Eastern Region Behavioral Health Initiative
Improving Entry Recommendations for the ERBHI Access System
Concept Proposal

BACKGROUND
The Improving Entry Implementation Team held three subcommittee meetings over the month of August to discuss how to implement the vision of the Improving Entry Task Force (a task force with representatives from the Steering Committee, the Behavioral Health Advisory Board and the Improving Entry Implementation Team). The Task Force vision is to create a behavioral health care system that provides persons seeking information and/or services with one contact to access mental health and substance abuse services in the Eastern Region; the system focuses on the individual seeking behavioral health services, shares information, is efficient, and is value-added for the Eastern region.

ERBHI ACCESS SYSTEM PROPOSAL – HOPE
Each of the subcommittees looked in-depth at different areas related to access in the behavioral health system. Together, they propose the development of HOPE, a regional phone center that can be accessed (see Diagram A):

- By an agency staff member who has determined that his/her agency cannot appropriately serve the individual seeking services (either because of a waiting list or because the needed services are not provided by the agency), or
- By an individual seeking behavioral health services calling the phone center directly, or
- By a community organization (such as United Way’s 211 or a community provider) that needs to provide additional assistance to an individual seeking behavioral health services.

Regardless of how the HOPE regional phone center is accessed, it will provide the individual seeking behavioral health services with:

- ERBHI screening\(^1\) (if it has not already been completed or updated to provide the most current information),
- Referral\(^2\), including working with the individual until an appointment is made and kept at the appropriate agency, also making a connection with immediate crisis services the collaborations with crisis information and help lines in established organizations (i.e. NCADA help line) if needed, and
- Client engagement\(^3\) until individual is linked to appropriate services.

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1 Defined as providing the initial identification of the type of services an individual is seeking and identifying the reason the individual is seeking services. A screening also assesses the type and degree of an individual’s behavioral health condition to determine whether services are needed.

2 Defined as linking the individual to the most appropriate and available service.

3 Defined as the process of developing a trusting relationship, reaching out to the client, empathically understanding their situation and goals, offering practical assistance, and eventually helping them to understand that treatment can help him or her to reach those goals.
The HOPE regional phone center will be staffed using consumers and provider staff – a combination of peer specialists and supervising community support workers who will provide screening and engagement services for individuals seeking services. These individuals will be supported by staff from CPS and ADA agencies (staff may have temporary assignments or serve on a rotating basis⁴). All staff working in the HOPE regional phone center will have appropriate training to handle the calls that are received. A more detailed staffing plan will be developed in the coming months. The peer specialists or community support workers will be reimbursable through Medicaid.

The Improving Entry team recommends that the HOPE regional phone center be located within a facility that has the existing technology to support the center to leverage existing expertise and be coordinated with existing consumer organizations with warm lines that provide similar services.

The team will explore a variety of funding options pending approval from the Steering Committee.

**HOPE Screening Process**

The ERBHI Access Tool (currently, the online screening tool) will remain an online database, but will be modified to a short, cascading tool that collects a minimal amount of information at the beginning, but allows for more detailed data collection and screening as appropriate (see Diagram B).

Proposed Procedure for Completing the ERBHI Access Tool

- **All calls** - All points of contact, except United Way’s 211, will be required to collect a caller’s basic information (eight demographic points of information), identify if a caller is in crisis, and identify the primary purpose of all calls in the ERBHI Access Tool.

- **Mental Health** - If the caller has a mental health issue, the screener is required to complete the suicide risk assessment and ask if the caller has been seeing anyone for help with mental health issues.
  - If the caller has seen or is seeing someone for help with mental health issues and appropriate for services, agencies will be required to collect information on the presenting problem, current diagnosis, treatment history, mental health provider and Cage Aid Substance Abuse Screening
  - If the caller has NOT seen someone for help with mental health issues and/or inappropriate for services, agencies have the option to complete the Mental Health Screening Tool (TBD) and the Cage Aid Substance Abuse Screening or transfer the call to HOPE (referral process outlined below).

- **Substance Abuse** - If the caller has a substance abuse issue, the screener is required to complete the suicide risk assessment, collect the client’s treatment history and complete the Cage Aid Substance Abuse Screening Tool and the Mental Health Screening Tool (TBD).
  - If the call is determined inappropriate for the provider’s services, the provider may continue to complete the screening or may transfer the client to the HOPE regional phone center (referral process outlined below).

- **Other needs** - The process for calls received with other primary purposes (information only, supportive services, etc.) will be outlined in detail in the coming months. However, the basic

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⁴ Supervision of peer specialists will not be a rotating responsibility.
principle will continue to be that a provider may refer a caller (referral process outlined below) to the HOPE regional phone center if/when the provider realizes they are unable to serve the client.

**HOPE Referral Process (Warm Hand-off)**

If an agency receives a call and determines that the caller cannot be served by the agency, the following steps will occur:

- Agency receiving the call completes entering data in ERBHI, makes a call to HOPE, transfers the caller to a live person and stays on the line to ensure the transfer is made.
- HOPE utilizes data collected in ERBHI and collects additional information, as needed, to make an appropriate referral, taking into consideration available services.
- HOPE offers several options for services and providers to the client and allows the client the opportunity to make an informed decision on the desired service provider.
- HOPE transfers the caller to a live person (at the agency of the client’s choice) and stays on the line to ensure the transfer is appropriate and a connection is made.
- If appropriate services are unavailable, HOPE remains engaged with the client and offers interim services through partnerships with peer-managed agencies (i.e. Self-help Center, Empowerment Center, NAMI help line) until the appropriate services are available. Interim services may include, but are not limited to:
  - Connection to the region’s warm-line hosted by the Empowerment Center
  - Connection with drop-in centers
  - Connection with support groups and/or self-help organizations such as Alcoholics Anonymous or other similar organizations, Mental Health Association groups, NAMI groups, procovery circles, etc.
  - Crisis oriented services
  - Contacting the individual on a regular basis
  - Interim case management
- All involved agencies are responsible for updating respective dispositions (outcomes of calls/transfers) in ERBHI.
- Additional requirements to be determined.

**HOPE Business Case**

- **Benefit**
  - Focuses on the individual seeking behavioral health services
    - Facilitates access to care
    - Involves consumers in the process:
      - Supports the consumer choice model
      - Aides in the reduction of stigma
      - Develops career paths for consumers
    - Allows time for the individual seeking services to tell their story and experiences
      - Provides one number and one place for them to tell their story
    - Has the ability to allow for the identification and tracking of regionally identified high utilizers
    - Communicates hope to individuals seeking services
Remains engaged with individuals seeking services until appropriate services are available

- Is able to share information
  - Allows for the collection of regional data
    - Waiting List of individuals who are in need but unable to receive services
      - Identifies need for behavioral health services in the region
    - Number and efficiency of referrals
- Is efficient
  - Eases the burden of referral from providers
  - Has the ability to identify cases/clientele for agencies
  - Provides current and reliable information on available services across disciplines
- Is value added for the Eastern Region
  - Allows individual agencies to retain control of access
  - Allows for the possibility of Medicaid funding.
  - Builds on the region’s existing expertise and strengths
  - Models a similar system in Maine
  - Engages advocacy organizations
  - Builds trust among providers
  - Provides regional ownership and collaboration
  - Regional integrated model for access

Barriers

- CIMOR interaction
- Long-term sustainability
- Identifying the role of existing call centers (BHR and BJC BH)
- Duplicative of existing services (i.e. NCADA information line, LifeCrisis, Provident Call Center, etc.)
- Opening up access on the front end may highlight limited capacity on the back end
- HIPAA and 42 CFR
- Stigma, regarding staffing consumers
- Confusion and mistrust over ownership and monitoring
- If the HOPE phone center does not have the ability to schedule appointments in the long term, it will be an additional barrier to access instead of meeting its intended purpose of increasing access.
- Information captured in ERBHI tool must be viewed as reliable information to build from or providers will continue to duplicate screenings
- Short term goal – Clearly defined protocols should be established for how to track waitlists (both HOPE phone center and provider generated) to get individuals into care. Long term goal – there should not be a waitlist to manage.
- The fee-for-service up to a cap payment structure creates a need for agreement on how organizations will take referrals.
Diagram A
Proposed Model for ERBHI Access System

Unable to serve this client

HOPE Regional Phone Center

CPS Agency

Individual seeking services Access Points

Community ORganization (i.e. United Ways 211)

ADA Agency

Screening, Referral and Client Engagement services

Screened using ERBHI**

Screened using ERBHI**

Screened using ERBHI**

Peer-managed Agencies:
Self-help Center
Empowerment Center
NAMI help line

Assessment and Intake process

* Details on the referral process (warm hand-off) are provided on page 2 under the HOPE Referral Process section.

** Details on the screening process are provided on page 2 under the HOPE Screening Process section.
Diagram B
ERBHI Access Tool Flow Chart for Screening Process

Demographics

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Primary Purpose of Call

Behavioral Health

Physical Health

Supportive Services

Other

Tier 1 (required on all calls)

Tier 2 (required on all calls)

Suicide Risk Assessment

MRI

Medications

Counseling

Mental Health

Substance Abuse

Tier 3 (optional to complete if agency is unable to serve client)

Cage Aid SA Screening (TBD)

MH Screening Cage Aid SA Screening

MH Screening (TBD)

Tier 4 (optional to complete if agency is unable to serve client)