance abuse systems at both the federal and state levels create barriers that are difficult to remedy. This leaves clients without access to services across system lines.

Two consequences for clients with co-occurring disorders have been: 1) denied care in a single system because of the complexity of their disorder; or 2) obtaining treatment for one disorder while the other goes ignored. Substance Abuse and Mental Health Services Administration (SAMSHA) reports that clients who have co-occurring mental health and substance abuse needs have substantial difficulty receiving access to mental health services. Although public behavioral health treatment systems are the responsibility of each state, these systems are largely shaped by federal financing and different treatment philosophy traditions administered by distinctive domains of regulation and oversight at the state level.

---

12 Missouri Department of Mental Health 2003, Missouri Hospital Association 2003.
MISSOURI PUBLIC BEHAVIORAL HEALTH SYSTEM

PSYCHIATRIC SERVICES
In 1974, Missouri recognized the opportunity to deliver the right care in the right place, and established a free-standing Department of Mental Health structure to manage, monitor and direct care. The Department includes a Division of Alcohol and Drug Abuse, Division of Comprehensive Psychiatric Services, and Division of Mental Retardation and Developmental Disabilities. (Prior to 1974, mental health programs were located in the Division of Mental Diseases – later called the Division of Mental Health – which was under the Missouri Department of Health and Welfare.)

The presence of an executive level department for mental health services offers important advantages for the state, service providers, individuals, and families. In recent years, the creation of the New Freedom Commission and their recommendations for transformation created an impetus on the federal level to transform the way the nation views and treats mental illness.

To meet the goals set out in the New Freedom Commission’s report, the Missouri Department of Mental Health Comprehensive Psychiatric Services has laid out five core strategic priorities for system transformation:

1. Prevention and Promotion
2. Science and Service
3. Access and Capacity
4. Consumer/Family Driven Services and System Accountability
5. Technology Supports

The Eastern Region Public Mental Health Planning Project is aligned with the science and service priority under “uniform screening and assessment” and with the access and capacity priority to “promoting early integrated screening, referral, and care coordination protocols between mental health/substance abuse and primary health care” and “regional planning/local community system of care infrastructure.”

ALCOHOL AND DRUG ABUSE SERVICES
Statewide substance abuse services in Missouri were first established in April 1967 as an alcoholism section in the Division of Mental Health, at which time the five state mental hospitals and three mental health centers were ordered to develop inpatient alcoholism treatment programs. In 1972, a separate drug abuse section was created in the Division of Mental Diseases Central Office (as it was called then). The local programs were independently run by the state facilities with coordination and statewide education services provided by the Central Office section.

As noted above, when the Division of Mental Health was elevated to department status, it had the authority to establish necessary divisions for carrying out the work of the
department. The department established the Division of Alcohol and Drug Abuse in June 1975.

The Missouri Department of Mental Health Division of Alcohol and Drug Abuse has outlined their strategic priorities for 2006 as:

1. Access to Recovery
2. Prevention

See Appendix 2 for an overview of DMH CPS and ADA core strategic priorities.
3.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: ACCESS TO CARE

In 2003, the St. Louis Regional Health Commission published “Building a Healthier St. Louis” to inform the community about the healthcare safety net, including a section on psychiatric and alcohol and drug abuse services. This current state assessment builds on that report and includes updated information from mental health and alcohol and drug abuse safety net providers to understand the size and use of the safety net system for adult behavioral health services.

The behavioral health system is separated from the system of physical health care in many ways. Safety net treatment and service delivery for behavioral health are coordinated through separate state departments and networks of providers than physical health service delivery.

Individuals covered under Missouri’s traditional (non-managed care) Medicaid program receive behavioral health services through programs administered by the Missouri Department of Mental Health. Mental health services and alcohol and drug abuse services are coordinated through separate divisions of the department. Uninsured individuals also rely on the Department of Mental Health. Individuals eligible for managed Medicaid (MC+) receive mental health services through various behavioral health organizations.14

BEHAVIORAL HEALTH PROVIDERS

Individuals receive care for behavioral health issues from a variety of service providers. Providers can be divided into psychiatric care and alcohol and drug abuse treatment, though some providers do provide both and will be noted.

PSYCHIATRIC CARE15

Psychiatric care refers to the treatment of a range of psychiatric, psychological, emotional and behavior disorders. Treatment is provided by psychiatrists, psychologists, counselors, social workers and case managers.

The state Department of Mental Health divides Missouri into 25 service areas for the administration of psychiatric services to the safety net. For each service area, the state contracts with a service provider designated as an Administrative Agent.

Administrative Agents (also called Community Mental Health Centers) are responsible for public mental health assessments and services. They also provide follow-up services for people released from state-operated inpatient services. Four Administrative Agents coordinate outpatient and residential services for the Eastern region: BJC Behavioral

---

14 This section is taken from the St. Louis Regional Health Commission’s 2003 “Building a Healthier St. Louis” report.
15 This section is updated from the St. Louis Regional Health Commission’s 2003 “Building a Healthier St. Louis” report.
Health Services, COMTREA Community Treatment, Inc., Crider Center for Mental Health and Hopewell Center.

In the Eastern region, three non-administrative agent agencies also provide community based mental health services for the Department of Mental Health. These organizations serve St. Louis City and County: Adapt of Missouri, Independence Center and Places for People.

Two public psychiatric hospitals provide adult inpatient safety net mental health care: Metropolitan St. Louis Psychiatric Center for acute inpatient care and St. Louis Psychiatric Rehabilitation Center for long-term inpatient care. Numerous private hospitals also provide acute adult inpatient care.

Crisis services are provided by Behavioral Health Response (BHR), a 24-hour mental health crisis service center offering crisis intervention services, mobile community crisis assessments and crisis stabilization beds. The Administrative Agents contract with BHR to handle calls after hours, on weekends and holidays.

Many providers who do not contract with the state Department of Mental Health also provide important mental health services to safety net clients in the community, including services for episodic mental health problems. Providers include private for-profit and non-profit practitioners, community and faith-based providers, some Federally Qualified Health Center locations and the St. Louis County Family Mental Health Collaborative. However, as noted earlier in this report, national research indicates that private providers are much more likely to limit Medicaid and uninsured patients in their practices than to limit privately insured or Medicare patients.

The Family Mental Health Collaborative combines the expertise of five non-profit social service organizations and St. Louis University to meet the mental health needs of children, adults and elderly living in St. Louis County who are unable to access adequate services due to the lack of insurance or geographic accessibility.

**SUBSTANCE ABUSE AND CO-OCcurring Care**

Substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress. The Division of Alcohol and Drug Abuse in the state Department of Mental Health provides services through a network of contractors who operate treatment and detoxification programs.

---

16 In addition, the John Cochran VA Medical Center, St. Louis VA Medical Center and St. Louis Veteran’s Center provide services to veterans who meet eligibility based on military service, behavioral health issues and/or homelessness.

17 The five organizations are BJC Behavioral Health, Catholic Family Services, Jewish Family & Children's Services, Lutheran Family & Children's Services and Provident Counseling.

18 This section updated from the St. Louis Regional Health Commission’s 2003 “Building a Healthier St. Louis” report.

19 Diagnostic and Statistical Manual for Mental Disorders.
Four contractors provide detoxification services in the Eastern region: Bridgeway Counseling’s St. Louis Center provides modified medical detoxification; Bridgeway Counseling’s St. Charles Center, COMTREA Community Treatment, Inc., Preferred Family Healthcare and the Salvation Army provide social detoxification. Residential and outpatient treatment services are provided through BASIC, Bridgeway Counseling Services, Center for Life Solutions, COMTREA Community Treatment, Inc., New Beginnings, Preferred Family Healthcare, Queen of Peace Center, St. Patrick’s Center and WestEnd Clinic. The recent addition of faith-based supportive services has enhanced the total array of services offered by the contract providers.

Additionally, many providers not contracted with the state Department of Mental Health provide important alcohol and drug abuse services to safety net clients in the community, including private practitioners and community providers; many of these organizations are certified by the Department of Mental Health, Alcohol and Drug Abuse Division. However, as noted earlier in this report, national research indicates that private providers are much more likely to limit Medicaid and uninsured patients in their practices than to limit privately insured or Medicare patients.

**MULTIPLE ENTRY POINTS**

Stakeholders in the public behavioral health system believe that a significant strength of the system is the many and varied entry points that individuals can use as an initial point of contact about available care. Individuals may begin the process of receiving care after being referred either from formal channels, such as community mental health centers and private practitioners, or informal channels such as family members or clergy.

However, stakeholders also acknowledged that individuals who don’t know where or how to start to receive care represent a significant challenge in the behavioral health system. While many starting points are available, people may not understand the services provided or areas served. Individuals or organizations who serve as informal entry points (e.g. family, clergy, friends) may be most at risk for not taking any action because they don’t know where to begin.20

The following chart demonstrates the large number and wide variety of entry points for individuals who want to make an initial point of contact into the behavioral health system.

---

20 The Alcohol and Drug Abuse Division has a program to educate clergy and faith organizations on identifying substance abuse issues and referring individuals to appropriate care.
*This list includes United Way agencies, but is not exhaustive of all community agencies.

** certified by DMH Division of Alcohol and Drug Abuse

Number 14 Organization

DMH Funded Substance Abuse Provider – BASIC, Bridgeway Counseling, Center for Life Solutions, COMTREA, New Beginnings, Preferred Family Healthcare, Queen of Peace Center, Salvation Army Harbor Light, St. Patrick Center, WestEnd Clinic


Clergy or Faith Organization

Private Practitioners

School, Education System

Concerned Family and/or Friends

Division of Family and Children and other government agencies

County Health Centers and Federally Qualified Health Centers – Family Health Care Centers, Grace Hill Neighborhood Health Centers, Myrtle Hilliard Davis Comprehensive Centers, People’s Health Centers, St. Louis County Health Centers

Community Substance Abuse Providers** – Assisted Recovery Centers, Community Alternatives, GFI Services, Harris House, Hopewell Center, Hyland Behavioral Health, Provident, St. Louis Metro Treatment **certified by DMH Division of Alcohol and Drug Abuse

Advocacy Organizations and Other Associations – Ntl Alliance for the Mentally Ill, Mental Health Assn., and others

Initial Point of Contact into the Behavioral Health System

Hospital Emergency Department – BJC, CenterPointe, Christian, DePaul, Des Peres, Forest Park, Jefferson Memorial, St. Alexius, St. Anthony’s Hyland, St. John’s Mercy, St. Joseph, SLU, St. Mary’s

Community Mental Health Centers – BJC, COMTREA, Crider, Hopewell

Affiliate Provider – ADAPT, Independence Center, Places for People

Behavioral Health Response (BHR) – 24/7 crisis referral

St. Louis Metropolitan Psychiatric Center (MPC) and St. Louis Psych. Rehab. Center

Law Enforcement, Crisis Intervention Training, Corrections, Probation and/or Mental Health or Drug Courts
OVERVIEW
As noted earlier, a wide variety of organizations provide behavioral health services. To receive behavioral health services, individuals move from initial point of contact → initial assessment and/or screening → referral → service delivery → final point of contact or recovery (exit) (see map below).

Eastern Region Public Mental Health Planning Project

High Level Process Map

While the map depicts a simple, linear progression from one step to the next, the reality for individuals with behavioral health issues is much more complicated. As noted earlier in this report, the President’s New Freedom Commission found that the fragmentation of the mental health system was an area of weakness in the system. Eastern region stakeholders report that after receiving a service or treatment, individuals may then have another assessment and continue a cycle of assessment, referral, service delivery, etc.\(^{21}\) Individuals may never reach the final point of contact or exit from the system. Or, individuals may complete a service or treatment and exit the system, but return for care/treatment at a different point in time.

The following diagram provides an overview of the organizations providing behavioral health services and the way individuals currently navigate the system.

\(^{21}\) Department of Mental Health Division of Alcohol and Drug Abuse has a standardized assessment tool and only pays for one assessment per client every six months.
**Behavioral Health System Organization Flow**

*This map reflects the way consumers currently navigate the mental health system, not a recommended flow for the future.*

1. **Initial Assessment and/or Screening** – conducted by any of the agencies/individuals on earlier chart (or any organization in dotted box below); may not address the dichotomy of issues for individuals with co-occurring disorders.

2. **Emergent Need** – need for immediate, inpatient care; medical detox for substance abuse; immediate danger to self or others for mental health.

3. **Urgent Need** – immediate, not inpatient.

4. **Routine need** – Where a person receives treatment depends on their initial point of contact, available capacity, where they live, severity of diagnosis, source of funding, and staff training and knowledge.

5. **No Treatment** – Issue was resolved or diffused, or there was no follow-up, or no treatment was needed at this time (but may be in the future).

**Psych ER** – MPC

**Medical ER** – BJC, CenterPointe, Christian, DePaul, Des Peres, Forest Park, Jefferson Memorial, St. Alexius, St. Anthony’s Hyland, St. John’s Mercy, St. Joseph, SLU, St. Mary’s

**Inpatient** – BJC, CenterPointe, Christian, DePaul, Des Peres, Forest Park, Jefferson Memorial, St. Alexius, St. Anthony’s Hyland, St. John’s Mercy, St. Joseph, SLU, St. Mary’s

**Psych ER** – MPC

**Social Detoxification** – Bridgeway Counseling, Preferred Family Healthcare, Queen of Peace Center

**Next day appointment** – assigned through BHR

**Community Mental Health Center** – BJC, COMTREA, Crider, Hopewell

**Outpatient**: CMHC, Affiliate, Alcohol and Drug Abuse Providers, Community Agencies, Private Hospitals

**Residential**: substance abuse or psychiatric group homes (run by CMHCs or independent)

**No further treatment**

**Crisis beds** – assigned through BHR; located at Hopewell, COMTREA, Crider

**Community Substance Abuse Providers** – Assisted Recovery Centers, Community Alternatives, GFI Services, Harris House, Hopewell Center, Hyland Behavioral Health, Provident, St. Louis Metro Treatment

**Affiliate Provider** – ADAPT, Independence Center, Places for People

**DMH Funded Substance Abuse Provider** – BASIC, Bridgeway Counseling, Center for Life Solutions, COMTREA, New Beginnings, Preferred Family Healthcare, Queen of Peace Center, Salvation Army Harbor Light, St. Patrick Center, WestEnd Clinic

**Law Enforcement**, CIT, Mental Health and Drug Courts, Corrections/Probation

**Where a person receives treatment depends on their initial point of contact, available capacity, where they live, severity of diagnosis, source of funding, and staff training and knowledge.**

**Psych ER** – MPC

**Medical ER** – BJC, CenterPointe, Christian, DePaul, Des Peres, Forest Park, Jefferson Memorial, St. Alexius, St. Anthony’s Hyland, St. John’s Mercy, St. Joseph, SLU, St. Mary’s

**Inpatient** – BJC, CenterPointe, Christian, DePaul, Des Peres, Forest Park, Jefferson Memorial, St. Alexius, St. Anthony’s Hyland, St. John’s Mercy, St. Joseph, SLU, St. Mary’s

**Psych ER** – MPC

**Social Detoxification** – Bridgeway Counseling, Preferred Family Healthcare, Queen of Peace Center

**Next day appointment** – assigned through BHR

**Community Mental Health Center** – BJC, COMTREA, Crider, Hopewell

**Outpatient**: CMHC, Affiliate, Alcohol and Drug Abuse Providers, Community Agencies, Private Hospitals

**Residential**: substance abuse or psychiatric group homes (run by CMHCs or independent)

**No further treatment**

**Crisis beds** – assigned through BHR; located at Hopewell, COMTREA, Crider

**Community Detoxification** – Bridgeway Counseling, Preferred Family Healthcare, Queen of Peace Center

**Next day appointment** – assigned through BHR

**Community Mental Health Center** – BJC, COMTREA, Crider, Hopewell

**Outpatient**: CMHC, Affiliate, Alcohol and Drug Abuse Providers, Community Agencies, Private Hospitals

**Residential**: substance abuse or psychiatric group homes (run by CMHCs or independent)

**No further treatment**

**Crisis beds** – assigned through BHR; located at Hopewell, COMTREA, Crider

**Social Detoxification** – Bridgeway Counseling, Preferred Family Healthcare, Queen of Peace Center

**Next day appointment** – assigned through BHR

**Community Mental Health Center** – BJC, COMTREA, Crider, Hopewell

**Outpatient**: CMHC, Affiliate, Alcohol and Drug Abuse Providers, Community Agencies, Private Hospitals

**Residential**: substance abuse or psychiatric group homes (run by CMHCs or independent)

**No further treatment**


***This list includes United Way agencies, but is not exhaustive of all community agencies.
Limited data is available to report exactly how many individuals experience a continuous cycle of assessment, referral, service delivery, or to report how many individuals stay in the system, etc. Additional research may be warranted in this area in the future. Additional barriers and gaps that cause individuals to fail to receive effective treatment can be found in the “Barriers to Care” section of this document.

Initial Contact

All behavioral health care begins with an initial assessment and/or screening that determines whether or not an individual is in crisis, defined as someone who is an immediate danger to themselves or others.  

<table>
<thead>
<tr>
<th><strong>Starts with:</strong></th>
<th><strong>Initial Assessment/Screening</strong></th>
<th><strong>Ends with:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Person who identifies or questions own need</td>
<td>Emergency Room</td>
<td>Accurately identified needs of a person</td>
</tr>
<tr>
<td>Concerned individual who questions or recognizes another’s need</td>
<td>Phone screen</td>
<td>Resources identified to best meet those needs</td>
</tr>
<tr>
<td>Face to face</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An individual who is in crisis is referred to the Metropolitan St. Louis Psychiatric Center or a hospital emergency room. After another screening, the individual may be admitted or discharged with a referral. An individual who is not in crisis is referred to one or more outpatient settings; the referral is based on several factors including the assessor’s training, knowledge and experience level, the individual’s initial point of contact, providers’ available capacity and/or where the individual lives. A diagram in Appendix 3 provides more detailed information about how individuals move through the initial screening/assessment step.

Next Steps

The initial assessment and/or screening also identifies individuals who are dealing with co-occurring issues of mental illness and substance abuse; however, both issues may not always be detected. These individuals may or may not be in crisis; regardless, treatment for substance abuse is usually provided first. After an individual receives treatment for substance abuse, s/he may resume the ongoing process of screening/assessment → referral → service delivery to treat mental health and other issues. A diagram in Appendix 4 provides more detail about how individuals with co-occurring issues move through the system to receive care.

It is important to recognize that at any point in the process, an individual may not move to the next step, i.e. not receive treatment. Reasons an individual may not receive

---

22 For the purposes of this project, crisis for alcohol and drug abuse services is defined as “an individual needing medical or modified medical detoxification.”

23 Out of the five steps in the process flow, workgroup members identified the screening/assessment as the most critical to create a more responsive behavioral health system.
treatment are many and varied; some are noted in the “Barriers to Care” section of this report.

**INDIVIDUALS ELIGIBLE FOR PUBLIC BEHAVIORAL HEALTH SERVICES**

**PSYCHIATRIC SERVICES**

The state Department of Mental Health serves four target populations for psychiatric services: persons with serious and persistent mental illness (SMI) (e.g. individuals who have been hospitalized more than once and/or have limited ability to function in key life areas, such as housing and employment, due to a mental illness); persons suffering from acute psychiatric conditions (e.g. individual in an acute psychiatric crisis); children and youth with serious emotional disturbances (SED) and forensic clients.

In addition, the state has identified four priority groups within the target populations: 1) individuals in crisis, 2) individuals who are homeless, 3) individuals recently discharged from inpatient care and 4) substantial users of public funds. These target populations currently constitute the majority of clients whom the Division serves both in inpatient and ambulatory settings.24

A standard means test is used to determine an individual’s ability to pay. Clients who are on Medicaid or below 150 percent of poverty level generally do not pay for services.

**ALCOHOL AND DRUG ABUSE SERVICES**

Alcohol and drug abuse providers who contract with the Missouri Department of Mental Health use standardized assessment tools and guidelines to determine the level of care a client needs.

The state requires that individuals seeking alcohol and drug abuse treatment must present valid Missouri identification and verify their income and family size. A standard means test is used to determine an individual’s ability to pay. Clients who are on Medicaid or below 150 percent of poverty generally do not pay for services. Clients above 150 percent of the poverty level pay for services based on a sliding fee scale.

**SERVICES AVAILABLE IN THE PUBLIC BEHAVIORAL HEALTH SYSTEM**

**PSYCHIATRIC SERVICES**

Mental health providers offer a range of services – from intensive, inpatient care to care designed to help an individual remain in the community. Although individual providers may not offer the full array of services, following is a general list of services available to clients in the Eastern region.25

- **Outpatient community-based services** – Outpatient services provided in an individual’s community offer the least restrictive environment for treatment. An evaluation and treatment team provides services utilizing the resources of the

---

24 Missouri Department of Mental Health website.

25 Missouri Department of Mental Health website.
individual, his/her family, and the community. Outpatient programs offer individual, group and family therapy, medication management, etc.

Outpatient programs may also include 1) targeted case management, which assists individuals in gaining access to psychiatric, medical, social and educational services and supports; and, 2) Community Psychiatric Rehabilitation (CPR), which is a client-centered approach that emphasizes individual choices and needs, features flexible community-based services and supports, uses existing community resources and natural support systems, and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. Both of these programs are Medicaid supported through the Rehabilitation Waiver.

∞ **Day treatment/partial hospitalization** – Day treatment offers the least restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than outpatient services can provide, but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services and educational services. The focus is on developing supportive medical, psychological and social work services.

∞ **Residential care/community placement** – Moderate-term placement in residential care provides services to persons with non-acute conditions who cannot be served in their own homes. A residential setting has more focused goals of providing a structured living environment in which to develop functional adaptive living skills, self-esteem, self-control of impulses, social skills, insight into personal issues, and enhanced family interactions.

∞ **Inpatient (Hospitalization)** – Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be dangerous to themselves or others as a result of their mental disorder.

**SUBSTANCE ABUSE SERVICES**
Alcohol and drug abuse providers offer a range of services – from intensive, inpatient care, to care designed to help an individual stay in the community. Although providers may not offer every service, following is a general list of available services at alcohol and drug abuse providers.26

∞ **Detoxification** – Substance abuse treatment often begins with detoxification, during which an individual is assisted in withdrawing from alcohol or other drugs in a safe, supportive environment. Options include social setting detoxification, modified medical detoxification and medical detoxification.

∞ **Residential Support** – In a residential treatment program, a person receives round-the-clock care, seven days a week. Rehabilitation includes assessment, individual and

---

26 Missouri Department of Mental Health website.
group counseling, family counseling, participation in self-help groups and other supportive interventions.

- **Outpatient Rehabilitation** – Outpatient programs and services are designed for persons whose substance abuse is less severe or chronic and who do not require residential settings for treatment. They are also designed for persons who have completed residential programs and need follow-up counseling and support.

- **CSTAR Program** – CSTAR (Comprehensive Substance Treatment and Rehabilitation) focuses on serving people in their communities with individual and group counseling, skill building, family therapy, education, case management, and, where necessary, supportive housing. The CSTAR program serves as a funding source and encompasses the care provided through the Residential Support and Outpatient Rehabilitation programs.
4.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: UTILIZATION OF SERVICES

Overview

As The President’s New Freedom Commission on Mental Health acknowledged in 2003, “mental illnesses are shockingly common; they affect almost every American family… No community is unaffected by mental illnesses; no school or workplace is untouched.”

That statement is compounded significantly when substance abuse and co-occurring disorders are included.

∞ Several national studies estimate that 5 – 7 percent of adults have a serious mental illness in any given year. Applying this data to the Eastern Region, we can estimate that between 103,400 – 144,800 individuals are in serious need of psychiatric care at any given time, out of a population in the region of just more than 2 million.

∞ Assuming that the need for services is at least as high for the safety net population in our region, it can be estimated that between 25,900 – 36,200 safety net individuals in the Eastern Region are in serious need of psychiatric care.

∞ The 2004 National Survey on Drug Use and Health estimates that 9.8 percent of the population is classified as needing substance abuse treatment. Applying this data to the Eastern Region, we can estimate that more than 202,000 individuals abuse or are dependent on substances, out of a population in the region of just more than 2 million.

∞ Assuming that the need for services is at least as high for the safety net population in our region, it can be estimated that 50,698 safety net individuals in the Eastern Region need treatment for substance abuse.

---

27 The President’s New Freedom Commission on Mental Health 2003.
29 Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured individuals in the Eastern Region (according to Kaiser Family Foundation, www.statehealthfacts.org, 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population. Individuals receiving behavioral health care may also be part of the safety net because of the severity of their diagnosis or because they utilized all of their private health insurance benefits; these individuals are not represented in this safety net calculation.
30 Needing treatment is defined in the survey as “persons dependent on or abusing a substance in the past 12 months or who received specialty treatment for a substance abuse problem within the past 12 months.”
31 2004 National Survey on Drug Use and Health, from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Eastern Region estimates based on 2005 census data.
32 Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured
EASTERN REGION SURVEY RESULTS

For this current state assessment, a survey was sent to 19 community mental health centers\textsuperscript{33}, affiliate providers\textsuperscript{34} and alcohol and drug abuse providers in the Eastern region. All community mental health centers (four) and affiliate providers (four) in the region participated; seven of 11 alcohol and drug abuse providers participated.\textsuperscript{35} A total of 15 surveys were returned for a 79 percent return rate.

The Missouri Department of Mental Health provided data about individuals served in the Eastern region. Data was also collected from hospitals and federally qualified health centers about the mental health and alcohol and drug abuse assessments and referrals they provide. The private hospital data includes information from 30 hospitals\textsuperscript{36} in the Eastern region. One federally qualified health center in the region also provided information.

Additionally, Behavioral Health Response (BHR), who coordinates access and crisis intervention services in the region for the community mental health centers, provided information about the calls they receive.

The following data are aggregate totals about the services provided from January 1, 2005 – December 31, 2005, unless otherwise noted. This project and survey focused on behavioral health services provided to adults in the Eastern Region. Several pieces of information that would have been informative for this survey are not currently available across all providers, such as an individual’s reasons for leaving or not seeking treatment, number of people attempting to access the system, services that are needed but not available, and number of times individuals access the system. Unless otherwise noted, the data was self-reported by each organization.

CLIENTS SERVED AND NEW ADMISSIONS

Together, the community mental health centers, alcohol and drug abuse providers and affiliate organizations in the Eastern region admitted 15,869 adults in 2005. Alcohol and drug abuse providers admitted half of those individuals in the Eastern Region (according to Kaiser Family Foundation, \url{www.statehealthfacts.org}, 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population.\textsuperscript{33} These organizations are also referred to as administrative agents.

An affiliate provider is a non-administrative agent agency that receives funding from the Department of Mental Health to provide community based mental health services.\textsuperscript{34} Survey participants include all Department of Mental Health funded psychiatric services in the region. Survey participants did not include all of the community agencies, which may offer some form of behavioral health services, but are not funded by DMH. A complete list of survey participants is found in Appendix 5.

\begin{center}
\textbf{Adult Clients Admitted -- 15,869 total}
\end{center}

\begin{center}
\includegraphics[width=0.5\textwidth]{chart}
\end{center}

In addition to hospitals in the Eastern region, the data includes one hospital from Washington County.\textsuperscript{36}
individuals (7,951), community mental health centers admitted 44 percent (6,973), and the affiliate providers admitted six percent (945).

The community mental health centers, affiliate organizations and alcohol and drug abuse providers serve a higher number of individuals in any given year than the number of admissions. Clients may be admitted one year and still be receiving services in the following year(s). The Department of Mental Health reports that community mental health centers served 12,175 clients in state fiscal year 2005. Affiliate organizations served 1,210 clients and alcohol and drug abuse providers served 13,559 clients.

### Served vs. Admitted

<table>
<thead>
<tr>
<th>TYPE OF PROVIDER</th>
<th>TOTAL SERVED</th>
<th>NEW ADMISSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Centers</td>
<td>12,175</td>
<td>6,973</td>
</tr>
<tr>
<td>Affiliate Organizations</td>
<td>1,210</td>
<td>945</td>
</tr>
<tr>
<td>Alcohol and Drug Abuse Providers</td>
<td>13,559</td>
<td>7,951</td>
</tr>
<tr>
<td>TOTALS</td>
<td>26,944</td>
<td>15,869</td>
</tr>
</tbody>
</table>

### Referral Sources

For all types of providers, most individuals refer themselves to these providers for service. Other significant referral sources changed for community mental health centers, affiliate organizations and alcohol and drug abuse providers.

### Referral Sources

<table>
<thead>
<tr>
<th>REFERRAL SOURCE</th>
<th>COMMUNITY MENTAL HEALTH CENTERS</th>
<th>AFFILIATE PROVIDERS</th>
<th>ALCOHOL AND DRUG ABUSE PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHR/Crisis Service</td>
<td>5%</td>
<td>--</td>
<td>1%</td>
</tr>
<tr>
<td>Courts</td>
<td>6%</td>
<td>3%</td>
<td>19%</td>
</tr>
<tr>
<td>DMH/MPC</td>
<td>8%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Family</td>
<td>9%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Hospital/Inpatient/Medical Doctor</td>
<td>13%</td>
<td>31%</td>
<td>3%</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>5%</td>
<td>&lt;1%</td>
<td>17%</td>
</tr>
<tr>
<td>Other CMHCs</td>
<td>3%</td>
<td>21%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Substance Abuse Program</td>
<td>1%</td>
<td>--</td>
<td>15%</td>
</tr>
<tr>
<td>Self</td>
<td>52%</td>
<td>31%</td>
<td>35%</td>
</tr>
</tbody>
</table>

### Services Provided

For community mental health centers, affiliate providers and alcohol and drug abuse providers, most individuals received outpatient services (47 percent for CMHCs/affiliates, 53 percent for alcohol and drug abuse providers).
### Services Provided – Community Mental Health Centers and Affiliate Providers

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Office</td>
<td>47%</td>
</tr>
<tr>
<td>Community Support/Home Based</td>
<td>16%</td>
</tr>
<tr>
<td>Case Management</td>
<td>15%</td>
</tr>
<tr>
<td>Therapy/Counseling</td>
<td>9%</td>
</tr>
<tr>
<td>Medication Clinics</td>
<td>9%</td>
</tr>
<tr>
<td>Day Programs</td>
<td>3%</td>
</tr>
<tr>
<td>Residential</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Crisis Beds</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

### Services Provided – Alcohol and Drug Abuse Providers

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>42%</td>
</tr>
<tr>
<td>CSTAR</td>
<td>18%</td>
</tr>
<tr>
<td>Residential Support</td>
<td>15%</td>
</tr>
<tr>
<td>Therapy/Counseling</td>
<td>15%</td>
</tr>
<tr>
<td>Community Support</td>
<td>7%</td>
</tr>
<tr>
<td>Detox</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Funding Sources**

Most of the care provided by participating organizations was paid for through the Department of Mental Health (44 percent). Participating organizations also received supplemental funding from a variety of organizations, such as the Missouri Foundation for Health, drug courts, Missouri Division of Vocational Rehabilitation, St. Louis City Mental Health Board and the Jefferson County sales tax. Many organizations use supplemental funding to cover uninsured patients and costs above state reimbursement levels.

More information about funding is provided in Section 5.0 Eastern Region Public Behavioral Health System: Financing the System.

---

37 Not included in this total are services provided by only one agency. Case management services (462 services) and day program services (1,696 services) were provided by only one alcohol and drug abuse provider.
Funding Sources – Community Mental Health Centers, Affiliates and Alcohol and Drug Abuse Providers

<table>
<thead>
<tr>
<th>FUNDING SOURCE</th>
<th>PERCENTAGE OF INDIVIDUALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Mental Health</td>
<td>44%</td>
</tr>
<tr>
<td>Traditional Missouri Medicaid</td>
<td>22%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15%</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>4%</td>
</tr>
<tr>
<td>Medicare</td>
<td>6%</td>
</tr>
<tr>
<td>Missouri MC+ Medicaid</td>
<td>3%</td>
</tr>
<tr>
<td>Private Contracts</td>
<td>2%</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Admin.</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>(SAMHSA) Grant</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>SAMSHA Federal Block Grant</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Local Mental Health Tax Levy</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

AVAILABLE STATE FUNDED COMMUNITY BASED BEDS
Together, the mental health and alcohol and drug abuse providers had a total of 389 beds available. The average daily census for these beds indicates that nearly all were operating at highest occupancy.

Alcohol and Drug Abuse Beds

Available Beds and Average Daily Census

<table>
<thead>
<tr>
<th>CMHCs AND AFFILIATES</th>
<th>ALCOHOL AND DRUG ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Bed</td>
<td># of Beds</td>
</tr>
<tr>
<td>Residential Care</td>
<td>94</td>
</tr>
<tr>
<td>Crisis</td>
<td>3</td>
</tr>
<tr>
<td>Dedicated Detox</td>
<td>NA</td>
</tr>
</tbody>
</table>

38 These services are described in more detail on pages 18 - 20.
Information about inpatient beds located at Metropolitan St. Louis Psychiatric Center (MPC) and private hospitals is noted below. Additional types of available beds not counted in these totals include emergency, transitional and permanent housing.

**OTHER SIGNIFICANT BEHAVIORAL HEALTH PROVIDERS**

**PUBLIC HOSPITALS**
The Metropolitan St. Louis Psychiatric Center provides acute adult inpatient safety net mental health care, with a limited number of beds dedicated to substance abuse needs. Individuals from the Eastern region made 1,628 unduplicated and 2,141 duplicated visits to the Metropolitan St. Louis Psychiatric Center emergency room in 2005. Of the individuals from the Eastern region who visited the emergency room, 92 percent were from St. Louis city and county.

**MPC Emergency Room Visits**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>UNDUPLECTED</th>
<th>Duplicated</th>
<th>% OF TOTAL ER VISITS UNDUP, DUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Region</td>
<td>1,628</td>
<td>2,141</td>
<td>94%, 95%</td>
</tr>
<tr>
<td>St. Louis City &amp; County</td>
<td>1,513</td>
<td>2,008</td>
<td>88%, 89%</td>
</tr>
</tbody>
</table>

In addition to MPC, the St. Louis Psychiatric Rehabilitation Center (SLPRC) provides long-term inpatient mental health care for adults in the safety net. Together, MPC and the St. Louis Psychiatric Rehabilitation Center had 308 beds available;\(^{39}\) MPC had an average occupancy of 81 percent.\(^{40}\) MPC admitted 1,597 unduplicated individuals from the Eastern region in 2005. Of those admissions, most individuals were from St. Louis city and county (85 percent of Eastern region admissions).

**MPC Admissions**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>UNDUPLECTED</th>
<th>Duplicated</th>
<th>% OF TOTAL ADMISSIONS UNDUP, DUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Region</td>
<td>1,597</td>
<td>2,000</td>
<td>85%, 87%</td>
</tr>
<tr>
<td>St. Louis City &amp; County</td>
<td>1,369</td>
<td>1,737</td>
<td>73%, 75%</td>
</tr>
</tbody>
</table>

\(^{39}\) Information from the Missouri Hospital Association, 2005 Annual Hospital Licensure Survey.

\(^{40}\) St. Louis Psychiatric Rehab Center provides long-term treatment with limited discharges; therefore, the average occupancy is 100 percent.
**Private Hospitals**

Hospitals in the Eastern region performed 30,625 emergency department assessments on individuals who had a primary diagnosis of mental health or substance abuse issues. Of those individuals, 14,042 were admitted to the hospital where they were evaluated. Individuals who visited the emergency department and received a primary or any secondary diagnosis of mental health or substance abuse issues totaled 100,925. Of those individuals, 59 percent were admitted to the hospital (59,806).

### Private Hospital Emergency Dept. Visits

<table>
<thead>
<tr>
<th>PRIMARY DIAGNOSIS</th>
<th>ED VISIT ONLY</th>
<th>ED VISIT + ADMISSION</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>10,378</td>
<td>11,384</td>
<td>21,762</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>6,205</td>
<td>2,658</td>
<td>8,863</td>
</tr>
<tr>
<td>Totals</td>
<td>16,583</td>
<td>14,042</td>
<td>30,625</td>
</tr>
</tbody>
</table>

### Private Hospital Emergency Department Visits

![Bar chart showing private hospital emergency department visits by primary diagnosis.](chart)

### Private Hospital Emergency Dept. Visits

<table>
<thead>
<tr>
<th>PRIMARY OR ANY SECONDARY DIAGNOSIS</th>
<th>ED VISIT ONLY</th>
<th>ED VISIT + ADMISSION</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and/or Substance Abuse</td>
<td>41,119</td>
<td>59,806</td>
<td>100,925</td>
</tr>
</tbody>
</table>

Private hospitals in the region had a total of 758 psychiatric beds available, with a weighted average occupancy of 78 percent.

---

41 2005 inpatient and outpatient administrative data from the Missouri Hospital Association’s Hospital Information Data Institute. In addition to hospitals in the Eastern region, the data includes one hospital from Washington County (total of 30 hospitals). The data includes children. VA and DMH hospitals are excluded.

42 Private hospitals included in this total: Barnes Jewish, CenterPointe, Christian, Forest Park, Jefferson Memorial, Missouri Baptist, SSM DePaul, SSM St. Joseph, SSM St. Mary’s, St. Louis University, St.
**Federally Qualified Health Centers**

One of the four federally qualified health centers (FQHC) in the region was able to provide information about mental health and substance abuse assessments. Family Care Health Centers conducted approximately 1,700 assessments during 2005, resulting in approximately 510 referrals for treatment. It should be noted that other FQHCs, including Grace Hill Neighborhood Health Centers, provide outpatient behavioral health services to the infant/adolescent populations.

**Behavioral Health Response**

BHR opened 19,200 cases during 2005. The majority of callers were the clients themselves (73 percent) but significant amounts of calls were received from concerned others, law enforcement officers and staff of social service agencies. Forty-one percent of the cases were individuals who reported that they were already receiving services from a Department of Mental Health provider.

### Behavioral Health Response Opened Cases

<table>
<thead>
<tr>
<th>Caller</th>
<th>Percentage of Total Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/Self</td>
<td>73%</td>
</tr>
<tr>
<td>Concerned Other</td>
<td>20%</td>
</tr>
<tr>
<td>Other Agency or Professional</td>
<td>3%</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>2%</td>
</tr>
<tr>
<td>Medical Facility/Hospital</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
<tr>
<td>Alcohol and Drug Staff</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

Slightly more than half of the BHR cases presented with non-acute mental health needs; 15 percent called in a crisis situation. BHR was able to resolve the problem in the course of the telephone intervention for 44 percent of the cases; just under 50 percent were referred to another provider; and, eight percent of the cases led to mobile outreach evaluations and/or immediate appointments or hospitalizations.

### Behavioral Health Response Case Outcome

<table>
<thead>
<tr>
<th>Result</th>
<th>Percentage of Total Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to another provider</td>
<td>47%</td>
</tr>
<tr>
<td>Problem resolved</td>
<td>44%</td>
</tr>
<tr>
<td>Mobile outreach/immediate</td>
<td>8%</td>
</tr>
<tr>
<td>appointment/hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

Alexius, St. Anthony’s, St. John’s Mercy. Includes some children and adolescent psychiatric beds. Information from the Missouri Hospital Association, 2005 Annual Hospital Licensure Survey.

43 A case documents all interventions provided for a given individual during a 24-hour period. As such, a case may incorporate multiple telephone calls.

44 Crisis is defined as an individual in danger of immediate harm to themselves or others and/or unable to meet basic needs.

45 “Resolve the problem” is defined as the client indicating satisfaction at the close of the call; therefore, no further action was planned.
# 5.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: FINANCING THE SYSTEM

## BACKGROUND

**FINANCIAL DATA ANALYSIS**

This financial analysis is intended to provide global estimates of the financial resources available to support clients who utilize public behavioral health services in the seven counties that make up the Eastern region. This includes crisis services, inpatient treatment, medical and social detoxification, social services and other wrap-around programs. In addition, area hospitals play a critical role in providing uncompensated care to safety net clients who require hospitalization. Further study of this issue is warranted in the future.

The methodologies employed in this analysis provide only “high-level” estimates of the need for care, the sources of funds to pay for this care, and the use of funds. More detailed study in this area may be warranted in the future. Much of the data used in this analysis has been voluntarily self-reported. In addition, funding information from a variety of state, federal, and local resources has been used. Public documents have been examined to verify information.

Categorization and allocation methods may vary from provider to provider. In some instances, existing data sources do not clearly identify uninsured patients or their cost of care, and payments received by providers are seldom explicitly earmarked as paying for the care of the uninsured.

Although the current focus for system improvements is oriented to adult care, the analysis includes funding available for children’s services. Children’s services funding is noted because these resources contribute substantially to overall program operations and support, including overhead for many local agencies.

Estimates of the true cost of behavioral health services in the region are speculative at best, considering the issues outlined above and additional variables such as multiple funding streams, levels of service intensity, duration of services and related costs of services, including housing and transportation. Accepting these limitations, a conservative estimate of $87 million in additional funds would be needed to provide adequate behavioral health services to the adult safety net population in the Eastern region. More detailed analysis is available in Appendix 6.

**MISSOURI DEPARTMENT OF MENTAL HEALTH**

The Missouri Department of Mental Health is “charged with the delivery of services to persons with mental illness throughout the State of Missouri.” There are eight adult inpatient hospitals, one children’s hospital, one children’s residential center and a number of group homes operated by the state and located throughout Missouri. DMH specifically

---

46 Missouri Department of Mental Health website, 2005.
targets four populations with special needs: (a) persons with severe/persistent mental illness, (b) persons with acute episodes of mental illness, (c) children and youth, and (d) forensic clients. To accomplish the goals of the DMH, the state is divided into 25 service areas, each with a Community Mental Health Center. In addition, the state funds an array of substance abuse services that are delivered by community based programs, including mental health centers. These programs focus on prevention, education, intervention and treatment for persons with abusing and addictions issues.

In FY 2006, the state appropriated $971 million to fund all DMH services. Of that amount, $103 million was available for ADA services while the CPS received approximately $369.6 million for the year. Federal funding makes up about 30 percent of that CPS total. Each Division, in turn, allocates expenditures to regions of the state and specifically to programs under contract or operated by the DMH.

**Understanding Medicaid**

Medicaid is a program managed by the states and funded jointly by the states and federal government to provide health insurance that pays for medical assistance for certain individuals and families with low incomes and few resources. Medicaid is the largest source of funding for medical and health-related services for people with limited incomes.

The state of Missouri, like other states across the nation, has consistently made efforts to increase funding by billing Medicaid for services to disabled populations in our communities. Each new recipient in the program increases the number of “covered lives” for which matching funds may be used. Missouri currently has about 900,000 Medicaid eligible people who qualify for benefits. Based on income or covered conditions, the legislature can set eligibility criteria during each session. These changes in eligibility levels impact the service capacity of programs.

The matching formula for Medicaid funds requires states to provide approximately 40 percent of the funds needed for services, while the federal share makes up the balance, or about 60 percent. Approximately $66.2 million of General Revenue (GR) Comprehensive Psychiatric Services funds were used in FY 2006 to earn $108 million in Medicaid match. Some general revenue funds that are appropriated to CPS must be used to provide services for uninsured individuals who do not qualify for Medicaid, but need an array of safety net services to cope with their disabilities. As a result, Medicaid match totals just 30 percent of the 2006 CPS budget. As general revenue budgets are reduced, Medicaid funds will also necessarily go down. Appendix 7 provides more information on the funding formula used to calculate payment levels to the state.

**Purchase of Service**

State psychiatric facilities are directly funded and managed by the Department of Mental Health. Community mental health centers, substance abuse and affiliate programs are operated under Purchase of Service (POS) contracts with DMH. POS contracts are

---

47 The remaining $501.4 million funds the Division of Mental Retardation and Developmental Disabilities.
48 See Appendix 7 for additional information on state eligibility and funding sources.
reimbursed with a blend of state and federal dollars in a fee-for-service system. POS dollars ($202 million in FY 2006) now make up 55 percent of the mental health CPS budget in Missouri. Each POS contractor receives an allocation at the start of the fiscal year. However, payment is made only after services are delivered and billed. Since there are no state operated substance abuse programs in the eastern region, Alcohol and Drug Abuse contracts have always been awarded to community programs.

There are a number of factors that influence the level of funding and pricing of services for specific ADA and CPS programs. Each service area receives a variable amount of funding based on their current contracts from ADA and CPS. Populations served and each agency’s history in the federal funding cycle are important determinants of funding. ADA funds are primarily based on a competitive process, but the rates are set by the state. Mental health centers, however, usually receive a standard set price for any given service.

**CURRENT FUNDING IN THE EASTERN REGION**

**STATE FUNDING**
The formula for CPS allocations is largely driven by historical per capita rates that have been established with each service area/administrative agent. As implied by the name, “per capita” simply means that the service area population is multiplied by the specified rate as determined by the DMH. A service area of 100,000 people, for example, would receive $850,000 if their rate were the regional average of $8.50 per capita. Today, those rates (for adult services) range from $8 to $12 per capita in most service areas. The average per capita rate for the region is about $8.50. These funds are appropriated as general revenue.

In the past, per capita rates were driven by adjustments for poverty and the history of federal funding for a specific program. Today, rates continue to vary widely across the state. Funding to state hospitals remains the purview of the general assembly and does not take capitation into account. Each facility has a general revenue budget approved by the general assembly.

State funds for the CPS and ADA programs in the *Eastern Region* totaled $98.1 million in FY 2005. The total CPS funding (general revenue and Medicaid) for the region during FY 2005 was $80.8 million when all children’s services were included. These funding levels include the cost of operating the 198 long-term beds at the St. Louis Psychiatric Rehabilitation Center (PRC), the acute care Metropolitan St. Louis Psychiatric Center (MPC) and the Hawthorn Children’s Psychiatric Hospital. ADA contract funds for the region, including Medicaid, were approximately $17,306,000 for FY 2005.

Resources not spent by year-end in any individual program may be shifted to other areas of high need. State funding levels for CPS and ADA programs in the Eastern region are shown on Table 1, on the next page.

---

49 Information from the Missouri Coalition of Mental Health Centers and Missouri Department of Mental Health, fall 2006.
Table 1
Eastern Region, State Funding - FY 2005

<table>
<thead>
<tr>
<th>Area</th>
<th>Agency</th>
<th>Adult</th>
<th>Child</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>Comp. Psych Services</td>
<td>$20,955,029</td>
<td>$16,105,475</td>
<td>$37,060,504*</td>
</tr>
<tr>
<td>Region</td>
<td>Alcohol &amp; Drug Abuse</td>
<td>14,912,488</td>
<td>2,393,512</td>
<td>17,306,000 *</td>
</tr>
<tr>
<td>State</td>
<td>St. Louis Psychiatric Rehab Center, St.</td>
<td>--</td>
<td>--</td>
<td>41,639,496</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Louis Metro Psychiatric Center &amp; Hawthorn Ctr.</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Region</td>
<td>Behavioral Health Response – Crisis</td>
<td></td>
<td></td>
<td>2,100,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total: $98,106,000</td>
</tr>
</tbody>
</table>

*Includes administrative agents & affiliate agency funds

The break down of ADA, general revenue funding and Medicaid are shown in Appendix 8. Medicaid, 34 percent of total ADA funds in the region, provides significant support for services. As a result, many of the ADA services are targeted for Medicaid-eligible clients. Appendix 9 illustrates the proportion of FY 2006 CPS funds statewide coming from federal (29 percent) and general revenue sources.

State general revenue funding is also available from the Office of State Court Administrators (OSCA), and is targeted to provide substance abuse treatment to offenders in drug court programs. The drug court commission administers funds to operating drug courts in 96 counties, which include 45 judicial districts statewide. The state general revenue appropriation for FY 2006 is approximately $3.1 million. The Eastern region receives about $1 million.

LOCAL FUNDING

1. City and County Taxes
Local mental health/substance abuse agencies in the region have access to additional sources of public funds that are collected by city or county taxing authorities. These local funds are usually controlled by independent boards appointed by the taxing entity. In the Eastern region, St. Louis City, Jefferson County, and St. Charles County communities support behavioral health services through such a dedicated taxing source; St. Louis County, Lincoln County, Franklin County, Warren County do not. Funds supporting behavioral health services in St. Louis County are appropriated annually as a part of the budget of the Health Department.

In some instances, the tax board may serve as the governing board for the agency that receives the funds. County mental health levy (SB 652) funds may be administered in this manner. Some counties may also elect to use a portion of their money as “matching funds” in order to receive additional Medicaid support for clients. At least four counties in Missouri are using some form of local match (40 percent local to 60 percent federal) to increase Medicaid support for their treatment services.
2. Private Foundations/United Way
Depending on competitive applications for available grants, provider agencies in the region may receive Missouri Foundation for Health and United Way support, as well as local and national grants; all of these options have become an important source of funding for behavioral health services in the region. The amount of this support varies from year-to-year and among agencies. In general, these fund sources account for more than an estimated 10 percent of total dollars in the region supporting behavioral health care.

Table 2 provides a summary of local public and private funding sources for the Eastern region.

**Table 2**
**Eastern Region, Local Funding Sources**

<table>
<thead>
<tr>
<th>Source</th>
<th>Agency</th>
<th>Target Population</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jefferson County</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mill &amp; Sales Tax</td>
<td>Comtrace</td>
<td>Adult/Child</td>
<td>$4,800,000</td>
</tr>
<tr>
<td>St. Louis City &amp; Property Tax</td>
<td>Several</td>
<td>Adult/Child</td>
<td>8,000,000</td>
</tr>
<tr>
<td>St. Louis County Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td>Several</td>
<td>Adult – Outpatient</td>
<td>600,000</td>
</tr>
<tr>
<td>St. Charles Sales Tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Courts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSCA</td>
<td>Several</td>
<td>Adult/Teen</td>
<td>995,000</td>
</tr>
<tr>
<td>Uncompensated Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>All</td>
<td>13,566,250</td>
<td></td>
</tr>
<tr>
<td>United Way</td>
<td></td>
<td></td>
<td>7,200,000</td>
</tr>
<tr>
<td>MO Foundation for Health</td>
<td></td>
<td></td>
<td>10,500,000</td>
</tr>
<tr>
<td>Total:</td>
<td></td>
<td></td>
<td>$50,661,250</td>
</tr>
</tbody>
</table>

---

50 Uncompensated care is 1) care provided for patients who are unable to pay for their treatment, provided they meet charity care financial guidelines; 2) any shortfall in Medicaid reimbursement.
51 Funding is a summary of grants awarded during the 2005 calendar year.
52 Funding is a summary of grants awarded by MFH during the 2005 calendar year. Amount includes multi-year awards and may fluctuate annually based on dollars available and funding priorities.
**Other Funding Sources**

1. Uncompensated Care by Community Hospitals

   Community hospitals in the region often treat patients needing psychiatric care in the safety net system. The emergency rooms at these facilities routinely screen large numbers of clients needing acute care. The hospitals, regardless of whether they have dedicated psychiatric beds, may bill Medicaid for clients who qualify. Local hospitals in the region billed an estimated $28.7 million for services to psychiatric patients in 2005. Medicaid income totals nearly 30 percent of the revenues estimated for these patients. Self-pay amounts are usually minimal and result in “uncompensated care,” which generates a loss for the hospitals.

   The amount spent on uncompensated care self-reported to the St. Louis Regional Health Commission by community hospitals in the region is estimated to be approximately $13.5 million in 2005.

2. Disproportionate Share Funding

   The mental health system in the Eastern region, like other areas in the state, benefits from disproportionate share (DSH) funds that are allocated to community hospitals that serve Medicaid populations. Federal payments are made to hospitals to compensate these facilities for the volume of uninsured services they provide. These DSH payments generate funding for hospitals that serve “disproportionately” large numbers of uninsured

---

53 HIDI data, adults only.
recipients. Private psychiatric hospitals usually do not receive DSH payments. Facilities that are not “Institutes for Mental Disease” (IMD) qualify to receive these funds. The state hospital facilities usually earn the majority of these funds. However, DSH income received by state owned agencies returns to general revenue. The general revenue funds are then allocated by the state legislature to support various state needs, including mental health.

3. Federally Qualified Health Centers
The St. Louis region also benefits from the services of four federally qualified health centers (FQHC) which receive direct federal funding to deliver primary medical care. In addition, the St. Louis County Department of Health (DOH) also provides an array of services which includes primary care. Mental health interventions do occur in these health settings even in the absence of direct funding. This analysis includes a conservative estimated cost of these services at $1.5 million based on the assumption that at least 10 percent of a primary care caseload may require assessment and/or referral to a mental health provider. Caseload information was provided by the health centers for FY 2005.

Table 3 presents a summary of funding data from all known sources of funding for behavioral health services. In addition to above mentioned state and local sources, it includes Disproportionate Share (DSH) payments received by the state facilities (and returned to general revenue) and community hospital uncompensated care. It also includes an estimate of Federally Qualified Health Centers (FQHC) and the St. Louis County Department of Health funds that are used to support behavioral health services.
### Table 3
**Eastern Region, All Funding Sources – FY 2005/2006**

<table>
<thead>
<tr>
<th>Source</th>
<th>ADA</th>
<th>CPS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State general revenue, Medicaid &amp; DSH</td>
<td>$17,306,000</td>
<td>$80,800,000</td>
<td>$98,106,000</td>
</tr>
<tr>
<td>General revenue – Office of State Court Administrators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(OSCA-Drug Courts)</td>
<td>1,000,000</td>
<td>--</td>
<td>1,000,000</td>
</tr>
<tr>
<td>County &amp; City taxes&lt;sup&gt;54&lt;/sup&gt;</td>
<td>--</td>
<td>--</td>
<td>17,800,000</td>
</tr>
<tr>
<td>United Way Greater St. Louis</td>
<td>--</td>
<td>--</td>
<td>7,200,000</td>
</tr>
<tr>
<td>MO Foundation for Health – ‘05</td>
<td>--</td>
<td>--</td>
<td>10,500,000</td>
</tr>
<tr>
<td>Community Hospital-Medicaid</td>
<td>--</td>
<td>--</td>
<td>38,694,600</td>
</tr>
<tr>
<td>Fed. Qualified Health. Ctrs. and St. Louis County Health Department</td>
<td>--</td>
<td>--</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Uncompensated Care</td>
<td>--</td>
<td>--</td>
<td>13,566,250</td>
</tr>
<tr>
<td><strong>Total All Categories</strong></td>
<td></td>
<td></td>
<td><strong>$188,366,850</strong></td>
</tr>
</tbody>
</table>

<sup>54</sup> County taxes - $9.8 million, city taxes - $8 million
6.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: BARRIERS TO CARE

NEED FOR SERVICES

As noted earlier, an estimated 25,900 – 36,200 safety net individuals in the Eastern Region are in serious need of psychiatric care.\textsuperscript{55} The majority of mental health services for the adult safety net population are coordinated through Department of Mental Health providers, who serve 13,041 unduplicated clients in a given year, or between 36 – 50 percent\textsuperscript{56} of the safety net population estimated to be in serious need of services.

For alcohol and drug abuse services, as noted earlier, an estimated 48,628 safety net individuals in the Eastern Region abuse or are dependent on substances.\textsuperscript{57} The state reports that state funded alcohol and drug abuse providers serve 13,559 unduplicated clients in a given year, or 28 percent\textsuperscript{58} of the safety net population estimated to be in need of services.

This is a conservative estimate which does not include an estimate for individuals who: 1) have private insurance but lack behavioral health care insurance, or 2) fully exhaust all of their behavioral health care benefits, or 3) have severe diagnosis or service needs and cannot find behavioral health care, or 4) are forensic clients.

WAITING LISTS

Seventy-three percent of survey participants utilize a wait list for services, including two Community Mental Health Centers, four affiliates and five alcohol and drug abuse providers. During 2005, a total average of 458 individuals were on the wait lists on any given day, with most of those individuals on the wait lists for alcohol and drug abuse services.

Community mental health centers and affiliates averaged 106 individuals on their wait lists (average of 18 individuals per organization). This is a conservative estimate of the number of individuals waiting for care because of several factors: some individuals give up waiting until a crisis occurs, some organizations do not keep formal wait lists, some organizations cap their wait lists, and some organizations have a wait list but do not keep track of the number of individuals on it.

\textsuperscript{55} Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured individuals in the Eastern Region (according to Kaiser Family Foundation, \url{www.statehealthfacts.org}, 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population.\textsuperscript{56} Equals 12,859 – 23,159 individuals. Average number of individuals is 18,009.

\textsuperscript{57} Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured individuals in the Eastern Region (according to Kaiser Family Foundation, \url{www.statehealthfacts.org}, 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population.\textsuperscript{58} Equals 35,069 individuals.
Alcohol and drug abuse providers averaged 352 individuals on their wait lists (average of 70 individuals per organization). Although individuals may be on the wait lists at multiple organizations, this is a conservative estimate of the number of individuals waiting for care because of the reasons noted above.

Nine organizations (60 percent of survey participants) kept data about the length of time individuals were on their wait list.

**Average Length of Time on Wait List**

<table>
<thead>
<tr>
<th>LENGTH OF TIME</th>
<th>NUMBER OF ORGANIZATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>31+ days</td>
<td>4</td>
</tr>
<tr>
<td>15 – 30 days</td>
<td>3</td>
</tr>
<tr>
<td>8 – 14 days</td>
<td>1</td>
</tr>
<tr>
<td>0 – 7 days</td>
<td>1</td>
</tr>
</tbody>
</table>

**EXPERT OPINIONS ON BARRIERS TO CARE**

**CLIENT OPINIONS**

Stakeholders asked approximately 75 clients what prevented them from effectively accessing behavioral health services. The most common responses included lack of funds or insurance to pay for care and/or medicine, difficulty in getting the right medicine, limited transportation, wait lists to receive services (psychiatrists, ADA, etc.) and staff turnover.

Other challenges for clients included the stigma of mental illness, lack of support and respect from professionals and family, and difficult paperwork. Clients drew attention to the need for increased sensitivity to culture, race, ethnicity and language differences. Many clients and family members expressed an absolute frustration with the system. One individual commented that once you are in the system, you are in forever; another equated a mental illness diagnosis with a death sentence.

**STAKEHOLDER OPINIONS**

More than 40 individuals who are involved in behavioral health services participated in discussions to identify barriers that prevent individuals from receiving behavioral health services or limit the care individuals receive. These statements were not quantified during this project; however, the following list notes stakeholders’ opinions on barriers that are systemic throughout the public behavioral health system.

- **Coordination of health care** – Stakeholders emphasized that the behavioral and physical health needs of an individual should not be separated – they are inextricably linked to the individual’s overall health and well-being. However, mental and physical health services are rarely coordinated and providers rarely have time to follow-up on referrals made for another service. A few pilot projects, such as the

---

59 Discussions were held as part of Eastern Region Public Mental Health Planning Project steering committee, advisory board and workgroup meetings.
Medical Risk Management project with community mental health centers and the Family Mental Health Collaborative, are working to develop a more collaborative model of care.

- **Coordination of mental health and substance abuse** – National statistics estimate that more than half of the adults with severe mental illness in public mental health systems are further impaired by co-occurring substance use disorders (abuse or dependence related to alcohol or other drugs). However, care is often fragmented because simultaneous treatment is limited, providers are unaware of available resources, and providers do not coordinate treatment.

- **Cultural awareness** – Racial, ethnic and economic differences between service providers and clients influence an individual’s health care encounter and affect whether or not individuals receive care. The U.S. Department of Health and Human Services reports that “race and ethnicity influence a patient’s chance of receiving many specific procedures and treatments. There is growing evidence that cultural expectations, assumptions and language are factors that affect the quality of care.”

- **Funding and treatment options** – Stakeholders noted that individuals are not able to access care because of limited funding and restrictions on how funding can be used.

   Individuals with mental illness in the safety net system are often unable to access care unless they are in a crisis situation. As a result, the system has been forced increasingly to rely more on inpatient care, instead of providing less restrictive care before individuals are in a crisis. Because of specific guidelines that dictate who qualifies for state funded services, individuals who suffer from non-chronic, non-crisis illness rarely receive treatment in the public mental health system. Stakeholders also related anecdotal examples of individuals who understand the criteria for entry into the mental health system, and claim to meet the criteria in order to receive care; however, on closer review, the individual may not actually meet the criteria.

   Additionally, stakeholders recognized that individuals often receive care based on what services are available at the provider to which they are assigned. Individuals are designated to receive treatment from community mental health centers or affiliate providers based on the zip code they live in. Service types and quality may vary among providers; however, client choice for mental health services is often limited by the individual’s home address.

- **Awareness of entry points and available resources** – Both providers and clients see it as advantageous that individuals can enter the behavioral health system through a

---

60 Substance Abuse and Mental Health Services Administration, National Mental Health Information Center, Evidence-Based Practices, Co-Occurring Disorders: Integrated Dual Disorders Treatment, Implementation Resource Kit.


62 It is important to note that substance abuse services are not administered on the basis of the individual’s zip code. Substance abuse services are available to individuals at any location in Missouri.
variety of formal and informal organizations and/or providers; however, there is a limited awareness in the community of the available entry points, treatment options and resources. Additionally, even within the system, providers make referrals based on their knowledge, training and experience, but may not be aware of the treatment options that are available.

Follow-up with clients – Throughout the system, stakeholders recognized that most referrals involve giving an individual a name and phone number and relying on the individual to take the next step. These were identified as “cold” hand-offs, compared to a “warm” referral which would involve assisting the person with making contact with referral sources, overcoming any barriers to accessing the care and following-up to make sure the person was connected with the appropriate provider/organization. Additionally, clients who are receiving services who do not follow through with treatment recommendations have limited follow-up.

Communication among providers – As one stakeholder noted, “We really don’t know each other.” Another stakeholder recognized that providers set one another and clients up for failure by referring clients inappropriately (for services that aren’t provided, etc.). Organizations and service providers have limited communication among themselves about clients or services. Communication is made more difficult because of staff turnover. Organizations change the treatment options and services delivered, and many times other providers are not aware of the changes. Privacy restrictions of HIPAA are often cited as a barrier to communicating about clients. Limited communication results in a system that does not maximize efficiencies, including repetitive screenings/assessments, no services, duplicate services, etc.

On-going regional planning – Stakeholders recognized that many of the challenges noted above are the result of the lack of on-going regional planning efforts. Although some planning efforts have been undertaken in the past, the accomplishment of expected outcomes was limited. Stakeholders recommend increased buy-in and focus on implementation of recommendations with achievable results.

In addition to the systemic barriers noted above, which happen throughout the delivery of behavioral health services, stakeholders identified specific barriers an individual may experience during the initial assessment/screening, referral and service delivery steps of the process.

Social Supports – Clients often lack adequate resources and supports necessary for treatment to be effective. Clients need safe and stable housing, stable employment, reliable transportation, child care and family/network support to attain their highest level of quality of life.

Transportation – Stakeholders noted that transportation can be difficult for individuals in the public behavioral health system because of a lack of available public transportation, concerns about safety for mental health clients, etc.
**Staff Training** – Staff members who work in the safety net system are very committed to clients; however, staff members are frequently “burned out,” resulting in high turnover. Entry level staff, who handle some of the most difficult and confusing situations, often have limited training. All levels of staff would benefit from more cross-training to help them recognize multiple diagnoses, identify appropriate referral sources, etc.

**Treatment Options** – Other barriers identified related to the actual treatment options. Stakeholders highlighted limited evidence based models of care, limited research on how to help clients maintain gains and limits to the medications (and accessing and paying for the medications).

A list of stakeholder identified barriers and gaps can be found in **Appendix 10** at the end of this report.
APPENDIX 1

Eastern Region Public Mental Health Planning Project
Committee Structure

Eastern Region Public Mental Health Planning Project Steering Committee:

Dr. Karl Wilson, President/CEO, Crider Center for Mental Health, Chair
Francie Broderick, Executive Director, Places for People
John Eiler, Executive Vice-President, SSM Healthcare
Dr. Dolores Gunn, Director of Health, St. Louis County
Mary Ann Hampton, Chief Nursing Officer, Forest Park Hospital
Jim House, Executive Director, Mental Health Association of Greater St. Louis
Dr. Steve Huss, President/CEO, COMTREA Community Treatment
Laurent Javois, CEO, Public Psychiatric Hospitals of Eastern Missouri
Barbara Keehn, District Administrator, MO DMH Division of Alcohol and Drug Abuse
Betty Jean Kerr, CEO, People’s Health Centers
Jackie Lukitsch, Executive Director, NAMI St. Louis
Dr. Amanda Murphy, President/CEO (represented by Regina Trotter, Vice-President), Hopewell Center
Connie Neumann, Executive Director, Queen of Peace Center
Mark Stansberry, Executive Director, BJC Behavioral Health
Janet Woodburn, President/CEO, Bridgeway Counseling Services
Joe Yancey, Community Mental Health Manager, MO DMH Comprehensive Psychiatric Services
APPENDIX 2

Missouri Department of Mental Health
Comprehensive Psychiatric Services Division
Core Strategic Priorities for System Transformation

1. Prevention & Promotion
From a Disability to a Public Health Model of Service
New Freedom Commission Goal: Missourians understand that Mental Health is Essential to Overall Health
- Integrated Prevention Effort with DHSS
- Expanded Strategic Prevention Framework
- Suicide Prevention, Relapse Prevention & Early Detection
- Mental Health Disaster Preparedness
- Mental Health Literacy and Anti-stigma Campaign
- Early Childhood Mental Health Promotion

2. Science & Service
Toward Evidence-Based Practice and a Culturally Competent System of Care
New Freedom Commission Goal: Excellent Mental Health Care is Delivered and Research is Accelerated
- EBP Steering Committee
  - Uniform Screening and Assessment
  - Integrated Dual Diagnosis Treatment (IDDT)
  - Supported Employment
  - Consumer Operated Service Programs (COSP)
  - Assertive Community Treatment (ACT)
- Research Consortium
- Coordinating Centers of Excellence
- Workforce Development
- Procovery Foundation with Trauma-Informed and Culturally Competent Care

3. Access & Capacity
From Fragmentation to Appropriate Consultation, Collaboration and Integration; Toward Equal Access with Balanced Public-Private Capacity and State-Local Ownership and Investment
New Freedom Commission Goals: Disparities are Eliminated, Early Mental Health Screening, Assessment and Referral to Local Services are Common Practice
- Early Integrated Screening, Referral and Care Coordination Protocols
  - Statewide Crisis Intervention Team Planning & Justice Grant
  - Statewide Mental Health/ED Task Force
- System Capacity Development
  - Home and Community-based Services Expansion
  - Housing Task Force
  - Special Populations (e.g. Deaf & Hard of Hearing)
4. **Consumer/Family Driven Services & System Accountability**

Toward a State-Wide Consumer and Family Voice that Drives Decision-making and Services at all levels of the System

**New Freedom Commission Goal:** Mental Health Care is Consumer and Family Driven

- Procovery
- Individual Plans of Care
- Comprehensive State Plan with Active Consumer & Family Involvement in Planning and Evaluation
- Consumer & Family Mentors
- Quality Infrastructure with Integrated Consumer & Family Monitoring
  - System Integrity & Risk Management – Safety & Basic Assurances
  - Fidelity Assessment & Quality Service Review (QSR)
  - Outcomes
  - Shared “System” Scorecards
  - Performance Improvement
- Expansion of Consumer and Family Organizations and Service Programs

5. **Technology Supports**

Toward the use of Technology to Support and Sustain Transformation

**New Freedom Commission Goal:** Technology is Used to Support Access to Services and Information

- Data Warehouse
- Network of Care
- Tele-services
- Technology Transfer
- Electronic Medical Records
APPENDIX 2 CONTINUED

Missouri Department of Mental Health
Division of Alcohol and Drug Abuse
Core Strategic Priorities

1. **Access to Recovery**
   - Expanding consumer choice by **implementing a voucher system** that allows consumers to select the services and providers that best meet their personal needs.
   - **Increasing the involvement of the faith community** in addressing the problems of alcohol and drug dependence and in providing support services.
   - **Measuring results** through the collection of outcome measures including abstinence from drugs and alcohol, no involvement with the criminal justice system, and acquiring employment and stable housing.
   - **Increasing treatment capacity** by adding treatment programs in underserved areas, and expanding the availability of treatment options, such as trauma counseling, relapse prevention, and peer support services.

   **Goal 1:** Recruit, enroll and train eligible faith-based agencies to provide recovery supports.

   **Goal 2:** Assess the effectiveness of the Access to Recovery initiative in improving consumer outcomes.

2. **Prevention**
   - Assist local community coalitions in developing programs, practices and policies to promote substance abuse prevention, using the five steps of the strategic prevention framework:
     - Profiling needs, resources, and readiness to address problems and gaps
     - Mobilizing and/or building capacity to address needs
     - Developing a comprehensive strategic plan
     - Implementing evidence-based prevention programs
     - Evaluating effectiveness, and sustaining effective programs

   **Goal 1:** Promote development of local prevention initiatives utilizing the Strategic Prevention Framework.

**Statewide Prevention Framework State Incentive Grant**

Missouri’s Strategic Prevention Framework State Incentive Grant (SPF SIG) priority is to reduce risky drinking (binge and underage) among Missouri residents ages 12 through 25.
**Strategies**

- Implementation of the Strategic Prevention Framework and its five steps at state and community levels.
- Support of the statewide epidemiological work group in collection, analysis and use of consequence and consumption data.
- Mobilization and capacity building for increased collaboration and partnership development among all substance abuse prevention stakeholders.
- Funding and promotion of the use of data-driven, culturally-competent, evidence-based programs, practices and policies that can be adapted at the community level to capture targeted outcomes sensitive to geographic and population diversity.
This map reflects the way clients currently navigate the mental health system, not a recommended flow for the future.

* A “cold hand-off” is described as giving an individual contact or referral information and relying on the individual to take the next step. A “warm hand-off” is described as relying on the referral and receiving providers/agencies to ensure the client receives service at the next step – such as scheduling an appointment and arranging transportation, etc.
This map reflects the way clients currently navigate the mental health system, not a recommended flow for the future.
APPENDIX 5

Eastern Region Public Mental Health Planning Project
Survey Participants

<table>
<thead>
<tr>
<th>Type</th>
<th>Organization</th>
<th>Completed Survey?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliate</td>
<td>Adapt of Missouri</td>
<td>Yes</td>
</tr>
<tr>
<td>Affiliate</td>
<td>Places for People</td>
<td>Yes</td>
</tr>
<tr>
<td>Affiliate</td>
<td>Independence Center</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Community Alternatives*</td>
<td></td>
</tr>
<tr>
<td>CMHC</td>
<td>BJC Behavioral Health</td>
<td>Yes</td>
</tr>
<tr>
<td>CMHC</td>
<td>COMTREA</td>
<td>Yes</td>
</tr>
<tr>
<td>CMHC</td>
<td>Crider Center</td>
<td>Yes</td>
</tr>
<tr>
<td>CMHC</td>
<td>Hopewell Center</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>BASIC</td>
<td>No</td>
</tr>
<tr>
<td>ADA</td>
<td>Bridgeway Counseling Services</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>Center for Life Solutions</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>COMTREA</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>Harris House Foundation</td>
<td>No</td>
</tr>
<tr>
<td>ADA</td>
<td>New Beginnings –CSTAR, Inc.</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>Preferred Family Healthcare, Inc.</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>Provident</td>
<td>No</td>
</tr>
<tr>
<td>ADA</td>
<td>Queen of Peace Center</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>St. Patrick Center</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>Salvation Army Harbor Light</td>
<td>Yes</td>
</tr>
<tr>
<td>ADA</td>
<td>WestEnd Clinic</td>
<td>No</td>
</tr>
</tbody>
</table>

* Provides affiliate-type services, but is not officially an “affiliate provider” with the Missouri Department of Mental Health. Also provides alcohol and drug abuse services.
APPENDIX 6

Behavioral Health Services
Estimates of Funding Need

Estimates of the true cost of behavioral health services in the region are speculative at best, given multiple funding streams, levels of service intensity, duration of services given and related costs of service including housing and transportation (which many agencies provide or contract for). Accepting those limitations, several global estimates of aggregated per patient costs are given below. The rationale or calculations for each number are also reported. The dollar amounts, number of individuals served and number of individuals in need of service are reported in earlier sections of this assessment.

These estimates do not assume any changes in system efficiency, cost structures or cost offsets.

Summary of estimated new money needed
Estimate 1 $ 86,949,932
Estimate 2 $194,106,246
Estimate 3 $289,062,788
Estimate 4 $111,251,488
Estimate 1
This estimate breaks down the number of individuals in need of services based on ADA services and different types of CPS services.

Estimated number of individuals in need of ADA services: 35,069
Multiplied by the estimated cost per person: $1,357
New money needed to serve ADA safety net population: $47,588,633

For CPS services, an estimated 18,009 individuals in the safety net need psychiatric services. However, not all of the individuals would need the same level of service. Providers estimate about 20 percent of the individuals would need more in-depth, comprehensive community support services, and about 80 percent would need outpatient only psychiatric services. Providers estimate the cost of providing the in-depth community support services to be $5,500 and the cost of providing outpatient only services to be $1,357 (based on the ADA per person cost).

These numbers are estimates and require more study and analysis.

Number of individuals in need of CPS services: 18,009

20 percent of individuals needing more in-depth community services: 3,602
Multiplied by the estimated cost per person: $5,500
New money needed to serve 20% of CPS safety net population: $19,811,000

80 percent of individuals needing outpatient services: 14,407
Multiplied by the estimated cost per person: $1,357
New money needed to serve 80% of CPS safety net population: $19,550,299

Total of ADA and CPS:
New money needed to serve ADA safety net population: $47,588,633
New money needed to serve 20% of CPS safety net population: $19,811,000
New money needed to serve 80% of CPS safety net population: $19,550,299

Total new money needed to serve ADA and CPS safety net population: $86,949,932

---

65 Taken from page 37 of the Barriers to Care section. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services.
66 Reported by the Missouri Department of Mental Health Division of Alcohol and Drug Abuse.
67 This is a best-guess estimate based on the ADA per person cost for similar types of services.
68 Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served.
69 Estimated percentage of individuals who would need more in-depth, comprehensive community support services.
70 Estimated percentage of individuals who would need outpatient only psychiatric services.
Estimate 2
This estimate separates the costs per person for Alcohol and Drug Abuse Services and
Comprehensive Psychiatric Services.

Documented costs of state funded ADA services: $17,306,000
Reported individuals receiving ADA services: 13,559

$1,276 cost per person

Documented costs of state funded CPS services: $80,800,000
Reported individuals receiving CPS services: 13,385

$6,037 cost per person

If we average or “blend” the ADA and CPS costs, we have a per person cost of $3,657.

Estimated number of individuals in need of services: 53,078
Multiplied by the averaged cost per person: $3,657

Total new money needed to serve safety net population: $194,106,246

∞ This estimate includes costs of state-funded inpatient facilities, but it does not include
individuals served in those facilities.
∞ Several ADA providers report that this estimate of cost per person is lower than their
actual average costs; they estimate their average cost to be approximately $2,500 per
person. The Missouri Department of Mental Health Division of Alcohol and Drug
Abuse estimates the average cost to be $1,357 per person.

---

71 Reported in table 1 of the Financing the Safety Net section.
72 Reported on page 23 of the Utilization of Services section.
73 Substance abuse providers report their average costs are actually higher – averaging $2,500 per person.
74 Reported on table 1 of the Financing the Safety Net section.
75 Reported on page 23 of the Utilization of Services section; individuals served by CMHCs and affiliate organizations.
76 Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services. Then, the CPS and ADA numbers were added together to equal 53,078.
Estimate 3
This estimate subtracts the costs of state-funded inpatient facilities from the total dollars funding service delivery in the region. Then, the number is divided by the number of individuals served by state contracted providers. ADA and CPS funds and clients are all included in the totals.

Total documented costs of service delivery in the region: $188,366,850
Subtract DMH facility budgets (state inpatient costs): - 41,639,496
$146,727,354

Reported number of people served (ADA and CPS): $146,727,354
26,944

$5,446 cost per person

Estimated number of individuals in need of services: 53,078
Multiplied by the estimated cost per person $5,446

Total new money needed to serve safety net population: $289,062,788

∞ This estimate does not include funding for state inpatient facilities.
∞ This estimate includes funding from United Way and the Missouri Foundation for Health, but it does not necessarily include an estimate of individuals served with those funds.
∞ The number of people served only includes individuals served by state contracted alcohol and drug abuse and community-based comprehensive psychiatric providers.

77 Reported in table 3 of the Financing the Safety Net section.
78 Reported in table 3 of the Financing the Safety Net section.
79 Reported on page 23 of the Utilization of Services section.
80 Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services. Then, the CPS and ADA numbers were added together to equal 53,078.
Estimate 4
This estimate only includes the costs of state funded ADA services and community-based CPS services in the region. It does not include regional funding sources or state inpatient facility funding. ADA and CPS funds and clients are all included in the totals.

Documented costs of state funded ADA and community-based CPS services in the region: $56,466,504\(^{81}\)  
Reported number of people served (ADA and CPS): 26,944\(^{82}\)  
\[
\frac{56,466,504}{26,944} = 2,096 \text{ cost per person}
\]

Estimated number of individuals in need of services: 53,078\(^{83}\)  
Multiplied by the estimated cost per person $2,096

**Total new money needed to serve safety net population:** $111,251,488

∞ This estimate does not include funding for or individuals served by state inpatient facilities, United Way, or the Missouri Foundation for Health.

---

\(^{81}\) Reported in table 1 of the Financing the Safety Net section.

\(^{82}\) Reported on page 23 of the Utilization of Services section.

\(^{83}\) Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services. Then, the CPS and ADA numbers were added together to equal 53,078.
APPENDIX 7

Explanation of Medicaid

Medicaid Defined
The Medicaid program provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance. Although the federal government establishes general guidelines for the program, the Medicaid program requirements are established by each state. Whether or not a person is eligible for Medicaid depends on the state where he or she lives.

Eligibility
States are required to include certain types of individuals or eligibility groups under their Medicaid plans, and may elect to include additional groups. State eligibility groups are considered one of the following: categorically needy, medically need, or special groups. Some of the key eligibility groups may include the following:

- Families who meet states’ Aid to Families with Dependent Children (AFDC) eligibility requirements.
- Pregnant women and children under age six whose family income is at or below 133 percent of the Federal poverty level.
- Children ages 6 to 19 with family income up to 100 percent of the Federal poverty level.
- Caretakers (relatives or legal guardians who take care of children under age 18).
- Supplemental Security Income (SSI) recipients.
- Individuals and couples who are living in medical institutions and who have monthly income up to 300 percent of the SSI income standard.  

Funding Sources
The State of Missouri and federal government provide funding for Medicaid programs. The amount of Medicaid funding provided by the government is based on the Federal Medical Assistance Percentage (FMAP), and is based on a three-year average of the state per-capita personal income. That level is then compared to the national average. For a wealthy state, the federal contribution might be limited to 50 percent of every dollar the state pays out; the maximum federal contribution, no matter how poor the state, is 83 percent.  

Missouri’s state Medicaid funds generate federal matching funds at a 61.60 percent rate for most individuals and 73.13 percent for the State Children’s Health Insurance Program (SCHIP) in federal FY 2007. Currently, Missouri Medicaid spending generates $1.574 in federal matching funds for every state dollar spent; SCHIP spending generates $2.678 in matching funds. 

---

84 Information from “Medicaid At A Glance,” Centers for Medicare & Medicaid Services.
86 Federal Register: November 30, 2005.
## APPENDIX 8

### Eastern Region, ADA - Expenditures by Fund Source

<table>
<thead>
<tr>
<th>Medicaid versus Non-Medicaid</th>
<th>FY 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
<td><strong>General Revenue</strong></td>
</tr>
<tr>
<td>Medicaid</td>
<td>$1,136,702</td>
</tr>
<tr>
<td>Non-Medicaid</td>
<td>4,461,285</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$5,597,987</td>
</tr>
</tbody>
</table>

(1) Funding from tax on cigarettes that is dedicated to substance abuse Treatment  
(2) Funding from tobacco settlement funds  
(3) Funding from various grants

**Medicaid and Non-Medicaid Funding**

- The Medicaid line item represents dollars expended for Medicaid eligible services.  
- The non-Medicaid line item represents two types of services/clients:  
  - Non-Medicaid eligible services to Medicaid eligible clients (examples include adult residential services, child care, or academic education for adolescents); and,  
  - Service to non-Medicaid clients
APPENDIX 9

CPS FY 2006 BUDGET (in millions)

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Revenue</td>
<td>$260.1 M</td>
<td>70.3</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>$108.3 M</td>
<td>29.3</td>
</tr>
<tr>
<td>Other</td>
<td>$1.4 M</td>
<td>.4</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$369.8M</td>
<td>100.0</td>
</tr>
</tbody>
</table>

CPS FY 2006 Budget

- General Revenue, 260,100,000, 71%
- Federal Funds, 108,300,000, 29%
- Other, 1,400,000, 0%
**APPENDIX 10**

**Eastern Region Public Mental Health Planning Project**  
**High-Level Map of Service Delivery**  
**Stakeholder Identified Strengths and Gaps – 3 pages**

<table>
<thead>
<tr>
<th>Initial Point of Entry</th>
<th>Initial Screening and/or Assessment</th>
<th>Referral</th>
<th>Service Delivery</th>
<th>Final Contact with Provider (exit)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRENGTHS – WHAT IS WORKING WELL IN THE SYSTEM?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lots of points of entry</td>
<td>• Good psych assessment tools/instruments</td>
<td>• Staff commitment</td>
<td>• Transportation</td>
<td></td>
</tr>
<tr>
<td>• Expertise and diversity of providers</td>
<td>• Experienced, committed staff</td>
<td>• Community very interested in this area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consumer survivor skills</td>
<td>• Formal and informal collaborations</td>
<td>•</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ACI system provides timely, 24/7 MH assessments via phone and/or face to face</td>
<td>• Many available programs</td>
<td>•</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• State, county and city funded programs</td>
<td>• MH courts</td>
<td>•</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CIT policing</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BARRIERS – WHAT WALLS ARE SO HIGH PEOPLE CAN’T GET OVER THEM?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transportation not available</td>
<td>• Rigid system eligibility</td>
<td>• Affiliates not well integrated</td>
<td>• Capacity/funding</td>
<td></td>
</tr>
<tr>
<td>• Transportation not safe for MH clients</td>
<td>• Transportatio n</td>
<td>• Services/programs not even among catchment areas</td>
<td>• Access for medications for co-occurring</td>
<td></td>
</tr>
<tr>
<td>• Stigma associated with mental illness</td>
<td>• Wrong diagnosis</td>
<td>• Limitations of programs</td>
<td>• Limitations of programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Criteria of each program</td>
<td>•</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not enough time to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

(Initial Point of Entry) → (Initial Screening and/or Assessment) → (Referral) → (Service Delivery) → (Final Contact with Provider (exit))
<p>| GAPS – WHAT ARE GAPS PEOPLE FALL THROUGH? (→ = problem throughout the system, not just during one step) |
|--------------------------------------------------|--------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| → Lack of standardized quality                   | → Client not aware of available resources          | → Lack of follow up                              | → Specific services                              | → Transportation                                 | → Types of services available                     | → Co-occurring relapse prevention                 | → Short follow-ups                               | → Limited outcome measurement to know what works | → Limited support services (such as job training) | → Few consumer led support groups |
| → Some populations better served? →               | → No standardized screening/assessment tool       | → No standardized assessment tool                | → Limited treatment options                      | → Limited transportation                         | → Limited housing, housing – specialized and affordable | → Co-occurring offenders with terminal illness    | → Limited housing, housing – specialized and affordable | → Childcare                                      | → Funds not available                             | → Lack of intensive community support to keep housing |</p>
<table>
<thead>
<tr>
<th>OBSERVATIONS</th>
<th>Lack of general awareness of services</th>
<th>Assessments are redundant</th>
<th>Assessments are redundant</th>
<th>We don’t know each other’s organizations</th>
<th>Assessments are redundant</th>
<th>Disproportionate funding</th>
<th>Lack of uniform discharge criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTES THAT DON’T FIT ANYWHERE ELSE</td>
<td>Lack of general awareness of services</td>
<td>Limited public awareness of entry points</td>
<td>Initial Point of Entry</td>
<td>Initial Screening and/or Assessment</td>
<td>Referral</td>
<td>Service Delivery</td>
<td>Final Contact with Provider (exit)</td>
</tr>
<tr>
<td>ACRONYMS USED</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADA</td>
<td>Alcohol and Drug Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHR</td>
<td>Behavioral Health Response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC</td>
<td>community mental health centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPS</td>
<td>Comprehensive Psychiatric Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMH</td>
<td>Missouri Department of Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSH</td>
<td>Disproportionate Share</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MPC</td>
<td>Metropolitan St. Louis Psychiatric Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RHC</td>
<td>St. Louis Regional Health Commission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EASTERN REGION PUBLIC MENTAL HEALTH PLANNING PROJECT

RECOMMENDATIONS

DECEMBER 2006
SECTION A: COORDINATE AND PLAN ON A REGIONAL LEVEL ................................................................. 5
A1: Partner existing network of Eastern Region behavioral health providers with representation from St. Louis Integrated Health Network to permanently coordinate and integrate the delivery of: 1) safety net behavioral health services, and 2) behavioral health services with other health care providers.
A2: Advocate for system of care principles and system changes to improve children’s behavioral health services.

SECTION B: INTEGRATE BEHAVIORAL HEALTH AND PHYSICAL HEALTH SYSTEMS ........................................... 8
B1: Examine opportunities to increase services and/or revenues through collaboration and integration between behavioral health and primary health care providers.
B2: Develop infrastructure to increase behavioral health screenings and referrals by safety net primary care providers.
B3: Develop infrastructure to increase physical health screenings and referrals by safety net behavioral health care providers.

SECTION C: ENHANCE AND STREAMLINE FUNDING ............................................................................. 12
C1: Explore the feasibility of enhancing public funding streams for behavioral health service delivery to provide adequate funding for behavioral health services.
C2: Require all non-forensic admissions to state operated acute psychiatric beds to be: 1) clinically screened using a standardized screening tool, and 2) be authorized in a timely manner by a triage system.
C3: Examine the potential to convert state funding mechanisms from time/unit reimbursement to case rate or other alternative reimbursement based upon outcomes achieved in order to provide incentives to adopt evidence-based practices and increase accountability.
C4: Develop funding incentives to increase collaboration between and among programs, including but not limited to collaboration between alcohol and drug abuse and mental health programs.
C5: Direct Department of Mental Health Disproportionate Share to Hospital (DSH) funds in region that are currently generated through inpatient psychiatric care for the uninsured to support developments/improvements in the system, including investment in community-based alternatives to inpatient care.

SECTION D: INCREASE CAPACITY FOR BEHAVIORAL HEALTH SERVICES ..................................................... 17
D1: Increase partnerships among behavioral health organizations and local universities and junior colleges.
D2: Explore options to increase capacity by increasing efficiencies within behavioral health organizations and within the behavioral health system.
D3: Advocate to expand capacity for behavioral health services to individuals who need non-crisis care but do not have access to Medicaid or private insurance.
D4: Advocate and explore options to expand capacity at existing behavioral health providers to reduce current wait lists for behavioral health services.
D5: Improve care and explore need for additional treatment options for high-users of the behavioral health system, individuals at risk of being high-users of the behavioral health system, and high inappropriate users of other systems, in order to improve care and reduce costs.

SECTION E: IMPROVE SERVICE DELIVERY

E1: Expand implementation of current best practices into behavioral health care delivery.
E2: Incorporate families into the behavioral health care process (to the extent possible).
E3: Develop alternatives to Missouri Department of Mental Health purchased or provided inpatient psychiatric services.
E4: Create a behavioral health system that enhances the treatment of co-occurring diagnosed patients.
E5: Increase information concerning availability of appointments and services at other agencies.
E6: Create comprehensive health literacy programs for behavioral health services in the Eastern region.
E7: Explore options to streamline and enhance service delivery continuums of care for safety net behavioral health clients to provide a full array of services and treatment options.
E8: Explore options to develop a relationship with a client(s) to ensure client’s engagement in the recommended panel of services.
E9: Explore options to improve treatment options for clients by increasing availability of home-based services or telemedicine appointments.

SECTION F: REDUCE ACCESS BARRIERS

F1: Build relationships to better inform community groups, police and law enforcement, health professionals, clergy, education settings and shelters, about behavioral health issues, available resources, informal screenings, etc.
F2: Identify and advocate for changes in state and federal laws and policies that create barriers to access, and cause duplication and expense.
F3: Develop “no wrong door” for individuals. During first contact, individuals receive an initial screening and a “warm transfer” to an appropriate service provider.
F4: Increase 24/7 transportation options in the Eastern region.
F5: Increase treatment options and community support services during evening/night hours, weekends and holidays.
F6: Create psychological accessibility for clients by addressing cultural competency among behavioral health provider staff.

SECTION G: IMPROVE CRISIS SERVICES

G1: Develop comprehensive crisis management systems to ensure appropriate levels of care.
G2: Explore diversion options from emergency rooms for individuals with non-emergent behavioral health issues.
G3: Create a regional crisis center (web-based crisis center) to help determine best alternatives for crisis/triage services.
G4: Develop a “warm hand-off” for individuals who visit emergency rooms with an urgent need, but who do not need to be admitted as an inpatient.

G5: Establish outreach and crisis behavioral health services for young adults (ages 17 – 23).

SECTION H: REDESIGN ASSESSMENT AND SCREENING PROCESS

H1: Utilize a standardized screening and common assessment tool(s) for use by all behavioral health providers/organizations. Also encourage informal entry points to use standardized screening tool.

H2: Cross-train staff in diagnosing co-occurring (mental health and substance use/abuse) needs and diagnosis and physical health needs (for referral).

SECTION I: DEVELOP A MASTER PATIENT INDEX

I1: Develop a web-based Master Patient Index system that combines behavioral health with a primary care home.
SECTION A: COORDINATE AND PLAN ON A REGIONAL LEVEL

RECOMMENDATION A1: Partner existing network of Eastern Region behavioral health providers with representation from St. Louis Integrated Health Network to permanently coordinate and integrate the delivery of: 1) safety net behavioral health services, and 2) behavioral health services with other health care providers.

CRITERIA MET: Improves coordination of health care. Improves coordination of behavioral health. Improves system structure.

TIMEFRAME: Short-term

DESCRIPTION: Building on the successes of the Eastern Region Public Mental Health project in 2006, continue to partner existing network of behavioral health providers from the Department of Mental Health (DMH) Eastern Region with the St. Louis Integrated Health Network (IHN) members to:

- Coordinate and integrate the delivery of safety net behavioral and physical health services in the Eastern region.
- Ensure consistent and appropriate utilization of behavioral health clinical protocols across the safety net.

The behavioral health network (in collaboration/coordination with the IHN) will be responsible for improving integration and the delivery of safety net behavioral health services, including but not limited to the RHC recommendations. Consider expanding membership of Eastern region behavioral health network to include leadership from additional behavioral health service providers in region.

In some specific areas, such as housing services for the mentally ill, consider regionalizing/consolidating the provision of services from multiple agencies to one agency in order to aggregate specialized skills into a centralized entity and to streamline costs.

RATIONALE/BENEFITS:

- Increases integration between safety net behavioral health providers, and with physical health systems.
- Provides a lead entity responsible for the coordination and integration of the behavioral health system in the region.
- Provides opportunities for collaboration among behavioral health safety net providers.

BARRIERS:

- None.

NEXT STEPS:

- Seek funding for Phase II of Eastern Region Public Behavioral Health project; examine potential for long-term financial staffing support.
- Complete feasibility study on regionalization of service opportunities.
SECTION A: COORDINATE AND PLAN ON A REGIONAL LEVEL

RECOMMENDATION A2: Advocate for system of care principles and system changes to improve children’s and family behavioral health services.

CRITERIA MET: Improves coordination of health care. Improves coordination of behavioral health. Improves system structure.

TIMEFRAME: Short-term

DESCRIPTION: Building on the successes of the Eastern Region Public Mental Health project in 2006, expand the work to include children’s and family behavioral health services. Develop a task force to focus specifically on this population. The work should include:

- A comprehensive vision for children’s and family behavioral health services.
- An analysis of the current behavioral health services that are available for children, youth, and families and gaps in the existing system. Include an analysis of where children and families currently receive services and opportunities for increasing service utilization through alternative delivery locations.
- A review of best practices and alternative models of children’s and family behavioral health services.
- Recommendations for improvements in the system.

Other core advocacy principles may include:

- Developing a more collaborative, comprehensive and outcome-based children’s behavioral health system.
- Increasing and protecting reimbursement for children’s behavioral health service providers.
- Improving recruitment and retention of children’s safety net behavioral health service providers.

RATIONALE/BENEFITS:

- Improves access to behavioral health services for children and families.
- Early intervention in a child’s life may decrease the need for services later on; early intervention will also ensure a child receives necessary treatment in the least restrictive setting.
- Increases integration between safety net behavioral health providers, and with physical health systems.
- Provides a specific focus on a vulnerable population.
- Provides opportunities for collaboration among behavioral health safety net providers.
- Increases likelihood that families can receive behavioral health services in a coordinated manner.

BARRIERS:

- Requires funding.
- Current lack of coordinating body for children’s behavioral health services.
NEXT STEPS:
∞ Appoint taskforce to direct work.
∞ Prioritize any “quick changes/improvements” that could be made or advocated for in the system.
∞ Develop vision for children’s and family behavioral health services and conduct analysis of current services, gaps, funding, etc.
∞ Review best practices for children’s and family behavioral health services in the region and across country.
∞ Develop and implement recommendations for system change.
SECTION B: INTEGRATE PHYSICAL HEALTH AND BEHAVIORAL HEALTH SYSTEMS

RECOMMENDATION B1: Examine opportunities to increase services and/or revenues through collaboration and integration between behavioral health and primary health care providers.

CRITERIA MET: Improves coordination of health care. Streamlines care coordination and service delivery. Improves system structure.

TIMEFRAME: Short-term

DESCRIPTION: Expand existing local best practice collaborations that integrate behavioral and physical health. Collaborations include, but are not limited to:

- Co-locate psychiatrists, psychologists, social workers, alcohol and drug abuse trained staff, nurses, mental health clinicians, physicians, licensed professional counselors, etc., in physical and behavioral health sites.
- Provide seamless connections between behavioral and primary health care services, through more effective referrals and information sharing among providers.
- Identify other best practices to integrate behavioral and physical health, such as formal organizational integration and/or collaborative grant application.
- Share information among behavioral and physical health providers about upcoming training sessions, topics/issues on which training could be provided, and/or training needs that organizations may have. Examples include physical health risks of behavioral health medications, behavioral health literacy, co-occurring disorders, etc. Explore use of technology to increase training options.

Related to recommendation I1 regarding a Master Patient Index.

RATIONALE/BENEFITS:
- Reinforces connectedness between behavioral and physical health.
- Reduces barriers to client/patient visits to both behavioral health care and primary care providers.
- Enables client/patient to see behavioral health provider and primary care provider in same visit, and/or at same location.
- Facilitates communication and coordination between behavioral health care and primary care providers.
- Facilitates referral process between behavioral health care and primary care providers.

BARRIERS:
- May require funding.
- Potential space constraints of existing behavioral health facilities and primary care locations.
- Co-location alone may not result in integration or collaboration.
- Coordination of limited resources.
NEXT STEPS:
- Expand existing local best practice collaborations that integrate behavioral and physical health.
- Identify additional organizations willing to integrate behavioral and physical health.
- Identify additional best practices that increase services and/or revenues through integration of behavioral and physical health.
SECTION B: INTEGRATE PHYSICAL HEALTH AND BEHAVIORAL HEALTH SYSTEMS

RECOMMENDATION B2: Develop infrastructure to increase behavioral health screenings and referrals by safety net primary care providers.

CRITERIA MET: Improves coordination of health care. Streamlines care coordination and service delivery. Improves system structure.

TIMEFRAME: Mid-term

DESCRIPTION: Develop infrastructure which will encourage safety net primary care providers to conduct behavioral health screenings on patients, provide treatment (where appropriate), and provide referrals to behavioral health providers. Improve communication between primary care and behavioral health providers to ensure both providers are aware of all the health needs and care provided to a client/patient. Train primary care safety net physicians to better recognize and, where clinically appropriate, treat the behavioral health needs of their patients.

RATIONALE/BENEFITS:
- Recent data indicates that individuals with severe mental illness, who are part of the public mental health system die, on average, at least 25 years earlier than the general population. (Presentation to National Association of State Mental Health Program Directors, Medical Directors Council, July 2006).
- Reinforces connectedness between behavioral and physical health.
- Reduces barriers to client/patient visits to both behavioral health care and primary care providers.
- Facilitates communication and coordination between behavioral health care and primary care providers.
- Facilitates referral process between behavioral health care and primary care providers.
- Increases likelihood that client will follow-through with recommended treatment plan.
- Increases capacity of behavioral health needs where clinically appropriate.

BARRIERS:
- Requires funding.
- Coordination of limited resources, including limited staff time.
- Current capacity in the behavioral health system is very limited; resources for treatment may not be available or individual may not qualify for services.
- Ensure evaluation includes co-morbidity of physical and behavioral health, especially in elderly clients, at every stage of assessment and referral.

NEXT STEPS:
- Identify specific existing barriers that discourage primary care providers from conducting behavioral health screenings.
- Develop plan to reduce and remove barriers, and improve communication among providers.
- Secure funding and implement plan.
SECTION B: INTEGRATE PHYSICAL HEALTH AND BEHAVIORAL HEALTH SYSTEMS

RECOMMENDATION B3: Develop infrastructure to increase physical health screenings and referrals by safety net behavioral health care providers.

CRITERIA MET: Improves coordination of health care. Streamlines care coordination and service delivery. Improves system structure.

TIMEFRAME: Mid-term

DESCRIPTION: Develop infrastructure which will encourage safety net behavioral health care providers to conduct primary health screenings on patients and provide referrals to physical health providers. Improve communication between primary care and behavioral health providers to ensure both providers are aware of all the health needs and care provided to an client/patient. Train safety net behavioral health care providers to better recognize the physical health needs of their clients and make referrals where appropriate.

RATIONALE/BENEFITS:
- Recent data indicates that individuals with severe mental illness, who are part of the public mental health system die, on average, at least 25 years earlier than the general population. (Presentation to National Association of State Mental Health Program Directors, Medical Directors Council, July 2006).
- Reinforces connectedness between behavioral and physical health.
- Reduces barriers to client/patient visits to both behavioral health care and primary care providers.
- Facilitates communication and coordination between behavioral health care and primary care providers.
- Facilitates referral process between behavioral health care and primary care providers.
- Increases likelihood that client will follow-through with recommended treatment plan.
- Increases capacity to meet behavioral health needs where clinically appropriate.

BARRIERS:
- Requires funding.
- Coordination of limited resources, including limited staff time.
- Current capacity in the behavioral health system is limited; resources for treatment may not be available or client may not qualify for services.
- Ensure evaluation includes co-morbidity of physical and behavioral health, especially in elderly clients, at every stage of assessment and referral.

NEXT STEPS:
- Identify specific existing barriers that discourage behavioral health care providers from conducting physical health screenings.
- Develop plan to reduce and remove barriers, and improve communication among providers.
- Secure funding and implement plan.
SECTION C: ENHANCE AND STREAMLINE FUNDING

RECOMMENDATION C1: Explore the feasibility of enhancing public funding streams for behavioral health service delivery to provide adequate funding for behavioral health services.

CRITERIA MET: Improves coordination of behavioral health. Increases funding and reduces restrictions on funding.

TIMEFRAME: Long-term

DESCRIPTION: Analyze feasibility of enhancing public funding streams for behavioral health service delivery through:

- Explore feasibility of creating Community Mental Health Funds or Children’s Services funds for the counties in the region that do not have dedicated local taxes.
- Explore feasibility of potential collaboration between providers and drug and mental health courts to increase funding streams.
- Analyze federal funding streams to ensure maximum federal funding is captured as appropriate.
- Determine cost per person served in Eastern public behavioral health system in comparison to other areas of the state; utilize to advocate at state level for larger share of state funding in region.

Analyze opportunities for use of funding, including support to offer behavioral health services through mental health providers, community organizations and elementary, middle and high schools.

RATIONALE/BENEFITS:

- Diversifies funding opportunities for behavioral health providers.
- Enables adequate funding to provide needed behavioral health services in region.

BARRIERS:

- Developing broad-based support for safety net behavioral health funding.
- Competing potential uses of any new tax.
- Identifying a sponsor organization to coordinate campaign/public awareness activities.
- Lack of funding for indirect care activities in the behavioral health arena in the short-term.

NEXT STEPS:

- Conduct analyses on creating community taxing districts and other opportunities for diversifying funding streams.
- Complete federal funding analysis and determine revenue maximization opportunities.
- Complete cost per person analysis for Eastern region; coordinate communication efforts to state with Eastern region providers.
SECTION C: ENHANCE AND STREAMLINE FUNDING

RECOMMENDATION C2: Require all non-forensic admissions to state operated acute psychiatric beds to be: 1) clinically screened using a standardized screening tool, and 2) be authorized in a timely manner by a triage system. This recommendation does not apply to specialized beds set-aside for Alcohol and Drug Abuse involuntary commitment patients.

CRITERIA MET: Improves coordination of behavioral health. Improves coordination between community and inpatient services. Streamlines care coordination and service delivery.

TIMEFRAME: Mid-term

DESCRIPTION: All providers will utilize a standardized clinical screening tool before recommending admission to state operated acute psychiatric facilities. Develop a community triage system that manages and approves admissions to state operated acute psychiatric facilities, or identifies available and appropriate community-based alternatives for care. Related to recommendation E3 regarding developing alternatives to inpatient psychiatric care.

RATIONALE/BENEFITS:
∞ Increases coordination between community and inpatient psychiatric health programs.
∞ Ensures clients receive care in the least restrictive setting.
∞ Encourages increased and appropriate use of community-based treatment options.

BARRIERS:
∞ Ensuring clients receive appropriate care in a timely manner.
∞ Clarifying process for clients with co-occurring issues of psychiatric and substance abuse issues.
∞ Ensuring the definition of “timely manner” is agreed upon by providers and consistently met.
∞ Ensuring clients are stabilized, assessed and treated for medical needs.
∞ Ensuring a hand-off is available 24/7.
∞ Clarifying and ensuring agreement by providers on the definition of “triage system.”

NEXT STEPS:
∞ Conduct feasibility analyses on scope of pilot, potential risks, implementation costs.
∞ Develop alternatives to inpatient psychiatric care, as noted in recommendation E3.
∞ Examine existing state statutes designating administrative agent functions.
∞ Create implementation and communication plans.
SECTION C: ENHANCE AND STREAMLINE FUNDING

RECOMMENDATION C3: Examine the potential to convert state funding mechanisms from time/unit reimbursement to case rate or other alternative reimbursement based upon outcomes achieved in order to provide incentives to adopt evidence-based practices and increase accountability.

CRITERIA MET: Improves coordination of behavioral health. Improves system structure.

TIMEFRAME: Long-term

DESCRIPTION: Convene group to examine the potential to have payment of services from State of Missouri Department of Mental Health to public behavioral health providers move from fee for service to case rate or other alternative reimbursement methodology based upon outcomes.

RATIONALE/BENEFITS:

• Encourages the deployment of evidence-based practices into the behavioral health system through alignment of financial incentives.
• May enhance the quality of care delivered for patients/families if properly designed.
• Encourages strong collaboration between behavioral health providers to determine appropriate reimbursement methodology.
• Ensures standard of service is more consistent throughout the Eastern region.

BARRIERS:

• Developing agreement upon reimbursement methodology.
• Developing appropriate risk rating modalities so providers are not penalized for taking “more difficult” or more disabled clients.
• Developing mechanism to ensure clients with severe, long-term needs are not disadvantaged in order for providers to improve outcome rating.
• Developing mechanism to compensate providers for clients who do not make progress because of the nature of their illness.

NEXT STEPS:

• Convene committee to explore potential for consensus on alternative reimbursement methodology, risk rating modalities, discharge criteria, etc. Include client input.
• Ensure strong consensus from Eastern region (local level) providers and clients prior to implementation.
• Develop a carefully planned, phased approach for implementation.
SECTION C: ENHANCE AND STREAMLINE FUNDING

RECOMMENDATION C4: Develop funding incentives to increase collaboration between and among programs, including but not limited to collaboration between alcohol and drug abuse and mental health programs.

CRITERIA MET: Improves coordination of health care. Improves coordination of behavioral health. Increases funding and reduces restrictions on funding. Streamlines care coordination and service delivery.

TIMEFRAME: Short-term

DESCRIPTION: Increase funding opportunities by the state and other funders to create incentives for providers to collaborate on programming, such as funding of collaborative treatment programs for co-occurring disorders or the placement of mental health and alcohol and drug abuse counselors in Federally Qualified Health Center settings. Also explore opportunities to maximize federal funding (including reimbursement through Section 330) for mental and behavioral health services through creative collaborations between area mental health, alcohol and drug abuse, and primary care providers.

RATIONALE/BENEFITS:
- Coordinated effort may provide greater access to funding from federal grants, state grants and private foundations.
- May diversify funding streams.
- Provides opportunity for collaboration among all area safety net providers.

BARRIERS:
- Current lack of staffing to identify and pursue joint funding opportunities.
- Dearth of flexible funds currently available to providers.

NEXT STEPS:
- Consider opportunities to develop permanent Eastern Region behavioral health network for regional planning and collaboration; coordinate closely with St. Louis Integrated Health Network.
- Convene behavioral health network, St. Louis Integrated Health Network and other providers as appropriate to identify opportunities for collaborative proposals and grant applications.
- Advocate for enhanced collaborative funding opportunities from state and local funders.
SECTION C: ENHANCE AND STREAMLINE FUNDING

RECOMMENDATION C5: Direct Department of Mental Health Disproportionate Share to Hospital (DSH) funds in region that are currently generated through inpatient psychiatric care for the uninsured to support developments/improvements in the system, including investment in community-based alternatives to inpatient care.

CRITERIA MET: Improves coordination of behavioral health. Increases funding and reduces restrictions on funding.

TIMEFRAME: Mid-term

DESCRIPTION: Increase funding opportunities for community-based alternatives to inpatient psychiatric care in the St. Louis region through capturing DSH funds generated by behavioral health providers, but not currently spent for direct care to uninsured. Funds could be targeted to increase capacity as described in recommendations D3 and D4.

RATIONALE/BENEFITS:
∞ Increases funding for behavioral health services in region and allows for expansion of public behavioral health capacity.
∞ Ensures funding is being directed to directly support care provision in region for uninsured.
∞ Decreases current reliance on inpatient psychiatric public mental health beds long-term.

BARRIERS:
∞ Determining funds available for reallocation.
∞ Garnering legislative support, as necessary.

NEXT STEPS:
∞ Conduct feasibility analyses on scope of project, potential risks and implementation costs.
∞ Determine pool of available funds and funding allocation methodologies.
∞ Create implementation and communication plans.
RECOMMENDATION D1: Increase partnerships among behavioral health organizations and local universities and community colleges.

CRITERIA MET: Improves coordination of behavioral health. Improves system structure.

TIMEFRAME: Short-term

DESCRIPTION: Increase partnerships among behavioral health organizations and local universities and community colleges who have mutual needs in areas such as program evaluation, staff or student training, internships, research into best practices, etc. Partnerships may result in mutual research projects, behavioral health staff participating in university classes, university staff or students training at the behavioral health organizations, etc.

RATIONALE/BENEFITS:
- Increased communication among behavioral health organizations and local universities.
- Increased knowledge level of all participants.
- Increased opportunities for research and program evaluation.
- Increased awareness of staff training needs of providers.

BARRIERS:
- Limited time and funding resources.
- Limited current best practice and research utilization in university setting.

NEXT STEPS:
- Identify behavioral health organizations and universities willing to develop partnerships and areas of interest.
- Develop inter-agency agreements among partners.
SECTION D: INCREASE CAPACITY FOR BEHAVIORAL HEALTH SERVICES

RECOMMENDATION D2: Explore options to increase capacity by increasing efficiencies within behavioral health organizations and within the behavioral health system.

CRITERIA MET: Improves coordination of behavioral health. Improves coordination between behavioral and physical health. Improves system structure.

TIMEFRAME: Short-term

DESCRIPTION: Explore options to increase existing capacity in the behavioral health system by increasing efficiencies within organizations and within the system. Identify best practices to increase efficiency among local and national behavioral health organizations and publish information about the best practices via the web or group training sessions. Potential areas for efficiencies include, but are not limited to:

- Increasing the use of technology in areas such as sharing training resources or serving clients through telemedicine.
- Increasing the use of internet-based technologies to assist with identifying available community programs based on the assessed needs of a client.

Related to recommendation B1 (increasing collaboration and integration among providers) and E1 (expanding implementation of best practices).

RATIONALE/BENEFITS:

- Increased communication among behavioral health organizations.
- Potential to increase clients served or level of care provided through increased efficiency.

BARRIERS:

- Limited time and funding resources.

NEXT STEPS:

- Identify best practices or areas to research regarding best practices.
- Publish information and/or organize training sessions about best practices.
SECTION D: INCREASE CAPACITY FOR BEHAVIORAL HEALTH SERVICES

RECOMMENDATION D3: Advocate to expand capacity for behavioral health services to individuals who need non-crisis care but do not have access to Medicaid or private insurance.

CRITERIA MET: Increases funding and reduces restrictions on funding. Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Long-term

DESCRIPTION: Advocate to expand capacity for behavioral health services to individuals who need non-crisis care, and for whom access to care may prevent escalation to the need for urgent or emergent care. Currently, to be eligible for state-funded psychiatric services, an individual must have a serious and persistent mental illness, be in an acute psychiatric crisis, be a forensic client or be a child or youth with a serious emotional disturbance. Individuals who need state-funded alcohol and drug abuse services are limited by the type of services a provider has state funding for and the capacity of the system. Individuals who: 1) don’t meet the above criteria, or 2) have access to private behavioral health insurance are often unable to access behavioral health care.

RATIONALE/BENEFITS:
∞ Reduces practical barriers for clients to access care.
∞ Early intervention may reduce hospital service use and shorten inpatient days.

BARRIERS:
∞ Requires funding.

NEXT STEPS:
∞ Use estimated number of individuals in need of care in the Current State Assessment to advocate for increased capacity.
∞ Estimate cost of providing routine services vs. emergent services to clients.
∞ Develop and implement communication and advocacy plans.
SECTION D: INCREASE CAPACITY FOR BEHAVIORAL HEALTH SERVICES

RECOMMENDATION D4: Advocate and explore options to expand capacity at existing behavioral health providers to reduce current wait lists for behavioral health services.

CRITERIA MET: Increases funding and reduces restrictions on funding. Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Long-term

DESCRIPTION: Advocate and explore options to expand capacity at existing behavioral health providers to reduce current wait lists for behavioral health services. During 2005, a total average of 458 individuals were on the wait lists on any given day at 11 behavioral health organizations in the region (11 represents the number of state-funded organizations who keep a wait list). Most of those individuals were on the wait lists for alcohol and drug abuse services (average of 18 individuals per organization for community mental health centers and affiliate organizations; average of 70 individuals per organizations for alcohol and drug abuse providers).

RATIONALE/BENEFITS:
- Reduces practical barriers for clients to access care.
- Early intervention may reduce hospital service use and shorten inpatient days.

BARRIERS:
- Requires funding.

NEXT STEPS:
- Estimate cost of eliminating wait lists at behavioral health organizations.
- Develop and implement communication and advocacy plans.
SECTION D: INCREASE CAPACITY FOR BEHAVIORAL HEALTH SERVICES

RECOMMENDATION D5: Improve care and explore need for additional treatment options for high-users of the behavioral health system, individuals at risk of being high-users of the behavioral health system, and high inappropriate users of other systems, in order to improve care and reduce costs.

CRITERIA MET: Improves coordination of behavioral health. Increases funding and reduces restrictions on funding. Reduces practical barriers and increases social supports for clients and family members. Streamlines care coordination and service delivery.

TIMEFRAME: Long-term

DESCRIPTION: Conduct an analysis of the services provided to high-users of the behavioral health system, individuals at risk of being high-users of the behavioral health system, and high inappropriate users of other systems. Areas to study include, but are not limited to, the services used, the frequency and time periods of use, the reasons for use and the cost of providing services. Use the analysis to develop strategies to improve care and outreach provided to individuals and reduce costs. Related to Section E, Improve Service Delivery.

RATIONALE/BENEFITS:
- Reduces practical barriers for clients to access care.
- Early intervention may reduce hospital service use and shorten inpatient days.

BARRIERS:
- Requires funding.
- No lead entity identified to conduct analysis.
- Current capacity in the behavioral health system is very limited; resources for treatment may not be available.
- Limitations of target and priority population eligibility requirements.

NEXT STEPS:
- Identify lead agency to conduct analysis.
- Gather and analyze information.
- Develop and implement strategies to improve care and outreach, and reduce costs.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E1: Expand implementation of current best practices into behavioral health care delivery.

CRITERIA MET: Improves coordination of health care. Improves coordination of behavioral health.

TIMEFRAME: Long-term

DESCRIPTION: Expand implementation of current best practices into behavioral health care delivery. Create or support current permanent regional or statewide entity to identify best practices both locally and nationally, and publish these best practices via website and group training sessions. Related to recommendation C3 (convert state funding mechanisms).

RATIONALE/BENEFITS:
- Improves quality of care delivered to patients and reduces long-term costs.
- Reduces barriers to patient visits to behavioral health providers.
- Reinforces connectedness between physical and behavioral health.
- Facilitates communication and coordination between all safety net health providers.
- Facilitates referral process between physical and behavioral health providers.

BARRIERS:
- Requires funding.
- Potential space constraints of existing primary care locations.

NEXT STEPS:
- Form committee to identify local and national best practices; select lead agency for implementation.
- State of Missouri, Eastern Region behavioral health network (Section A), and St. Louis Integrated Health Network coordinate to identify opportunities for expanded implementation of best practices.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E2: Incorporate families into the behavioral health care process (to the extent possible).

CRITERIA MET: Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Mid-term

DESCRIPTION: To the extent possible by the law and client consent, incorporate families into the behavioral health care process. This may include providing treatment and support to family member(s) if needed, involving family member(s) in treatment planning, and identifying a role for family member(s) to participate in the recovery process. Coordinate with the Missouri Department of Mental Health Transformation Grant and their efforts to create a family and client-driven system of care where appropriate.

RATIONALE/BENEFITS:
∞ May improve quality of care delivered to patients.
∞ May enhance quality of life experienced by family members.
∞ May reduce burden on case managers because duties can be shared with family members.
∞ May make recovery of the client possible, particularly in cases where case managers and families are at odds with the treatment plan.

BARRIERS:
∞ May require funding and potential reallocation of staff time to support families.
∞ May be constrained by privacy and other legal considerations.
∞ May be clinically contraindicated in some family situations.

NEXT STEPS:
∞ Form committee to identify local and national best practices; select lead agency for implementation. Address incorporation of family members as early topic to be researched and explored. As appropriate, include in local programming, and advocate for pilot funding from state and local funders to pilot best practices.
∞ Explore collaborative grants to deploy jointly across multiple agencies as appropriate.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E3: Develop alternatives to Missouri Department of Mental Health purchased or provided inpatient psychiatric services.

CRITERIA MET: Improves coordination of behavioral health. Improves coordination between community and inpatient services.

TIMEFRAME: Long-term (requires funding)

DESCRIPTION: Develop more comprehensive community-based care alternatives to reduce region’s comparatively high utilization of inpatient psychiatric beds. May be implemented in conjunction with funding recommendations concerning increasing funding streams for community-based care (section C). May also be implemented with recommendations to improve crisis services through creation of behavioral health crisis beds outside of the emergency room setting (section F).

RATIONALE/BENEFITS:
∞ Improves quality of care delivered to patients as individuals are treated in the least restrictive setting possible.
∞ Reduces cost of care through delivery in community-based settings.

BARRIERS:
∞ Requires funding.
∞ Limited availability of a continuum of community services for un/underinsured.
∞ Requires agreement on which community-based services to expand.
∞ Requires on-going education and training of staff on new and existing community based resources.
∞ No single entity identified to manage comprehensive crisis management system.

NEXT STEPS:
∞ Identify components of community-based care alternatives that need to be developed.
∞ Develop implementation plan to develop and manage crisis management services.
∞ Implement funding recommendations as detailed in Section C.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E4: Create a behavioral health system that enhances the treatment of co-occurring diagnosed patients.

CRITERIA MET: Improves coordination of behavioral health. Reduces practical barriers and limited social supports for clients and family members.

TIMEFRAME: Long-term

DESCRIPTION: Expand existing local best practice collaborations that integrate psychiatric care and substance abuse treatment. Co-locate psychiatrists, psychologists, and alcohol and drug abuse trained staff, nurses, etc., in physical and behavioral health sites. Provide seamless connections between psychiatric and substance abuse services, through more effective referrals and information sharing among providers. Identify other best practices to integrate treatment of co-occurring diagnosed patients. Related to recommendation I1 regarding a Master Patient Index.

RATIONALE/BENEFITS:
- Reinforces connectedness between behavioral health providers.
- Reduces barriers to client visits to both mental health care and substance abuse providers.
- Facilitates communication and coordination between behavioral health providers and improves delivery of care.
- Reduces redundant or contraindicated therapies and treatments through collaboration of providers.
- Facilitates referral process between psychiatric and substance abuse providers.

BARRIERS:
- May require funding.
- Current method of allocation of state funding does not encourage collaborative treatment of co-occurring disorders.
- Lack of adequately trained and/or cross-trained staff.
- Limited funds to pay for experienced and trained staff.
- Need for sustainable funding, not just one-time grants.

NEXT STEPS:
- Create task force to explore streamlining of treatment of co-occurring diagnosed patients. Discussions may include:
  - Recommendations for specific service integration or collaboration opportunities in the region.
  - Specific modifications to state funding allocation methods.
  - Identification of federal, state or local grants that pilot greater integration of psychiatric and substance abuse treatment.
  - Training and certification of staff.
- Ensure inclusion of both psychiatric and substance abuse providers in master patient index project.
- Identify additional best practices that increase services and/or revenues through integration of psychiatric and substance abuse treatments.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E5: Increase information concerning availability of appointments and services at other agencies.

CRITERIA MET: Improves coordination between behavioral health. Reduces practical barriers and increases social supports for clients and family members. Streamlines care coordination and service delivery.

TIMEFRAME: Mid-term

DESCRIPTION: Develop a database or expand on existing database of providers and services. Make the database available via the web to individuals and providers. Include availability of appointments, access to appointments, eligibility requirements, and a comprehensive list of services provided at each agency. Related to recommendation G3 regarding “no wrong door.”

An example program, called “Computer Assisted System for Patient Assessment and Referral, CASPAR” provides an assessment and helps professionals provide free or low cost service referrals for clients. Referral agencies include area United Way agencies and other non-profit organizations. Research from the program indicates that clients who are referred to and receive additional services (such as parenting skills, employment assistance, etc.) are more likely to stay engaged in their treatment plan for a longer period of time. (Information taken from a presentation by A. Thomas McLellan of the Treatment Research Institute to the “Blending Addiction Science and Practice: Bridges to the Future” conference in October 2006.)

RATIONALE/BENEFITS:
- Reinforces connectedness between behavioral health providers.
- Reduces barriers to client visits to behavioral health providers.
- Facilitates communication and coordination between behavioral health providers and improves delivery of care.
- Facilitates referral process between behavioral health providers.
- Enables greater client/individual options.
- Enhances ability of emergency rooms and primary care providers to refer to behavioral health agencies.

BARRIERS:
- Requires funding.
- Requires on-going, frequent updating of availability of services at each agency, which is complex and time-consuming for agencies.
- Publishing of lack of available appointments/long wait times on internet may discourage clients from entering system of care.

NEXT STEPS:
- Determine lead agency to create or maintain existing database of providers and services.
- Secure funding for ongoing maintenance of database from state or other funding entity.
May be implemented in conjunction with master patient index or emergency room diversion projects.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E6: Create comprehensive health literacy programs for behavioral health services in the Eastern region.

CRITERIA MET: Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: In conjunction with the St. Louis Regional Health Commission’s regional health literacy initiative, develop a coordinated health literacy program across the behavioral health safety net system to include:
- Public service announcements promoting behavioral health and how to access to behavioral health safety net services.
- Partnerships with school systems to provide comprehensive education and prevention programs re: behavioral health.
- Partnerships with community based organizations to provide education and prevention programs re: behavioral health.
- Development and distribution of behavioral health education materials written at a 6th to 8th grade reading level for individuals and family members.
- Comprehensive training programs for practitioners, staff members, and professional schools to educate providers and staff on the importance of communications in the delivery of care.

Related to recommendation E1 (expand implementation of current best practices).

RATIONALE/BENEFITS:
- Raises health literacy.
- Improves patient knowledge of behavioral health safety net system and how to access the system.
- May reduce the stigma sometimes associated with safety net care and behavioral health.

BARRIERS:
- Requires funding.

NEXT STEPS:
- Develop partnership with RHC’s Center for Health Literacy effort to be implemented January 2007.
- Ensure behavioral health representation on Center for Health Literacy committees; ensure implementation efforts include behavioral health entities.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E7: Explore options to streamline and enhance service delivery continuums of care for safety net behavioral health clients to provide a full array of services and treatment options.


TIMEFRAME: Long-term

DESCRIPTION: Explore options to provide a full array of services and treatment options for safety net behavioral health clients, including, but not limited to, the services outlined on the following pyramid.
RATIONALE/BENEFITS:
- Reinforces connectedness between behavioral health providers.
- Reduces barriers to client visits to behavioral health providers.
- Facilitates communication and coordination between behavioral health providers and improves delivery of care.
- Facilitates referral process between behavioral providers.
- Enables greater client/individual options.
- Enhances ability of emergency rooms and primary care providers to refer to behavioral health agencies.

BARRIERS:
- Requires funding.

NEXT STEPS:
- Quantify services currently available.
- Identify areas in the continuum of care that need to be enhanced.
- Develop plan to streamline and enhance continuum.
- Secure funding.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E8: Explore options to develop a relationship with a client(s) to ensure client’s engagement in the recommended panel of services.


TIMEFRAME: Long-term

DESCRIPTION: Explore options to develop a relationship with a client(s) to ensure client’s engagement in the recommended panel of services. Options to engage clients include, but are not limited to, intensive case management, care coordination, outreach and engagement, active follow-up and treatment adherence.

RATIONALE/BENEFITS:
- Reduces barriers to client visits to behavioral health providers.
- Facilitates communication and coordination between behavioral health providers and improves delivery of care.
- Increases likelihood that client will follow-through with treatment.
- Early intervention may reduce hospital service use and shorten inpatient days.

BARRIERS:
- Requires funding.
- Limited cultural competency of staff.
- Limited education and training of staff regarding meeting client needs.
- Restrictions of psychiatric service definitions.

NEXT STEPS:
- Research best practices and outline options to improve client retention.
- Secure funding.
SECTION E: IMPROVE SERVICE DELIVERY

RECOMMENDATION E9: Explore options to improve treatment options for clients by increasing availability of home-based services or telemedicine appointments.

CRITERIA MET: Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Long-term

DESCRIPTION: Explore options to improve treatment options for clients who may not be able to access services available in an office or clinic setting by increasing services such as home-based services and/or telemedicine appointments.

RATIONALE/BENEFITS:
- Reduces barriers to client visits to behavioral health providers.
- Increases likelihood that client will follow-through with treatment.

BARRIERS:
- Requires funding.
- Limited cultural competency of staff.
- Limited education and training of staff regarding meeting client needs.

NEXT STEPS:
- Identify home-based and telemedicine services already available. Analyze need for additional services.
- Develop plan to increase treatment options.
- Secure funding.
SECTION F: REDUCE ACCESS BARRIERS

RECOMMENDATION F1: Build relationships to better inform community groups, police and law enforcement, health professionals, clergy, education settings and shelters, about behavioral health issues, available resources, informal screenings, etc.

CRITERIA MET: Enhances formal and informal entry points. Streamlines care coordination and service delivery.

TIMEFRAME: Short-term

DESCRIPTION: Expand current efforts to inform community groups, police and law enforcement, health professionals, clergy, education settings and shelters, about mental health and substance abuse or dependence issues, tools, techniques and available resources, etc. Training includes information on warning signs, informal screenings and standardized tool, communications techniques, and referral resources and available services in the community.

RATIONALE/BENEFITS:

- Builds on existing programming in the Eastern Region.
- Early intervention may reduce hospital service use and shorten inpatient days.
- Police, social workers, clergy and health professionals often respond to situations involving individuals in a behavioral health crisis. Training program provides tools, techniques and resources for responding to these situations in an effective manner.
- Helps individuals in behavioral health crisis receive services more efficiently.

BARRIERS:

- Openness of individuals and organizations to receiving training.
- Requires funding.

NEXT STEPS:

- Identify opportunities to expand existing training efforts. Partner with existing coalitions such as police associations, Interfaith Partnership and Clergy Coalition.
- Secure funding.
SECTION F: REDUCE ACCESS BARRIERS

RECOMMENDATION F2: Identify and advocate for changes in state and federal laws and policies that create barriers to access, and cause duplication and expense.

CRITERIA MET: Streamlines funding and reduces restrictions on funding.

TIMEFRAME: Long-term

DESCRIPTION: Convene group to list and prioritize existing state and federal regulations, policies and laws that create barriers to access and/or cause duplication and expense. Work with Missouri Department of Mental Health and other state and federal agencies to recommend and implement changes. Examples include, but are not limited to, privacy laws that limit information sharing and Medicaid eligibility requirements (identity and citizenship, reapplication, spend-down, etc.).

RATIONALE/BENEFITS:
∞ Reduces barriers to access and duplicative work.
∞ Enhances provider efficiency.
∞ Results in more time available for client/patient care.

BARRIERS:
∞ May require legislative and/or regulatory action.

NEXT STEPS:
∞ Convene group to identify and prioritize problematic regulations, policies and laws.
∞ Build support for change.
SECTION F: REDUCE ACCESS BARRIERS

RECOMMENDATION F3: Develop “no wrong door” for individuals. During first contact, individuals receive an initial screening and a “warm transfer” to an appropriate service provider.

CRITERIA MET: Improves coordination of behavioral health. Enhances formal and informal entry points. Streamlines care coordination and service delivery.

TIMEFRAME: Short-term

DESCRIPTION: Explore ways to decrease barriers to accessing care; if capacity exists in the region, clients will receive treatment as expeditiously as possible, regardless of initial access point, where the client resides or service needs. Train and prepare staff in organizations that serve as initial points of contact in the behavioral health system to:

• Conduct an initial behavioral health screening on any individual who contacts the organization to inquire about services. The screening will determine the likelihood that an individual has a mental health problem and/or substance-use problem. The screening is less involved than an assessment, but it establishes the need for an in-depth assessment. Related to recommendation H2 to develop a standardized screening tool.
• Ensure the client/individual is stabilized.
• Identify the best available resource/provider agency for the client/individual. Related to recommendation E5 to increase information concerning available appointments and services at other agencies.
• Assist the client/individual in contacting the referral source and overcoming any barriers to accessing the care.
• Follow-up with the client/individual to make sure s/he connected with the appropriate resource/provider agency.

RATIONALE/BENEFITS:
• Eliminates “cold hand-offs,” when an individual is given a name and phone number and is not given any additional assistance to take the next step.
• Increases likelihood the client will follow-through to receive care.

BARRIERS:
• No up-to-date comprehensive inventory of services.
• Limited awareness of available resources among providers.
• Limited staff time or financial incentive to devote to individuals better served by another agency.
• Providers may be concerned about accepting screening/referral completed by another agency.
• Need to ensure compliance with HIPAA regulations.
• Need to coordinate with other funders and accreditation screening requirements.
• Need to ensure proper referrals from inpatient to other levels of care.
• Current capacity in the behavioral health system is very limited; resources for treatment may not be available.
• Restrictions of target populations and service area designations.

NEXT STEPS:
• Expand capacity in the behavioral health system.
• Develop standardized screening tool.
• Consider mechanisms to reduce barriers to access arising from service area designations and target population methodologies currently employed.
• Develop process to prevent inappropriate referrals and ensure providers with capacity do not inappropriately deny access to individuals.
• Develop training for staff to use the screening tool and identify appropriate resources.
• Train staff.
SECTION F: REDUCE ACCESS BARRIERS

RECOMMENDATION F4: Increase 24/7 transportation options for behavioral health clients in the Eastern region.

CRITERIA MET: Reduces practical barriers and increases social supports for clients and family members.

TIMELINE: Short-term (requires funding)

DESCRIPTION: Provide additional 24/7 transportation options for clients in rural and urban areas who are trying to access behavioral health services. Options may include, but are not limited to, increasing access to public transportation, providing caretakers to ride with clients who are unable to access public transportation on their own, providing vans or other vehicles to serve areas with limited or no public transportation, pooling resources to purchase cab vouchers or other public transportation passes.

RATIONALE/BENEFITS:
- Increases likelihood clients will follow-through to receive care.
- Reduces appointment no-shows for providers.

BARRIERS:
- Requires additional or reallocated funding.

NEXT STEPS:
- Identify gaps in transportation services.
- Develop implementation plan to fill gaps.
- Secure funding.
SECTION F: REDUCE ACCESS BARRIERS

RECOMMENDATION F5: Increase treatment options and community support services during evening/night hours, weekends and holidays.

CRITERIA MET: Improves coordination of behavioral health. Improves coordination between community and inpatient services. Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Long-term

DESCRIPTION: Behavioral health organizations explore opportunities to increase treatment options and community support services during evening/night hours, weekends and holidays to better meet the needs of clients. Organizations will focus on developing an individualized care plan that continues through the evening, weekend and holiday hours.

For example, organizations may offer care until 9:00 p.m. at least one day per week. On the day with the evening hours, the organization may open later (e.g. 11 a.m.) in order to limit associated costs. Or, organizations may offer community support services through a “warm-line” for individuals to call during evening/weekend hours to receive support services, home visits on the weekends to assist with medication, or scheduled activities during weekend hours. Other recommendations to increase outpatient treatment options during night hours outlined in Section F: Improve Crisis Services.

RATIONALE/BENEFITS:
- May decrease reliance on emergency rooms for non-emergent cases.
- Increases utilization of out-patient services.
- Increases likelihood that clients will follow-through with treatment.

BARRIERS:
- Evening, weekend and holiday hours may be underutilized by clients when first implemented.
- May require funding.

NEXT STEPS:
- Identify existing treatment options during evening/night, weekend and holiday hours.
- Identify need for additional service hours and types.
- Develop implementation and communication plans.
- Secure funding.
SECTION F: REDUCE ACCESS BARRIERS

RECOMMENDATION F6: Create psychological accessibility for clients by addressing cultural competency at the organizational level and among all staff in the behavioral health setting.

CRITERIA MET: Reduces practical barriers and increases social supports for clients and family members.

TIMEFRAME: Short-term

DESCRIPTION: Create an environment in the agency/organization which shows an appreciation for diversity throughout the agency. Create training and awareness programs for staff to increase awareness of psychological barriers for clients caused by limited cultural knowledge and sensitivity or the inability to communicate appropriate sensitivity.

In general the training will address the physical environment, material and resources, communication style, and values and attitudes.

RATIONALE/BENEFITS:
- Understanding other cultures and cultural impact on perception and behavior allows caregivers to provide better care to clients.
- Increases likelihood that clients will follow-through with treatment.
- Cultural sensitivity training fosters a team-oriented work environment and enhances staff morale and productivity.
- Improves client satisfaction, quality care and outcomes for clients.

BARRIERS:
- May require funding.
- Time involved in helping staff with attitudinal changes and knowledge based meaning.

NEXT STEPS:
- Determine interest of behavioral health organizations and staff in utilizing additional cultural competency training.
- Identify awareness and training program needs and develop or identify programs to meet needs. Partner with organizations to provide training/awareness programs.
- Coordinate with Coalition of Community Mental Health Centers’ work on cultural competency and certification program.
- Explore ways to work with colleges and universities to improve cultural competence among the behavioral health organizations’ workforce.
- Secure funding.

Physical Environment, Material and Resources:
- Display picture, poster and other materials that respect the culture ethnic background of those served and persons reflected in broader population.
• Magazines, brochures and printed materials in reception area and throughout the agency are interesting and reflect the different culture of clients seen.
• Videos, filming and other media resources for education, treatment and other interventions reflect those served and other cultures.

Communication Style:
• For those who speak other than English, attempt to learn key words in their language to promote better communication.
• Use visual aides and physical prompts and gestures to communicate.
• Use bilingual staff or trained/certified interpreters for assessment, treatments and other interventions. Work to put notices in the client’s language of origin.

Values and Attitudes:
• Avoid imposing values that may conflict or be inconsistent with those of culture and ethnic groups different from the major culture of the agency.
• Encourage everyone in the agency not to use racial or ethnic slurs.
• Screen movies, books and media resources for negative cultural, ethnic and racial stereotypes.
• Intervene in an appropriate manner when you observe staff, client or others in the agency engaging in behaviors that show cultural insensitivity, bias or prejudice.
• Recognize that family is defined differently by different cultures.
• Recognize that religions and other beliefs may influence how clients respond to illness, disease, disability and death.
• Beliefs about mental illness and emotional disability are culturally based. Accept that responses to these conditions and related treatment/interventions are influenced by culture.
• When treating persons from another culture, regardless of treatment setting, seek information on acceptable behavior, courtesies, customs and expectations that are unique to family groups served by the agency.
• Seek information from family members or other key community informants that will assist in service adaptation to better fit the preference of culturally and ethnically diverse clients served by the agency.
• Ensure that the agency’s mission statement, goals, policies and procedures, and web sites incorporate principles and practices that promote diversity and culture competence.
• Listen intently and work to make changes when persons from a different culture provide information which they feel shows lack of sensitivity for their culture.

Some material for this recommendation excerpted from the President’s New Freedom Commission report and resources from Georgetown University.
SECTION G: IMPROVE CRISIS SERVICES

RECOMMENDATION G1: Develop comprehensive crisis management systems to ensure appropriate levels of care.

CRITERIA MET: Improves coordination between community and inpatient services. Streamlines care coordination and service delivery.

TIMEFRAME: Long-term

DESCRIPTION: Develop comprehensive crisis management systems to ensure clients receive care in the least restrictive setting. The systems will include a broad continuum of care for crisis situations, including but not limited to, emergent situations, residential crisis stabilization, inpatient care, crisis respite, 23-hour observation beds and 24/7 mobile crisis response units. Services would be co-located with law enforcement, medical care and social service agencies where appropriate. Systems may also coordinate additional service(s) as needed, such as housing and employment. Related to recommendations F2 (develop a virtual crisis center) and F3 (develop a warm hand-off for individuals); also related to recommendation E7 (streamline and enhance a continuum of care).

RATIONALE/BENEFITS:
∞ May decrease reliance on emergency rooms for non-emergent cases.
∞ Encourages care in the least restrictive setting for the client.
∞ Increases utilization of out-patient/community services.
∞ Improves collaboration among inpatient and community providers.

BARRIERS:
∞ No single entity identified to manage comprehensive crisis management system.
∞ May require funding.
∞ Limited transportation options available to clients.

NEXT STEPS:
∞ Identify components of comprehensive crisis management services, including services already provided in region and services that need to be developed.
∞ Gather clinical data of current users of the crisis system and use case modeling based on that data.
∞ Identify organization to develop and manage crisis management system.
SECTION G: IMPROVE CRISIS SERVICES

RECOMMENDATION G2: Explore 24/7 diversion options from emergency rooms for individuals with non-emergent behavioral health issues.

CRITERIA MET: Improves coordination between community and inpatient services.

TIMEFRAME: Short-term

DESCRIPTION: Reduce unnecessary use of emergency room services through a pilot project designed to redirect individuals with non-emergent behavioral health needs to care in a community setting. The pilot project may include co-locating staff in the emergency room who have expertise in working with behavioral health needs, such as a case manager, or developing an actual site specifically created to work with individuals with urgent behavioral health needs. Expand current detoxification services to accommodate immediate access needs.

RATIONALE/BENEFITS:
- Decreases reliance on emergency rooms for non-emergent cases.
- Increases utilization of out-patient/community services.
- Encourages care in the least restrictive setting for the client.

BARRIERS:
- May require funding.
- COBRA/EMTALA and Medicare/Medicaid regulations that require certain processes once an individual is at an emergency room facility.
- Limited time and training to complete accurate assessments.
- Limited capacity in community-based settings to meet needs of clients.
- Limited types of community-based services and treatment options currently available.
- Limited availability of physicians and/or psychiatrists at alternative care sites.
- Limited transportation options available to clients.

NEXT STEPS:
- Gather clinical data of current users of the crisis system and use case modeling based on that data.
- Explore legal liabilities of “step-down site” and/or hospitals due to medical co-morbidities and severity of patient illnesses, if “step-down site” is proposed.
- Develop a pilot project, and identify hospitals and other providers willing to participate in it.
- Implement pilot project.
SECTION G: IMPROVE CRISIS SERVICES

RECOMMENDATION G3: Create a regional crisis center (web-based crisis center) to help determine best alternatives for crisis/triage services.

CRITERIA MET: Improves coordination between community and inpatient services.

TIMEFRAME: Long-term

DESCRIPTION: Create a regional crisis center (web-based) that connects emergency rooms, community mental health centers, alcohol and drug abuse providers, crisis lines, etc., and allows staff at participating facilities to determine the best alternatives for crisis/triage services. For example, staff at a crisis line would be able to access the crisis center to determine available inpatient beds in the case of an emergency, or set a next-day appointment with a provider for an urgent need.

RATIONAL/BENEFITS:
- May decrease reliance on emergency rooms for non-emergent cases.
- Increases utilization of outpatient/community services.
- Improves collaboration among inpatient and community providers.

BARRIERS:
- Requires funding.
- Requires on-going management and updating.
- Limited awareness of available resources among providers.

NEXT STEPS:
- Evaluate providers willing to participate.
- Determine whether to create a new or expand on an existing database, and who will be responsible to maintain it.
- Secure funding.
SECTION G: IMPROVE CRISIS SERVICES

RECOMMENDATION G4: Develop a “warm hand-off” for individuals who visit emergency rooms with an urgent need, but who do not need to be admitted as an inpatient.

CRITERIA MET: Improves coordination between community and inpatient services.

TIMEFRAME: Short-term

DESCRIPTION: Develop resources/programs that are available 24/7 to provide safe oversight and follow-up care for individuals who visit an emergency room with an urgent need, but are not admitted for inpatient care. The teams may provide crisis stabilization, 23-hour crisis respite beds, case management or other services. A “warm hand-off” includes identifying the best available resource/provider agency for the client/individual, assisting the client/individual in contacting the referral source and overcoming any barriers to accessing the care, and following-up with the client/individual to make sure s/he connected with the appropriate resource/provider agency.

RATIONAL/BENEFITS:
∞ May decrease reliance on emergency rooms for non-emergent cases.
∞ Encourages care in the least restrictive setting for the client.
∞ Increases utilization of out-patient/community services.
∞ Improves collaboration among inpatient and community providers.
∞ Increases likelihood client receives necessary and appropriate treatment.
∞ May allow for detoxification in a safe, appropriate setting.

BARRIERS:
∞ Requires funding.
∞ Limited types of community-based services and treatment options currently available.
∞ COBRA/EMTALA and Medicare/Medicaid regulations that require certain processes once an individual is at an emergency room facility.
∞ Need to ensure medically necessary care is provided.
∞ Limited transportation options, especially in rural areas.
∞ Limitations of target and priority population eligibility requirements.
∞ Current capacity in the behavioral health system is very limited; resources for treatment may not be available.
∞ If the recommended process works, it may result in an unintended increased use of emergency departments for assessment and admission into the behavioral health safety net system.

NEXT STEPS:
∞ Identify organization(s) able to staff teams.
- Define “urgent need” for emergency rooms and establish criteria for when resources/programs would be appropriate.
- Identify funding source(s) and available services.
SECTION G: IMPROVE CRISIS SERVICES

RECOMMENDATION G5: Establish outreach and crisis behavioral health services for young adults (ages 17 – 23).

CRITERIA MET: Improves coordination of behavioral health. Reduces practical barriers and improves social supports for clients and family members.

TIMEFRAME: Long-term

DESCRIPTION: Establish outreach and crisis behavioral health services for young adults (ages 17 – 23) who need behavioral health services.

Include specific plans to assist young adults transitioning out of the foster care system. Providers of services for young adults will identify client’s need for on-going treatment and establish contact with a provider(s) in behavioral health system. Young adults will receive a “warm hand-off” to the adult system, including assistance in contacting the referral source and overcoming any barriers to accessing the care, and follow-up to make sure s/he connected with the appropriate resource/provider agency. Coordinate with Missouri Department of Mental Health grant to improve transitions for this population.

RATIONALE/BENEFITS:
∞ Increases likelihood that clients will follow-through with treatment.
∞ Simplifies points of entry to make it easier for individuals.
∞ Outreach services may reduce and/or eliminate need for crisis services later on.

BARRIERS:
∞ Limited knowledge of available resources among young adult services providers.
∞ Limited staff time to ease transitions for young adults.
∞ Limitations on availability of services and young adult eligibility for services.
∞ Potential legislative changes required.

NEXT STEPS:
∞ Identify a coordinated resource to serve as a contact for young adult service providers in the Eastern Region.
∞ Distribute contact information to providers of young adult services.
∞ Continue to educate and inform providers of young adult services about available resources.
∞ Identify gaps in young adult behavioral health service system.
∞ Explore ways to develop leaders in young adult target population.
∞ Identify funding to support priority young adult behavioral health services.
SECTION H: REDESIGN ASSESSMENT AND SCREENING PROCESS

RECOMMENDATION H1: Utilize a standardized screening and common assessment tool(s) for use by all behavioral health providers/organizations. Also encourage informal entry points to use standardized screening tool.


TIMEFRAME: Short-term

DESCRIPTION: Standardized screening and common assessment tool(s) will help providers/organizations share basic information about clients instead of requiring clients to provide the same information multiple times. The tool(s) will coordinate with the alcohol and drug abuse tool already being used by providers. The tool(s) will work like a flow chart, with different questions based on different levels of care and service needs, so the assessor only needs to use the appropriate sections of the tool(s). The tool(s) will be part of the master patient index (see recommendation I1). Train and credential staff to ensure competency and quality assurance in use of the tool(s). Staff training should include elements of cultural competency.

A standardized screening tool will determine the likelihood that an individual has a mental health problem and/or substance-use problem and direct the individual and screener to the appropriate level of care. The screening is less involved than an assessment, but it establishes the need for an in-depth assessment. Informal entry points into the behavioral health system will be encouraged to use the screening tool as a way to evaluate the likelihood that an individual needs an in-depth assessment. Informal entry points will forward information they gather as part of the initial screening on to a provider in the behavioral health system. To the extent possible, behavioral health providers/organizations will agree to recognize and utilize one another’s completed screenings.

The common assessment tool(s) will determine the client’s readiness for change, identify client strengths or problem areas, link to a level of care and engage the client in the development of an appropriate treatment program. The assessment tool(s) should assess co-occurring disorders (substance abuse and mental illness), evaluate functioning in multiple domains, use standardized measures, and be culturally appropriate (Center for Mental Health Services Research). The assessment tool(s) should also assess other issues, such as physical health and developmental disabilities, for referral as appropriate. To the extent possible, behavioral health providers/organizations will agree to recognize and utilize one another’s completed assessments.

Related to recommendation E5 regarding a database of providers and services.

RATIONALE/BENEFITS:
- Simplifies points of entry to make it easier for individuals.
- Increases likelihood client will follow-through to receive care.
• Reduces barriers to access and duplicative work.
• Enhances provider efficiency.
• Results in more time available for client care.
• Increases collaboration among behavioral health providers.

BARRIERS:
• May require legislative or regulatory action.
• HIPAA requirements.
• Requirements of providers’ accreditation and funding organizations.

NEXT STEPS:
• Organize a group to develop the tool(s). The group will:
  o Identify core information needed by all agencies.
  o Identify additional information that should be included on screening and assessment tool(s), as identified by evidence based practices.
  o Identify existing screening and assessment tool(s) for possible adaptation/adoption.
  o Identify practical means to share the information among providers/agencies (master patient index).
• Coordinate with the Missouri Department of Mental Health to ensure they will accept and approve the screening and assessment tool(s).
• Develop inter-agency agreements among providers/organizations to share information and meet HIPAA requirements.
SECTION H: REDESIGN ASSESSMENT AND SCREENING PROCESS

RECOMMENDATION H2: Cross-train staff in diagnosing co-occurring (mental health and substance use/abuse) needs and diagnosis and physical health needs (for referral).

CRITERIA MET: Improves coordination of behavioral health. Streamlines care coordination and service delivery.

TIMEFRAME: Short-term

DESCRIPTION: Cross-train staff in co-occurring needs and diagnosis so that they are able to more accurately diagnose clients and ensure the clients receive appropriate treatment.

RATIONALE/BENEFITS:
∞ Increases coordination among mental health and alcohol and drug abuse providers.
∞ Meets clients’ needs more efficiently.

BARRIERS:
∞ Limited staff time to attend training or train staff at other agencies.
∞ Organizations and staff may have difficulty acknowledging and addressing co-occurring issues.
∞ May require funding.

NEXT STEPS:
∞ Encourage organizations to cross-train staff on an on-going basis.
∞ Identify staff “experts” who are able to train other organizations’ staff.
∞ Explore co-credentialing process among providers for staff members who conduct screenings and assessments.
∞ Coordinate with the Missouri Department of Mental Health efforts to credential co-occurring treatment programs.
SECTION I: DEVELOP A MASTER PATIENT INDEX

RECOMMENDATION II: Develop a web-based Master Patient Index system that combines behavioral health with a primary care home.


TIMEFRAME: Long-term (requires funding)

DESCRIPTION: Develop a collaborative, web-based Master Patient Index across all behavioral health safety net providers to allow tracking of patients within the safety net. The MPI includes demographic information, behavioral health and primary healthcare home information, case manager and physician contact information, medication information and discharge status. Includes inpatient and outpatient information. Coordinates with the Missouri Department of Mental Health Client Information Management Outcomes and Reporting (CIMOR) system and the St. Louis Integrated Health Network efforts. Related to recommendation D1 regarding integration of behavioral and physical health.

RATIONALE/BENEFITS:
∞ Provides practitioners real-time information to help assess the client’s physical and behavioral health condition and optimize care.
∞ Reduces risk of medication errors and adverse drug reactions.
∞ Ensures continuity of care through medical and behavioral health information that is accessible at all providers.
∞ Enhances provider productivity and communication across providers.
∞ Enhances staff productivity (reduces phone calls, chart pulls and need to manually copy and send records, etc.)
∞ Provides accurate and timely information specific to each client/patient.

BARRIERS:
∞ Requires funding.
∞ Need to integrate existing clinical information systems across providers.
∞ Need to integrate with physical health providers.
∞ Need to ensure compliance with HIPAA regulations.

NEXT STEPS:
∞ Assess the interest of behavioral health provider leadership and the Missouri Department of Mental Health in building the capacity to share patient information electronically.
∞ Assess technical feasibility.
∞ Determine a potential implementation schedule and costs. Coordinate and link with DMH information.
∞ Ensure compliance with HIPAA regulations.
∞ Secure funding.