MISSOURI HOSPITAL ASSOCIATION

Elimination Of State-Operated Acute Psychiatric Inpatient And Emergency Services In Missouri

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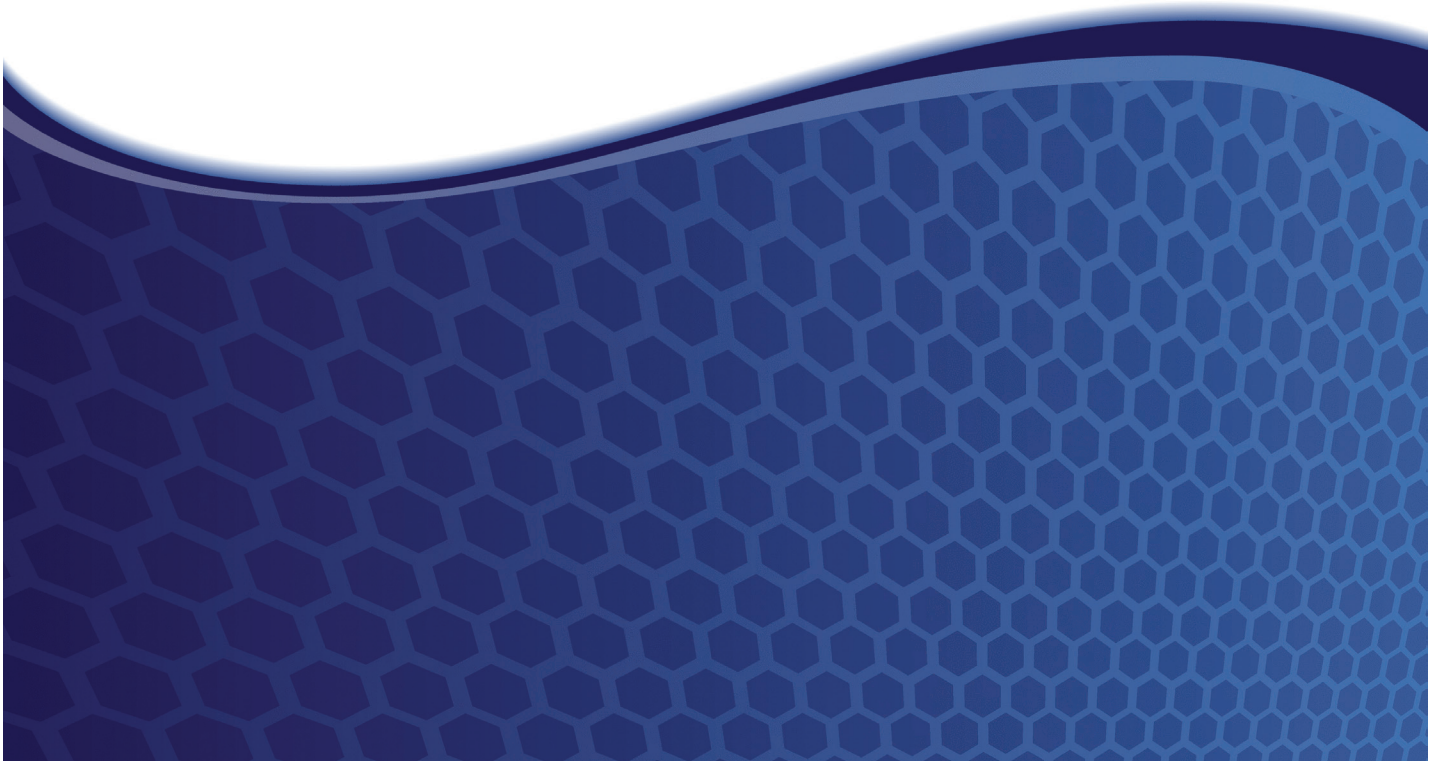


ELIMINATION OF STATE-OPERATED ACUTE PSYCHIATRIC INPATIENT AND EMERGENCY SERVICES IN MISSOURI

Introduction

This report provides an overview of the Missouri Department of Mental Health's closure or transfer of acute inpatient and emergency services from 2006 to 2011 and the subsequent effect on Missouri hospitals and behavioral health patients. The information used in this report is taken from administrative data submitted to the Missouri Hospital Association's Hospital Industry Data Institute, hospital surveys, DMH records and various publicly available reports. Additional information and insights were provided from interviews with hospital, community mental health center and DMH staff.

History

In the 1990s, Missouri was part of a national movement to move mental health patients out of state institutions and place them in their communities. From 1990 to 2008, DMH reduced the number of inpatient psychiatric beds it operated from 1,662 to 1,226. During this same period, private hospital beds decreased from 2,956 to 1,740. Although many of these reductions were the result of new and more effective psychotropic medications, enhancements in community-based care and a commitment to provide a more normalized living environment in community settings, cuts to DMH beds in recent years have been accelerated by the state's budget crisis.

The federal Institutions for Mental Diseases (IMD) law prohibits hospitals from receiving Medicaid reimbursement for inpatient stays for otherwise eligible individuals between the ages of 22-64. This exclusion raised real concerns about DMH's ability to provide quality acute care services given the state's low appropriated per diem rates. As a result, DMH began to decrease its adult inpatient beds in 2009. Today, DMH operates 1,228 beds and provides no emergency room services. Of these, only 32 are acute care beds (four for adults and 28 for children); 137 are intermediate or long-term stay hospital beds; 76 are adult residential/semi-independent beds; 48 are residential beds for children; and the remaining 935 beds are dedicated to sexual predators (178 beds), correctional patients with acute psychiatric needs (22 beds) and individuals with criminal court commitments associated with a mental illness (735 beds).

With the loss of acute care beds and reduction in long-term hospital beds operated by DMH, it has become increasingly difficult for private psychiatric providers to find psychiatric beds. This is especially true for patients who present with levels of aggression greater than what is usually seen in private psychiatric settings and for an increasing number of psychiatric patients who present with chronic medical conditions. Patients with morbid obesity, congestive heart failure and chronic obstructive pulmonary disease often require special equipment such as CPAP machines, oxygen and mechanical beds with side rails to enable the head of bed to be raised and facilitate turning and getting out of bed. This equipment may increase the risk of suicide by ligature and increase scrutiny by surveyors. Returning troops from Iraq and Afghanistan needing mental health and substance abuse care have also increased demand. Compounding the problems created by the closure of DMH acute care beds and emergency departments is that funding for DMH community-based services has been cut by $17.2 million in the past three years.

The private sector responded to DMH cuts by increasing psychiatric beds from 1,740 in 2008 to 1,931 as of January 2012. However, providers report that of the total, 428 are child/adolescent beds and339 are

gero-psychiatric beds. The need for additional adult inpatient beds can be seen by the reported increase in boarding of psychiatric patients in the ED while awaiting inpatient psychiatric services. In a 2011 August MHA survey of 89 acute care hospitals, 76 percent reported boarding a total of 530 psychiatric patients awaiting admission during the previous week. An additional 18 patients were admitted to nonpsychiatric units because of the unavailability of psychiatric beds. The most patients were boarded in the St. Louis (157) and southwest (152) areas of the state. This may be because in August, the St. Louis Regional Psychiatric Stabilization Center and the temporary psychiatric facility of the St. John's Regional Medical Center in Joplin had not yet opened. St. John's Regional Medical Center was destroyed by a tornado in May 2011. Eighty percent of boarded patients were adults between the ages of 21 and 64. For purposes of the survey, psychiatric boarding was defined as holding a patient in the ED for more than two hours after the decision to admit was made.

Boarding Psychiatric Patients
MHA Survey of Emergency Department Directors
August 2011

MHA District	Hospitals Surveyed	Boarded Patients	Younger Than 21	21- 64	65 and Older	Total Boarded Past Week
Northwest - 1	11	55%	2	18	3	23
Kansas City - 2	9	78%	1	34	3	38
Central/North Central - 3	19	74%	8	25	2	35
St. Louis - 4	16	88%	23	121	13	157
Southwest – 5	15	87%	11	136	5	152
Southeast - 6	12	58%	8	61	7	76
Unknown	7	86%	12	30	7	49
Total	89	75%	65	425	40	530

The top reasons given for boarding patients were as follows.

- lack of accepting facility because of a lack of beds
- lack of in-house inpatient psychiatric beds
- lack of accepting facility because of patient condition/needs
- lack of appropriate transport services

Overview of Psychiatric and Substance Abuse Private Hospital Utilization Data (Adult 18 and Older)

In 2010, there were 48,867 adults admitted to private psychiatric units and hospitals in Missouri, excluding state and federal hospitals. This represents 6.7 percent of all adult admissions and 10 percent of all adult inpatient bed days. An additional 14,240 adult patients with a primary major psychiatric (7,379) or substance abuse diagnosis (6,861) were admitted to nonpsychiatric units. (See Appendix A to view the psychiatric and substance abuse diagnosis codes used in this report). Including these numbers increases the percentage of patients primarily admitted for psychiatric or substance abuse disorders to 8.6 percent and the percentage of bed days to 12 percent.

The average length of stay for all patients in psychiatric units was 6.8 days. The ALOS for patients in a psychiatric unit with a primary psychiatric diagnosis was 6.6 days and 4.1 days for patients with a substance abuse disorder. For patients admitted to psychiatric units with a primary diagnosis other than

a psychiatric or substance abuse disorder but with a secondary psychiatric or substance abuse diagnosis, the ALOS was the highest at 9.15 days. The ALOS for all adult hospital admissions was 4.4 days.

The south/central region had one of the highest rates of admission and lowest ALOS. The north region has the lowest number of psychiatric beds (17 per 100,000) and one of the smallest rates of admission. (See Appendix A for a regional map.)

Of the patients admitted to psychiatric units, 81 percent were discharged to a home setting, 9.3 percent to a long-term care facility, 6.4 percent to another health care facility and 3.2 percent to other settings.

There were a total of 1.9 million adult ED visits in 2010, and 50,958 of these patients had a primary diagnosis of substance abuse (22,489) or psychiatric disorder (28,469). This represented 2.7 percent of all ED visits. For ED patients with a primary psychiatric diagnosis, 19.5 percent were admitted or transferred to a hospital. Only 6.7 percent of all ED patients with a primary substance abuse diagnosis were admitted or transferred to a hospital. ED patients accounted for 41 percent of all psychiatric admissions and 51 percent of all substance abuse admissions to psychiatric units. There was an average of 11.2 psychiatric/substance abuse ED visits per 1,000 adult population. This average was higher for the Kansas City, southeast, southwest and south central regions. The psychiatric unit admission rate was highest in the southeast (17 percent) and may reflect the higher number of psychiatric beds (40 per 100,000) in the region.

Although the uninsured account for 31 percent of all psychiatric/substance abuse ED visits, they only account for 13 percent of all psychiatric unit admissions. This reduction may reflect the conversion from self pay to Medicaid after patients are admitted as inpatients. See Appendix A for detailed graphs.

Time Line of DMH Inpatient and Emergency Department Services Closures

Center for Behavioral Medicine, Kansas City (previously Western Missouri Mental Health Center)
June 2006 — Truman Medical Centers Inc. leases 25 beds from the Center for Behavioral Medicine (CBM).
June 2007 — CBM operates 50 adult acute, 10 children acute, 25 intermediate, 78 residential and 12 ED beds.
July 2009 — Operation of 25 acute care beds and the ED is transferred to TMC.
October 2011 — CBM operates 25 forensic, 40 intermediate and 68 residential beds. TMC operates 50 adult acute care beds and 12 ED beds.

Mid-Missouri Mental Health Center, Columbia (now the Missouri Psychiatric Center)
June 2007 — Mid-Missouri Mental Health Center (Mid-MO) operates 59 adult and 10 child acute care beds. ED services are operated by Mid-MO.
July 2009 — Mid-MO closes. University of Missouri Health Care opens 14 pediatric and 45 adult beds at that site, now named the Missouri Psychiatric Center (MUPC).
November 2011 — MUPC operates 44 adult and 14 pediatric acute care beds. ED services are provided through UMHC.

Metropolitan St. Louis Psychiatric Center, St. Louis
June 2007 — Metropolitan St. Louis Psychiatric Center (MPC) operates 100 adult acute care beds and ED.
December 2009 — MPC closes 50 acute care beds.
July 2010 — MPC closes ED, 25 more acute care beds and transitions these acute care beds to forensic treatment.

April 2011 — MPC closes remaining 25 acute care beds and repurposes these acute care beds for forensic treatment.
January 2012 — The St. Louis Regional Psychiatric Stabilization Center (PSC), as a joint venture of BJC Healthcare and SSM Health Care, licenses 16 acute care stabilization beds at MPC. A Crisis Access Service is slated to open in summer 2012 and the CMS Medicaid Emergency Psychiatric Demonstration Pilot Project will allow expansion to 25 and potentially 50 acute care beds.

Southeast Missouri Mental Health Center, Farmington
June 2007 — Southeast Missouri Mental Health Center operates 54 adult acute care beds and ED.
July 2010 — The Center closes ED and all remaining acute care beds. There are no plans to transfer or reopen the ED or acute care beds.

St. John's Regional Medical Center, Joplin
May 2011 — Because of the May 22 tornado, 41 psychiatric beds are taken out of service.
October 2011 — With assistance from DMH, St. John's Regional Medical Center reopens 32 beds at a temporary location.

Effect of the Closures on Providers and Patients

Center for Behavioral Medicine
Because acute inpatient services at CBM were assumed by TMC through a lease agreement with the State, the effect of closing DMH acute beds on providers and patients in the region was minimized. DMH provided $1 million in funding to assist with service transfers, and the Health Care Foundation of Greater Kansas City provided another $1 million. Although it served all walk-ins and direct admissions from police, CBM reported a 31 percent diversion rate during its last year of operation by the state. Under TMC management, the diversion rate has averaged about 10 percent. With the change, the focus converted from providing intermediate level of care to acute care; lengths of stay were significantly reduced and the area bed capacity increased. CBM currently operates 50 intermediate to long-term stay beds.

The biggest challenges TMC faced were the improvements that were needed to the physical plant and resources required to train employees who were needed to staff 50 additional beds and the psychiatric ED. Because the space is leased from the state, problems persist with the physical plant because the state has not been able to fund depreciation and repairs are not being made as needed. This past summer, the state ordered that all state buildings set thermostat temperatures at 78-80 degrees, excluding patient care areas. Because heating, ventilation and air conditioning systems not properly working and with the insufficient state funding to repair all of them, there were times when the patient care units were above 85 degrees.

The effect on providers and patients in the region also was possibly minimized because of an initiative started In January 2010. ReDiscover, a community mental health center and a contract provider of DMH, started the Hospital Diversion Initiative through a grant from the Health Care Foundation of Greater Kansas City. The initiative was formed to divert individuals with psychiatric and addiction disorders from hospitals to alternative services.

The target population included uninsured and underinsured Jackson County and Kansas City adult residents with co-occurring conditions who frequent EDs and inpatient services. Their incomes are below the federal poverty level, and many are homeless. As of August 2011, more than 350 people have received services.

Hospital diversion teams provide an immediate response to hospitals' requests for service, including short-term, intensive response (stabilization, respite care, intensive case management) and longer-term supports that promote self-sufficiency (disease management, recovery management, aftercare planning, housing and transportation). Treatment retention strategies include outreach, assertive engagement, support services and family member involvement.

Although ReDiscover led the initiative, collaborators included other CMHCs and hospitals in the Kansas City area. The funding for ongoing mental health treatment was provided through DMH and the Jackson County Mental Health Fund.

According to a 2011 summary (See Appendix B), the initiative had significant results including reduced hospital and/or psychiatric inpatient recidivism rates, cost reduction, improved engagement into community treatment, and decreased mental illness symptoms. Consult the summary for specific outcome data.

Mid-Missouri Mental Health Center

In 2009, the DMH conveyed the building that formerly housed Mid-MO to University of Missouri Health Care, with the option of it returning to the state if UMHC elects to stop operating inpatient psychiatric services during the next eight years. By the time services were transferred to UMHC on July 1, 2009, Mid-MO was operating only 46 beds, down from 69 beds in 2007. Funding totaling $13 million throughout two years was appropriated for remodeling the out-dated patient care areas. Since the transfer of services, the length of stay for adults has decreased to six days from the previous average of 12 to 15 days. The Missouri Psychiatric Center (MUPC) has seen a sharp increase in adult volumes, with approximately 400 patient assessments and 250 to 275 admissions to the adult units per month. Approximately 30 pediatric patients are admitted per month, with an average length of stay of seven days. Although the diversion rate is much lower than before 2009, there has recently been a steady rise in the rate. In October 2011, 99 patients were diverted because of a lack of beds.

The transfer of beds and services to UMHC has positively affected providers and patients in the area. They still see the same clientele and can see more patients because of greater efficiencies, but providers are still unable to meet the current demand. The most troubling issue has been that it is very difficult to get non-Medicaid patients into DMH contracted community-based services, resulting in high rates of readmission for that population. However, DMH annually provides $431,000 to Burrell Behavioral Health to support rapid uptake of MUPC discharges from the ED or inpatient unit into their aftercare program. Since implementation two years ago, the program has achieved 800 warm handoffs from MUPC. Currently there are 125 individuals actively engaged in the aftercare program. Studies are currently being conducted to determine outcomes and initial data shows a significant drop in readmission rate during the first year of implementation.

DMH also annually provides $767,000 to Pathways Community Behavioral Healthcare to operate a 16 bed intensive residential service in Jefferson City for patients needing transitional support before reintegration into the community. The transitional unit shortens lengths of stay by providing a "step-down" unit for patients coming out of acute psychiatric hospitalization who were not ready to be interfaced back into community programs.

Metropolitan St. Louis Psychiatric Center

With the planned closure of the center in July 2010, DMH committed to providing $2 million annually to support hospital and/or community-based alternatives in the DMH eastern region. At the request of DMH, the St. Louis Regional Health Commission (RHC) formed an MPC Acute Care/ED Closure Planning Group to develop a regional plan to manage the closures and to provide input to three teams: the Short-

term Crisis Management Team, the Community Access Transformation Team and the Long-term Acute Care Psychiatric Capacity Team.

The Short-Term Crisis Management Team and MPC Planning Group began meeting in May 2010. The group submitted an "Impact Statement" and "Emergency Response Plan" to the state Aug. 16, 2010, which are available online. These teams addressed immediate and short-term issues related to the closure of services at MPC.

With the completion of the Short-Term Crisis Management Team's deliverables in August 2010, the RHC convened a Regional Psychiatric Capacity Task Force to develop additional analysis and longer-term solutions for the closure of services at MPC. In October, the RHC approved the task force's plan as outlined in the "MPC Regional Psychiatric Capacity Analysis and Recommendations." The primary recommendations of the plan were as follows.

- Develop a psychiatric access service/brief treatment unit to address the short-term acute care losses caused by the closure of MPC inpatient beds and ED and position the region to respond if additional psychiatric inpatient beds are lost in the future. As a result, an innovative private/public partnership formed the St. Louis Regional Psychiatric Stabilization Center, which opened in January 2012. Startup funding for the center was provided by DMH ($1 million), and the St. Louis Regional Health Commission ($1.5 million). Commitments are in place for an additional $1 million in annual operating subsidy from DMH and up to $500,000 each from BJC HealthCare and SSM Health Care.

- Develop a plan to use CMHCs to provide next-day appointments for high-risk patients discharged from EDs and inpatient psychiatric units and facilities that accept involuntary commitments. As a result, DMH allocated a portion of the savings derived from the closure of MPC to six CMHCs participating in the Hospital-Community Linkages Project (HCL) under the Behavioral Health Network (BHN) of Greater St. Louis. BHN, a new independent nonprofit organization, was formed in 2010 to improve the region's community behavioral health services.

The Hospital-Community Linkages Project was established to facilitate referrals and improve care coordination for patients between local hospitals and community mental health providers in the eastern region. See Appendix B for an overview of the HCL Project. The project focuses on getting people quickly and effectively linked with a community-based behavioral health care home upon their discharge from inpatient care. A HCL Regional Action Plan was subsequently developed to facilitate a consistent and coordinated approach for clients referred from inpatient hospital units to recovery-oriented community services throughout the eastern region.

The primary target population for the HCL Project was adults who are discharged from acute care behavioral health units of community hospitals that accept involuntary commitments, have ongoing behavioral health needs and meet the following criteria.

- uninsured or have regular Medicaid coverage
- not currently linked with a service provider who can oversee/coordinate care
- have a qualifying mental health condition (serious mental illness)

According to the 2011 Behavioral Health Network of Greater St. Louis Hospital-Community Linkages Project Annual Report, preliminary data collected to date for the HCL project indicates some early success indicators.

- Appropriate referrals are consistently being made across all participating hospitals. Only 5 percent of referrals made did not meet the target population eligibility criteria, and 80 percent of the referrals resulted in a scheduled appointment with a community provider.
- The project appears to address a very high level of need for community behavioral health services in the region. The overall number of referrals and subsequent appointments scheduled in the first six months far exceeded the designated slots available.
- The preliminary kept appointment rate calculated for this project is 56 percent, higher than the national average for individuals discharged from hospital psychiatric units (based on a review of the literature that included studies with population and institutional characteristics similar to those in this project).

As indicated in the 2011 annual report, limitations exist with the first round of data, but it is significant to note that this is the first time ever that such data is being routinely and uniformly collected across the region. The HCL Project is already viewed as a major success because of the unprecedented level of coordination among all 17 participating providers in the eastern region. For a listing of the 10 hospitals and six CMHCs participating with the Behavioral Health Network and the data collected and analyzed, refer to the 2011 annual report.

Southeast Missouri Mental Health Center

In spring 2010, DMH convened the Southeast Regional Workgroup, which consisted of the region's CMHCs and representatives from SEMMHC. Although participation by area hospitals at the standing workgroup meetings was very limited because of the size of the region and the distances involved, the DMH regional executive officer met with and solicited input from hospital leaders on an ongoing basis. The regional group was directed to devise a multiyear plan to address the region's mental health needs without the availability of state-sponsored acute inpatient services and emergency rooms. DMH informed the Southeast Regional Workgroup that it would receive $3 million annually for mental health services to allocate across the region's 31 counties.

In July, the workgroup submitted the Southeast Community Planning Inpatient Redesign Workgroup Three-Year Service Plan and Allocation Recommendations to DMH. See Appendix B for the plan.

Hospitals in the immediate area were especially concerned that the short-term impact of the immediate closure of the acute care units and the ED at SEMMHC would cause great difficulties for patients and the hospitals. As a result, the hospitals requested workgroup support for a proposal to continue offering mental health stabilization services for up to six months at the state facility location or another location in the Farmington area to ensure a smoother transition to the system outlined in the workgroup plan. However, DMH was not in a financial position to continue to operate its existing acute care services or fund its equivalent at another location.

Although the workgroup and the DMH agreed to leave the ED space at SEMMHC open for up to six months, no alternate source of funding and no local hospital was found to operate the ED and stabilization center. A consensus was eventually reached that there was not a shortage of acute care hospital beds in the region if patients could be appropriately diverted from EDs and alternative accommodations for patients who no longer needed hospital care could be found.

The workgroup developed a continuum of care model to improve existing urgent care and intensive community-based services offered by CMHCs to provide crisis stabilization and alternatives to ED visits or hospitalization. It has often been said that to reduce psychiatric patient boarding in the ED, you must either move patients out the back door faster or keep them from coming in the front door. The St. Louis

CMHCs worked on providing immediate services post-discharge from the ED or inpatient stay — the back door. The southeastern CMHCs decided to work on keeping patients from coming to the hospital — the front door.

Priorities Established by the Southeast Regional Workgroup

1. Urgent Mental Health Care Services

Each of the six service areas was allocated $200,000 — for a total of $1.2 million — to create or enhance site-based and mobile urgent mental health care services in the community to meet short-term, urgent needs and divert patients from coming to the EDs for care.

Higher populated areas would use a more intensive urgent mental health model with these and other components.

- qualified master's prepared staff available every day on location and mobile
- two staff on call at night in the ED and other sub-acute locations completely dedicated to this task
- extended walk-in and after-hours services
- options for same day/next day appointments and on-call availability during evenings, nights and weekends

Less populated rural areas would use a less intensive urgent mental health model and would be less likely to divert patients from EDs during off hours.

To support these urgent mental health services, allocated funding could be used to increase the number of qualified mental health professionals, specialty caseworkers, outreach staff and peer specialists; expand peer-to-peer training; enhance crisis hotline; expand walk-in hours; and create crisis teams.

2. Intensive Wraparound Stabilization Services

A total of $750,000 was allocated for creating or enhancing intensive community-based, wrap-around stabilization services to patients with substantial mental health needs who might otherwise be candidates for inpatient admission.

This allocation factored in the incremental client caseload changes for the Farmington service area throughout a three-year period, with the possibility for a Medicaid match for approximately half the clients served. This potentially makes the total amount $1.3 million.

- Year One: The Farmington service area received $250,000, and the remaining areas received $100,000 each.
- Year Two: The Farmington Service Area will receive $200,000, and the remaining areas will receive $110,000 each.
- Year Three: Allocation will be based on actual, adult population served in each service area.

3. Intensive Residential Treatment Services Beds

With the possibility of a Medicaid match, $1,050,000 was allocated to create 17 intensive, residential treatment services (IRTS) beds, potentially in six locations, to serve the immediate regional need for ED diversion options and for step-down beds for patients leaving the hospitals. The beds proposed for each area, with the possibility of more being available, were as follows.

Kennett:	four IRTS beds	Rolla:	two IRTS beds
West Plains:	four IRTS beds	Cape Girardeau:	three IRTS beds
Farmington:	three IRTS beds	Sikeston:	one IRTS bed

DMH reports that an evaluation process is underway to determine whether the changes were successful in reducing ED utilization and hospitalization in the southeast region.

Anecdotal Reports from Hospitals

In the August ED psychiatric boarding survey, ED directors also were asked to rate to what extent they agreed with a series of questions, with 5 being strongly agree, 4 agree, 3 neither agree nor disagree, 2 disagree and 1 strongly disagree. The chart below summarizes the responses of the respondents. With only 89 responding and a high rate of "unsure" responses, no definitive conclusions can be drawn about the data. Overall, the respondents disagreed with every statement. The results do indicate a need for crisis stabilization beds and for stronger ties between CMHCs and EDs.

Boarding Psychiatric Patients MHA Survey of ED Directors August 2011	
Care coordination in collaboration with community mental health providers has improved in the past six months in our ED.	2.5
In the past six months, the number of psychiatric patients boarded in the ED has remained about the same as the previous six months.	2.82
We are able to get same day or next day appointments for the Missouri Department of Mental Health's clients discharged from EDs who need urgent outpatient appointments.	2.45
We are able to get same day or next day appointments for non-DMH clients discharged from EDs who need urgent outpatient appointments.	2.35
To avoid psychiatric admissions, we are able to access a crisis stabilization bed in the community, when needed, for DMH clients.	1.78
Our CMHC or access crisis intervention center (ACI) provides valuable resources or assistance to our ED.	2.28
We frequently use our CMHC or ACI for assistance with evaluation and discharge planning.	2.42
Our CMHC or ACI is responsive to our needs.	2.4

Anecdotal responses to the survey illustrate the frustration felt by ED directors as they struggle to find inpatient psychiatric beds in a timely manner or make appropriate referrals to community-based services. Anecdotal reports of boarding of behavioral health patients for hours and even days in EDs or having to transport them across the state to find an available bed have substantially increased in recent years. This impedes the ability of EDs to provide timely, quality care to all patients seen in the ED. Boarding patients for days in the ED or transporting them across the state for treatment and away from their families negatively affects their recovery. The anecdotal responses also indicate a lack of knowledge about the community health system network of care system and a need for education and greater collaboration.

On the other hand, CMHCs are frustrated as well. Their state funding is insufficient for meeting all of the mental health needs in their service areas. Most of their state funding must be targeted to priority populations including people disabled by serious mental illness and individuals in forensic status.

Other Initiatives

In addition to the diversion and other crisis services described earlier, a number of other promising initiatives are underway.

The "Disease Management 3700" Project, implemented in November 2010, is a two-year collaborative project between MO HealthNet and the DMH to provide health care coordination for high cost, high risk Medicaid recipients with co-occurring medical and psychiatric conditions. The target population is individuals who incur $20,000 or higher annual total Medicaid costs (average cost is $50,000 per year), and are not currently enrolled in CMHC services. Specially trained CMHC staff locate these individuals and engage them in mental health services while attending to their physical health needs. To date, 1,872 individuals have been identified and enrolled in a CPR program and are receiving care coordination services. For the 1,298 enrollees who have been in the program for six months or more, there is a projected savings of $5.4 million annually.

Beginning in January 2012, Missouri pioneered a program for Medicaid beneficiaries with severe mental illness that is also based in CMHCs. The Missouri Primary Care Health Home Initiative provides care coordination and disease management to address the whole person including both mental illness and chronic medical conditions. The Health Home initiative is a partnership among Missouri's DMH, the MO HealthNet Division in the Department of Social Services, and the Missouri Coalition of Community Mental Health Centers.

CMHCs will be designated as the central care coordination site for patients without a regular primary care provider. All Missouri CMHCs have a primary care nurse liaison on site to educate the behavioral health staff about physical health issues, train case managers in recognizing and managing chronic medical conditions, and coordinating and integrating mental health disease management.

In addition to traditional behavioral health case management activities, the case managers will provide services such as assisting with adherence to medications, scheduling and keeping appointments, and obtaining a primary care provider. They will coordinate care across health care providers and between clinic visits.

Observations and Conclusions

Two years ago the behavioral health care system in Missouri was approaching a crisis state. State budget cuts led to the closure of acute psychiatric beds and emergency services in state-run mental health facilities and inadequate funding for community-based services. Too many behavioral health patients had no place to go for the care they needed.

During the past two years, DMH, private hospitals and CMHCs have worked together in certain areas of the state to develop and test innovative approaches to divert the crisis. Since 2008, private hospitals have increased the number of inpatient beds by 11 percent, from 1,740 to 1,931. Preliminary results indicate that CMHC initiatives have reduced readmission rates, ED visits and lengths of stay. Reallocation of DMH funds have created services that support more rapid uptake into community-based services and

the establishment of more crisis stabilization services and residential beds that provide alternatives to admission or step down care after discharge. Work remains in other areas to find funding to replicate these models.

Although careful planning has somewhat mitigated the effect of the elimination of state-operated acute psychiatric inpatient and emergency services, inpatient capacity remains inadequate at times in all areas and is more severe in some areas. Budget cuts and policies still make it difficult for many people to find timely outpatient psychiatric treatment in many communities, and they often must wait until a crisis occurs to receive treatment. The 24/7 availability of EDs makes hospitals the "safety net" or "provider of last resort" for behavioral health care. Many of these EDs are in general medical-surgical hospitals without psychiatric services and with limited access to behavioral health professionals. Because of this, patients are often boarded in EDs or transported across the state to find an available bed, which negatively affects patient care. A process is needed to be able to quickly locate appropriate inpatient beds.

Policymakers and practitioners agree that patients with mental illnesses are best cared for in community settings close to home before they face a crisis situation. However, adequate funding for local community resources has never been fully in place beyond the narrow group of patients with severe and persistent mental illness. Although CMHCs have proven to be a valuable service and their expansion into health homes may provide additional services for Medicaid patients, the hospital remains the primary behavioral health care provider for many of the uninsured and patients not covered by Medicaid.

Psychiatric units and CMHCs continue to struggle with the shortage of psychiatrists in the state. According to the Missouri Department of Health and Senior Services, there are only 637 licensed psychiatrists in the state, and 46 are certified in only child and adolescent psychiatry. Of added concern, is the 23 percent of licensed psychiatrists who are older than 65. This shortage could be somewhat mitigated through telepsychiatry involving out-of-state providers, but payment is not allowed under Missouri's Medicaid program. MO HealthNet's policy prohibits payments to Missouri licensed physicians who do not reside in Missouri or the contiguous states. Allowing psychiatrists who are licensed in Missouri but live across the country to see Missouri Medicaid patients via telepsychiatry could help reduce ED visits, hospitalizations and lengths of stay.

A system may need to be developed to provide psychiatric consultation to EDs in hospitals without psychiatric services. Connecting hospital EDs with mental health professionals through video consults 24/7 and medical record sharing may improve patient flow and care. In addition, there may be opportunities for hospital EDs to contract with local CMHCs to better facilitate the provision of mental health services in the ED and to support rapid uptake into community-based services.

This report demonstrates that policy makers, hospitals and CMHCs have the ability, capacity and trust to collaboratively address the challenges of providing quality care to behavioral health patients in Missouri. Much work remains, however. Stakeholders need to continue to monitor and assess the effectiveness of ongoing initiatives, build relationships and form partnerships to find the ways and means to more effectively deliver behavioral health services in the future.

Appendix A

Psychiatric and Substance Abuse Diagnostic Codes Used in Report

Inpatient Psychiatric Unit Admissions, Private Hospitals, 2010 Graphs

Psychiatric and Substance Abuse Emergency Department Visits, Private Hospitals, 2010 Graphs

Missouri Hospital Association Inpatient and Emergency Psychiatric Services Report Study Regions

Psychiatric and Substance Abuse Diagnostic Codes Used in Report

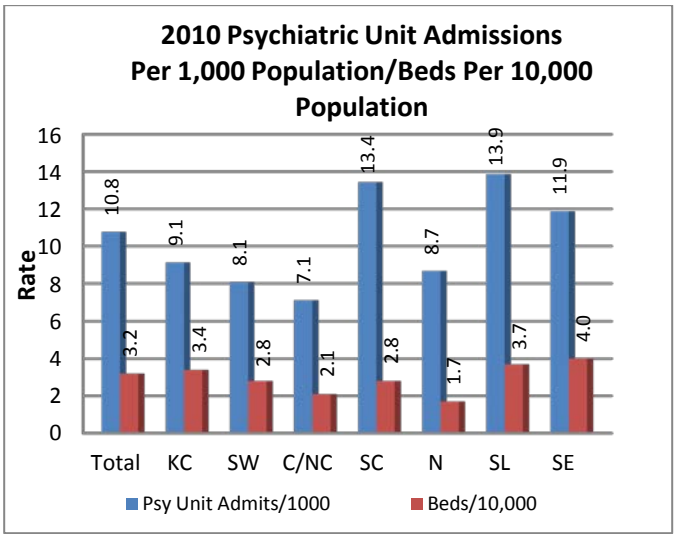
The following ICD-9-CM diagnosis codes were used for psychiatric conditions: 295, 296, 297, 298, 300 and 301.

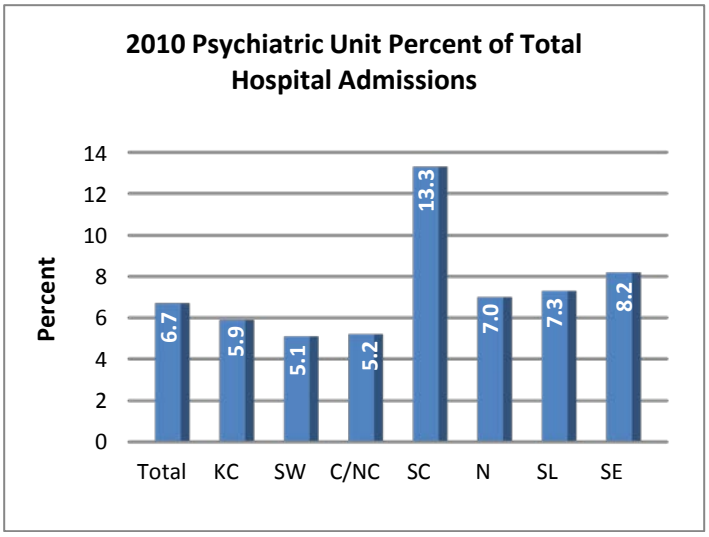
Note: The ICD-9-CM diagnosis code V62.84, suicide ideation, was not included in the study. There were an additional 2,688 patients seen in the emergency department with V62.84 as the primary diagnosis. There were 52 patients admitted with V62.84 as the primary diagnosis.

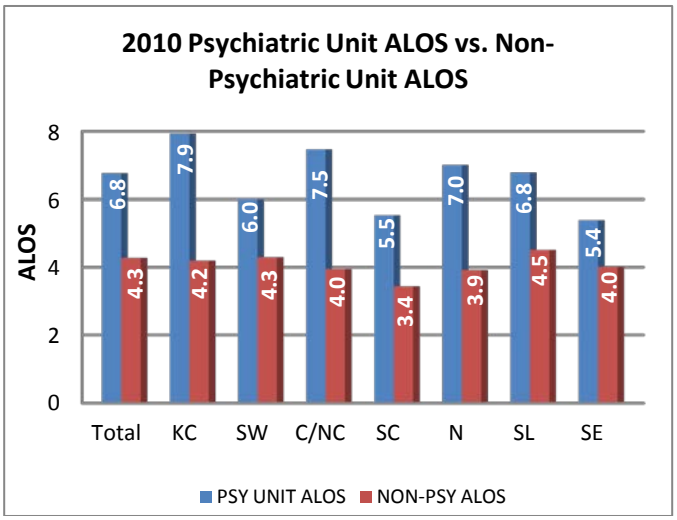
The following ICD-9-CM diagnostic codes were used for substance abuse conditions: 291, 292, 303, 304 and 305.

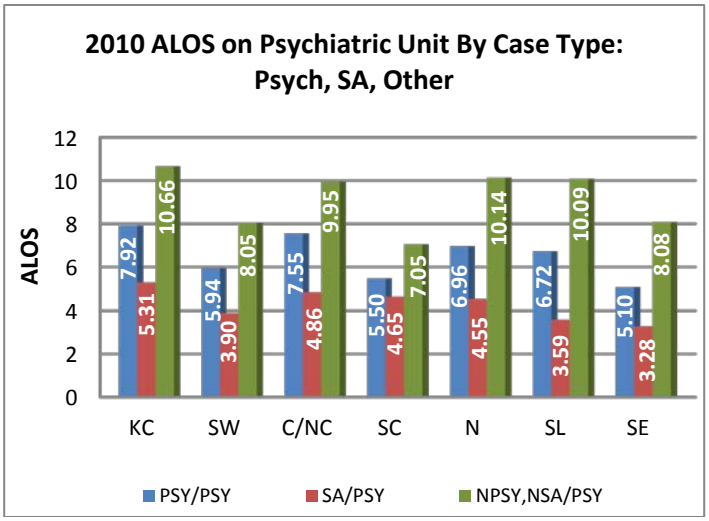
INPATIENT PSYCHIATRIC UNIT ADMISSIONS
PRIVATE HOSPITALS, 2010

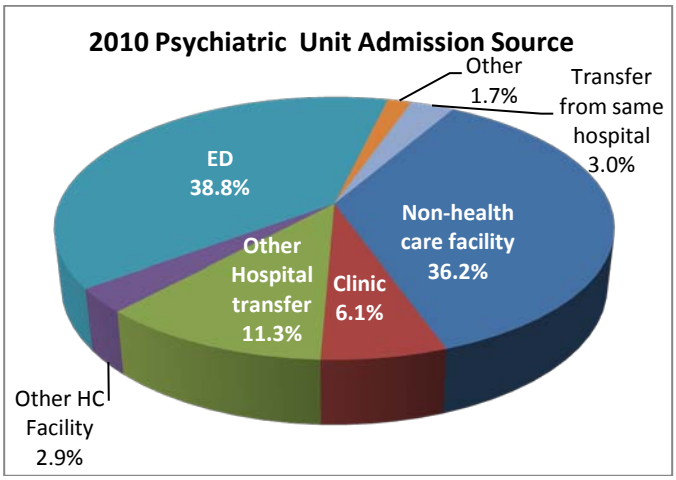
Graphs represent patients age 18 and older in private acute care and psychiatric hospitals. (Excludes children's, rehabilitation, long term care, federal and Department of Mental Health hospitals)











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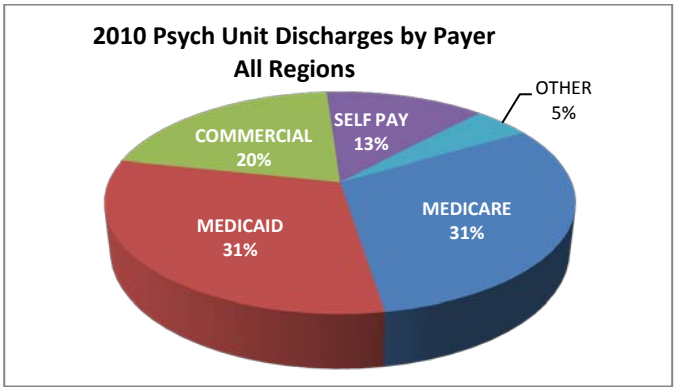

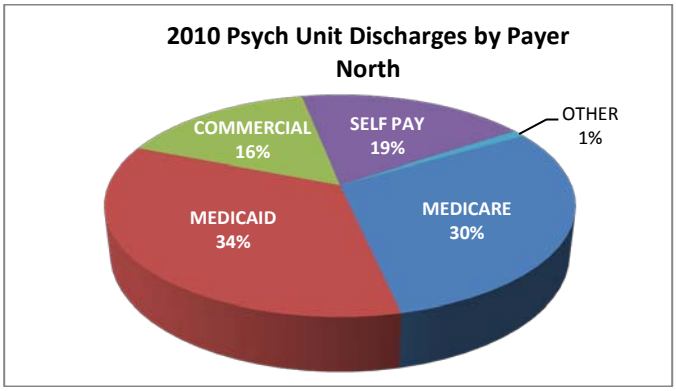

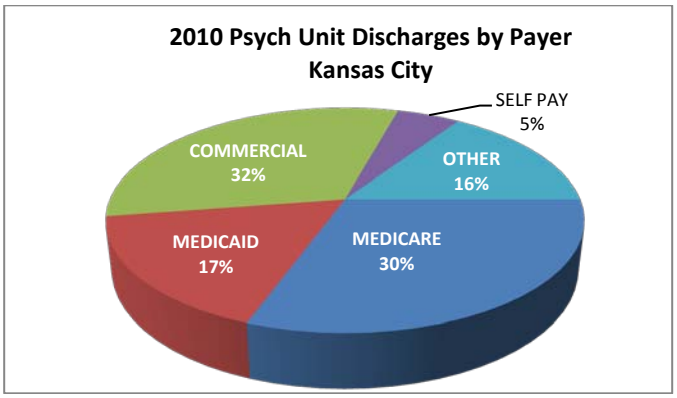

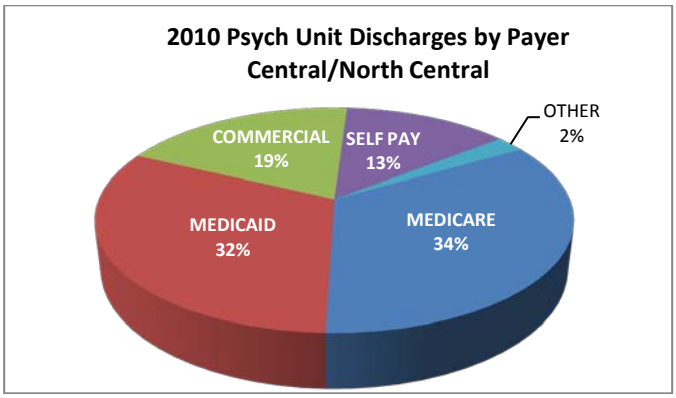

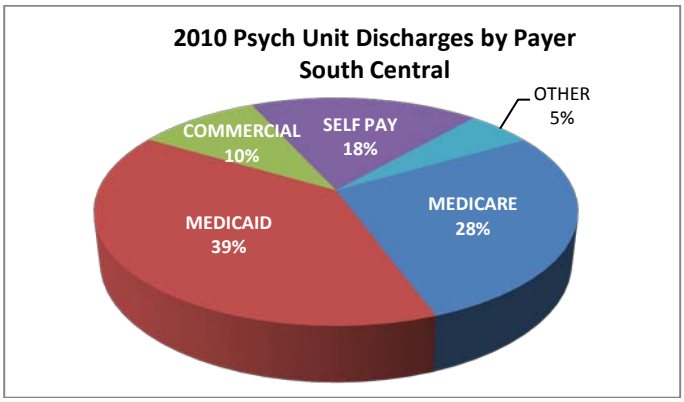

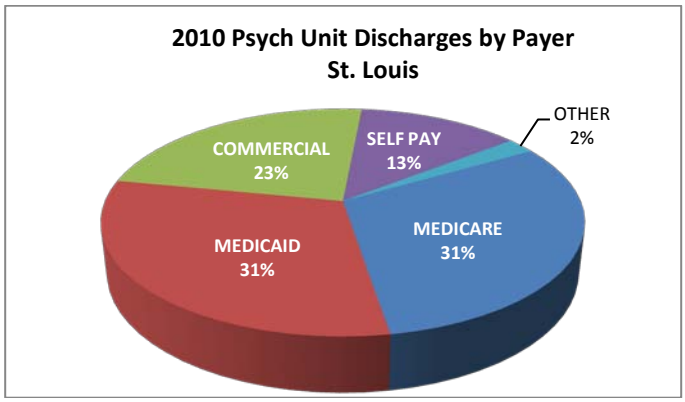

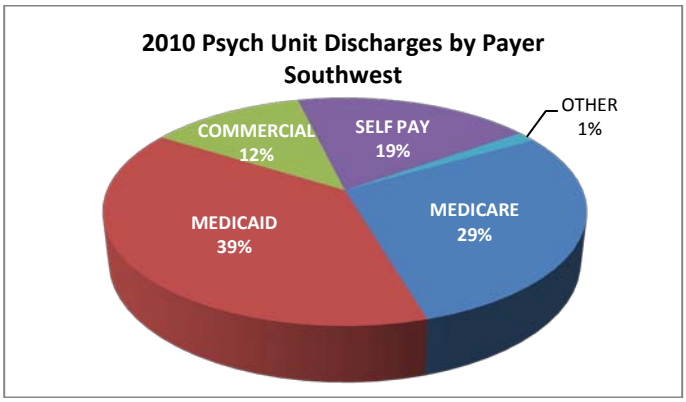

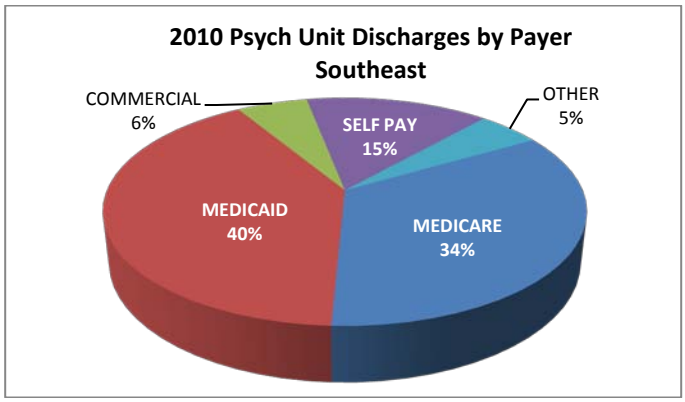

PSYCHIATRIC AND SUBSTANCE ABUSE EMERGENCY DEPARTMENT VISITS PRIVATE HOSPITALS, 2010

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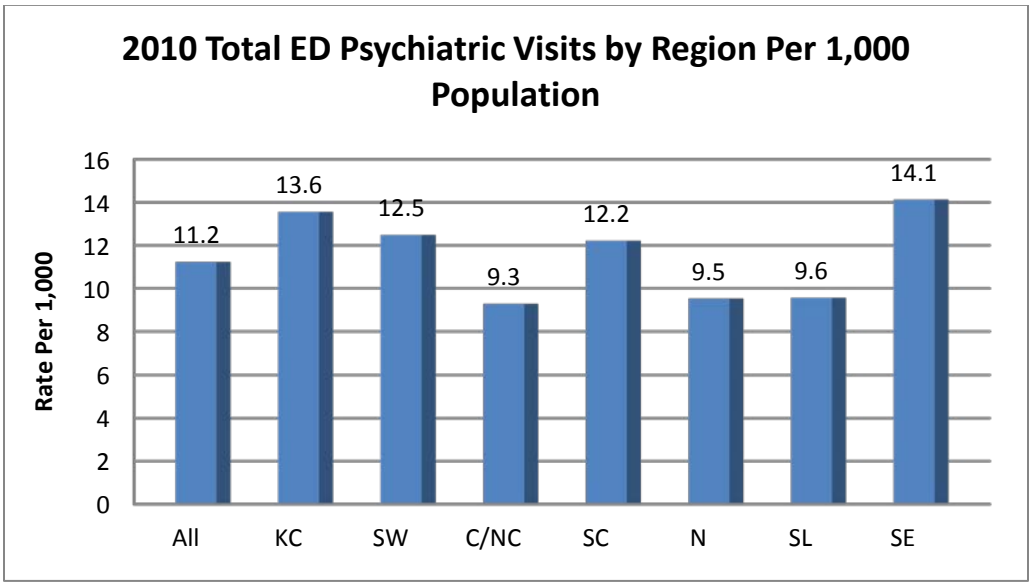

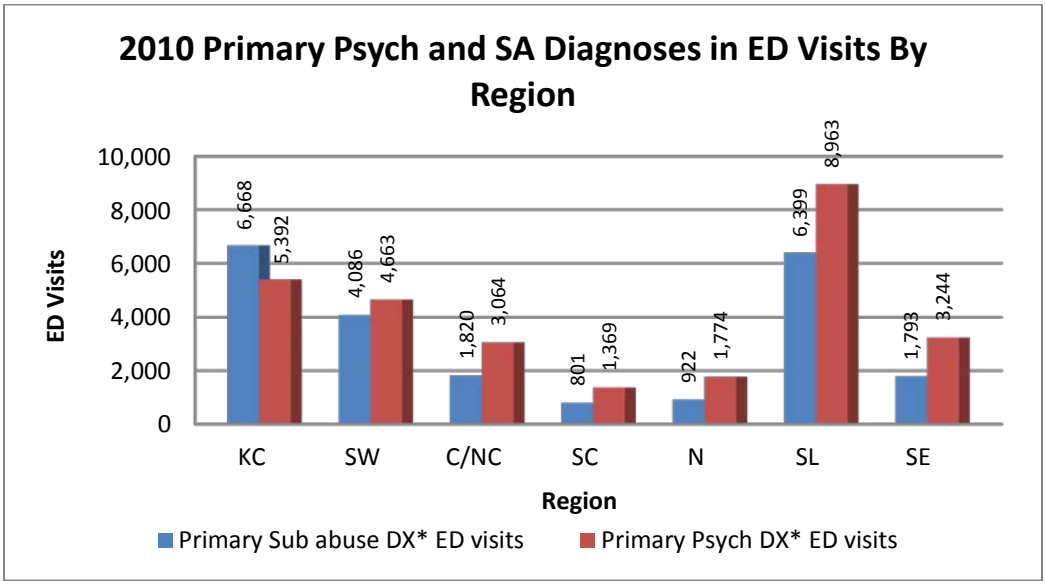

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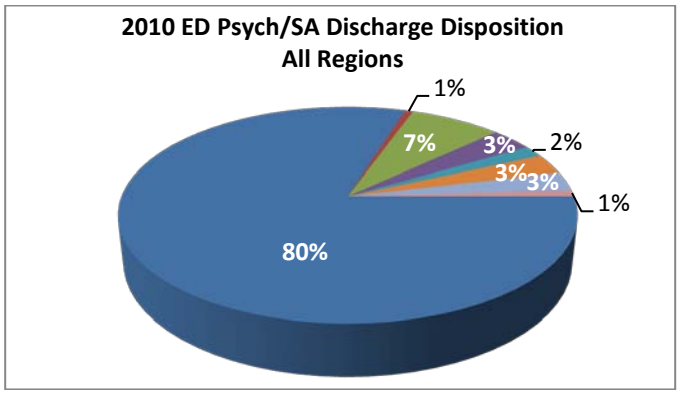

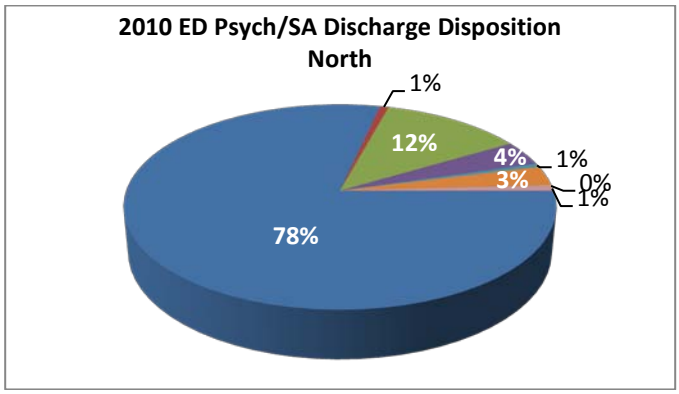

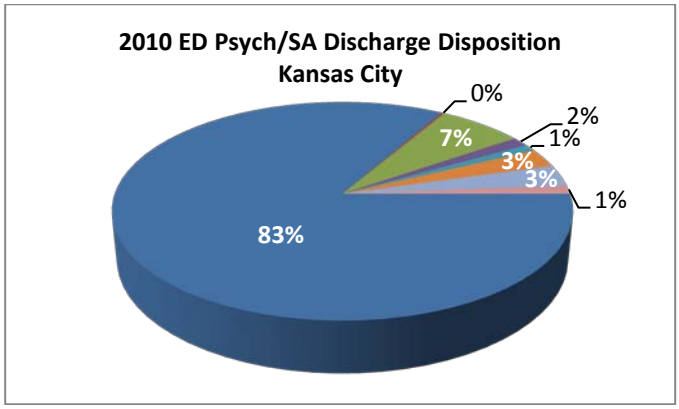

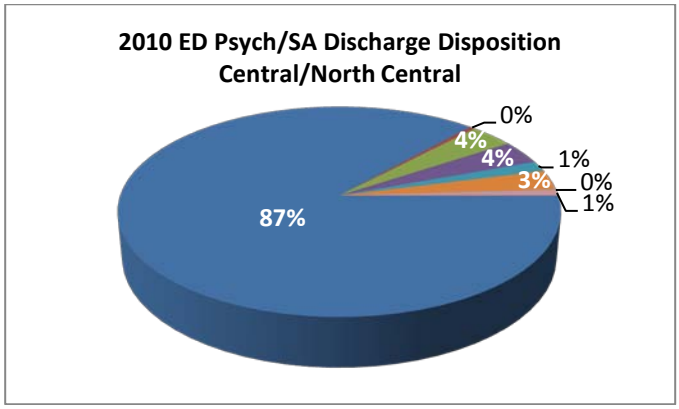

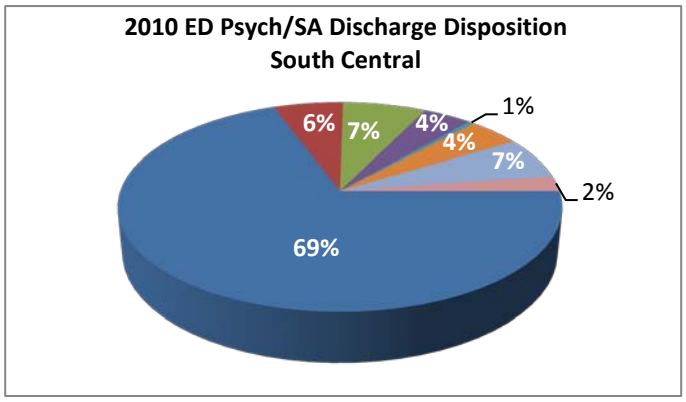

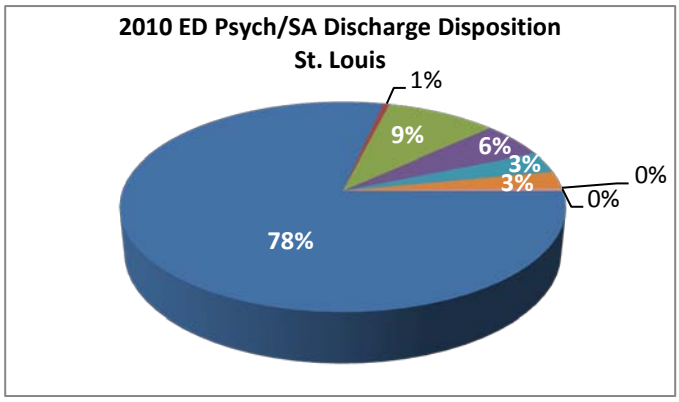

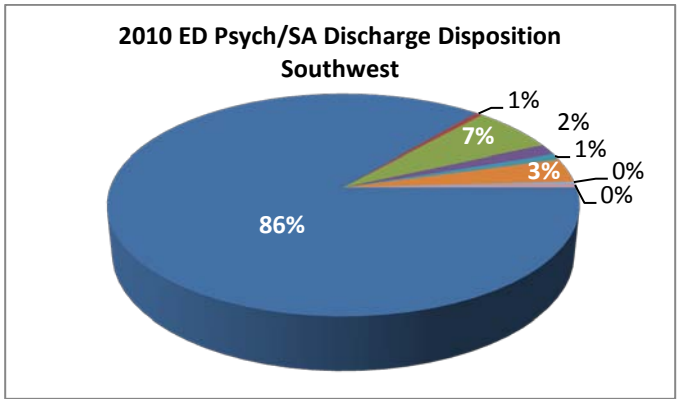

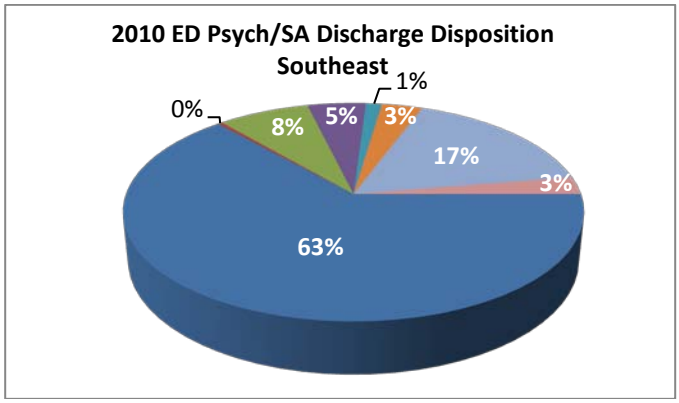

Home, HH, Hospice | LTC Facilities | Psych Hosp | Acute Care Hosp, CAH | Other Post-Acute Facility | AMA | Admitted Inpatient | Other

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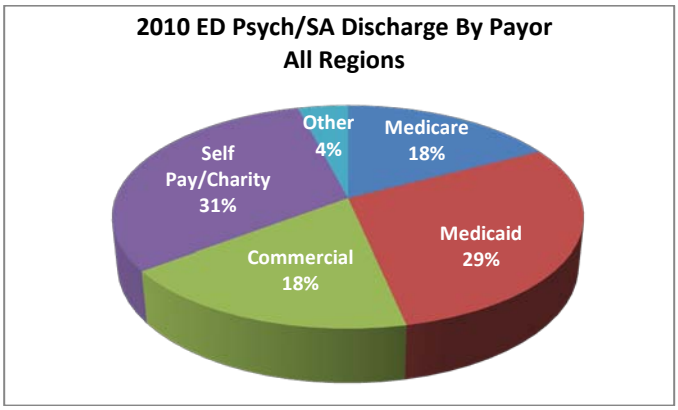
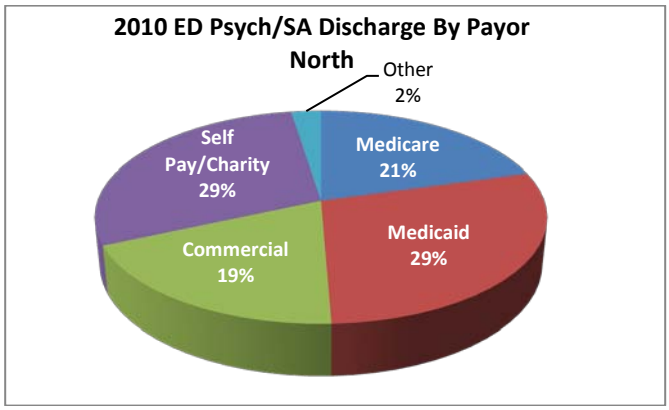
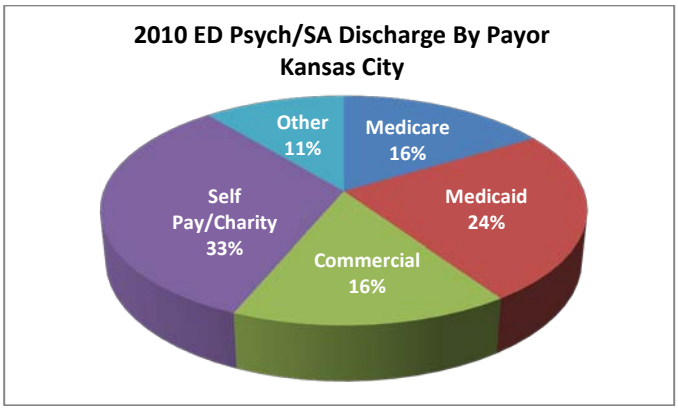
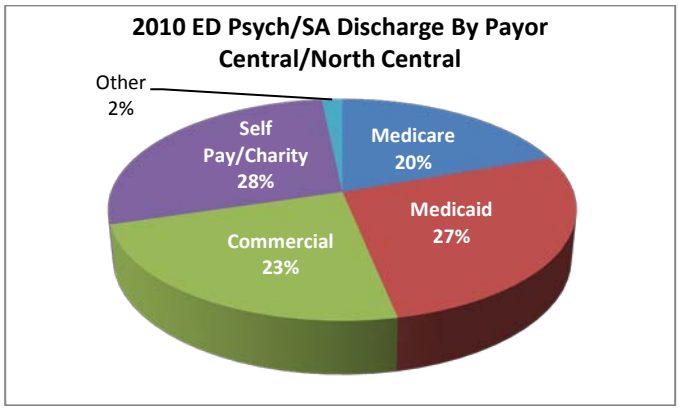
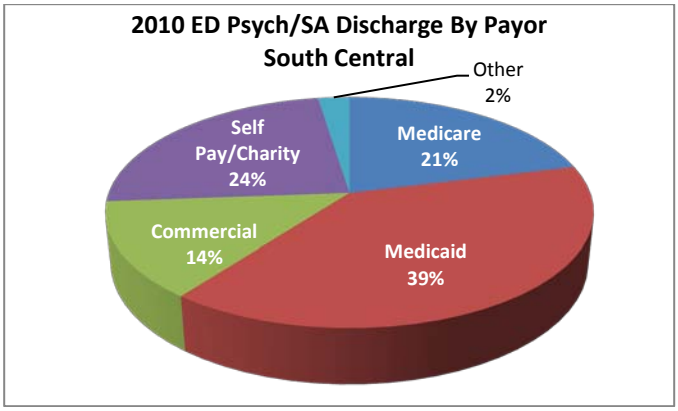
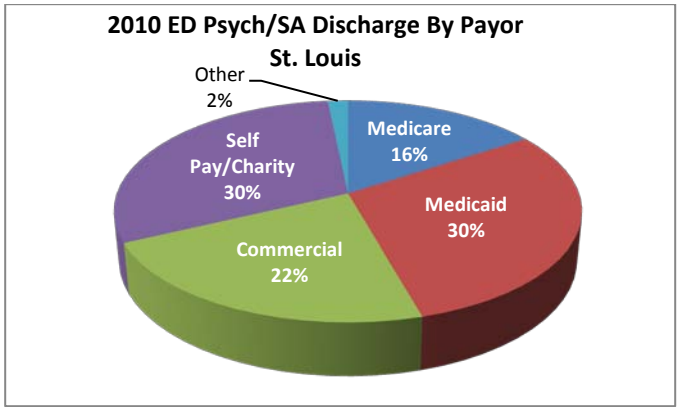


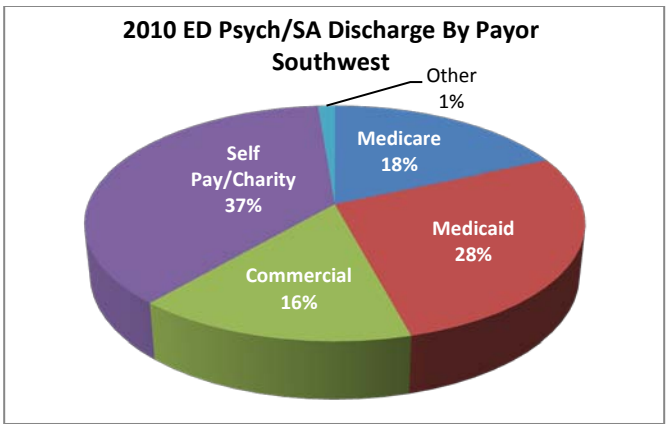


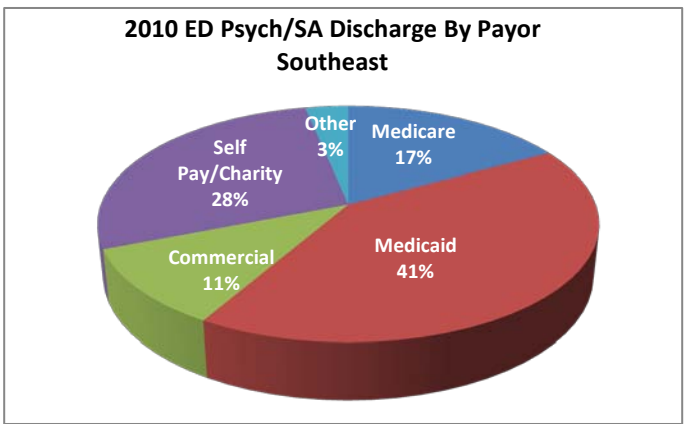






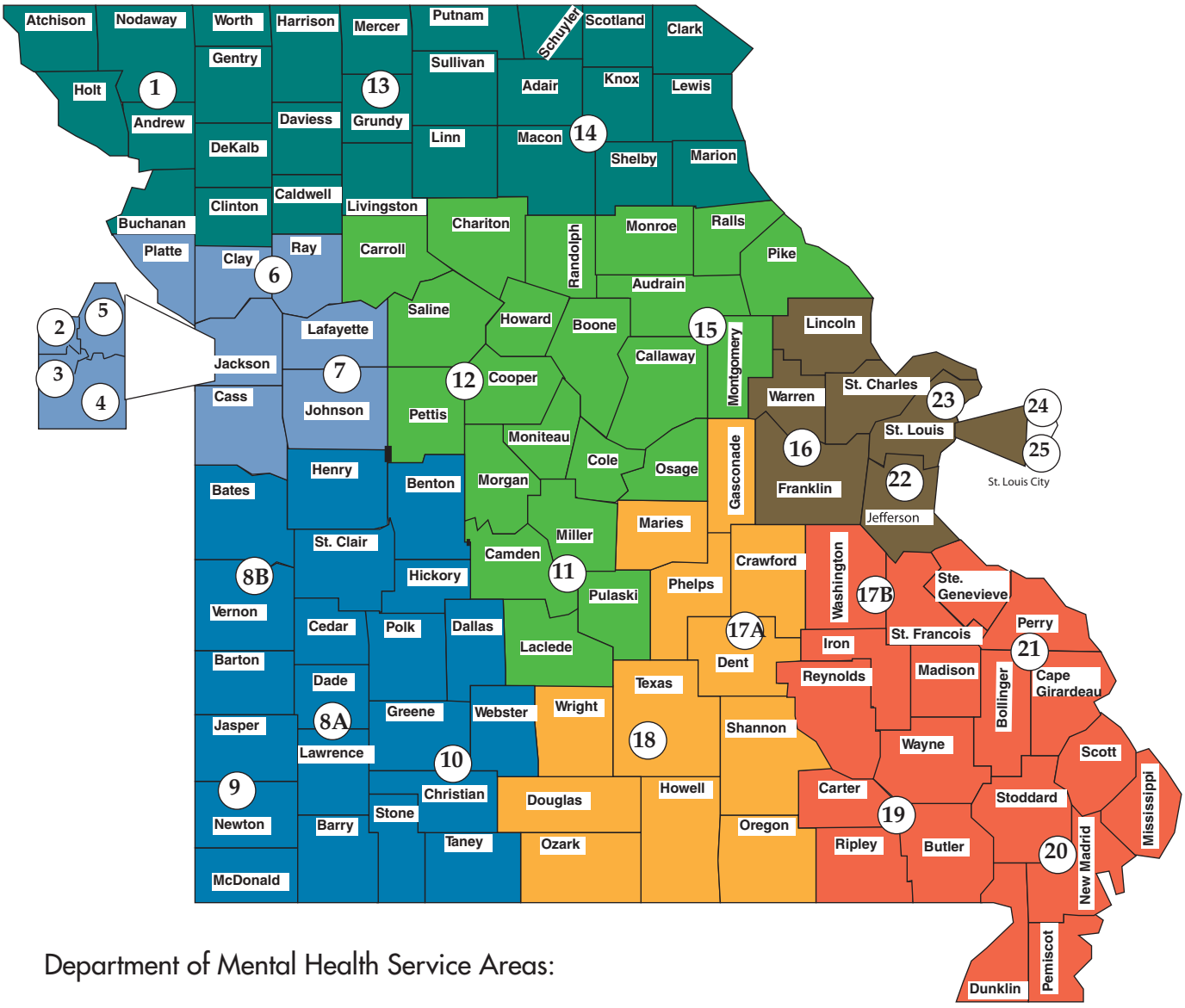






MISSOURI HOSPITAL ASSOCIATION

Missouri Hospital Association
Inpatient and Emergency Psychiatric Services Report
Study Regions



Department of Mental Health Service Areas:

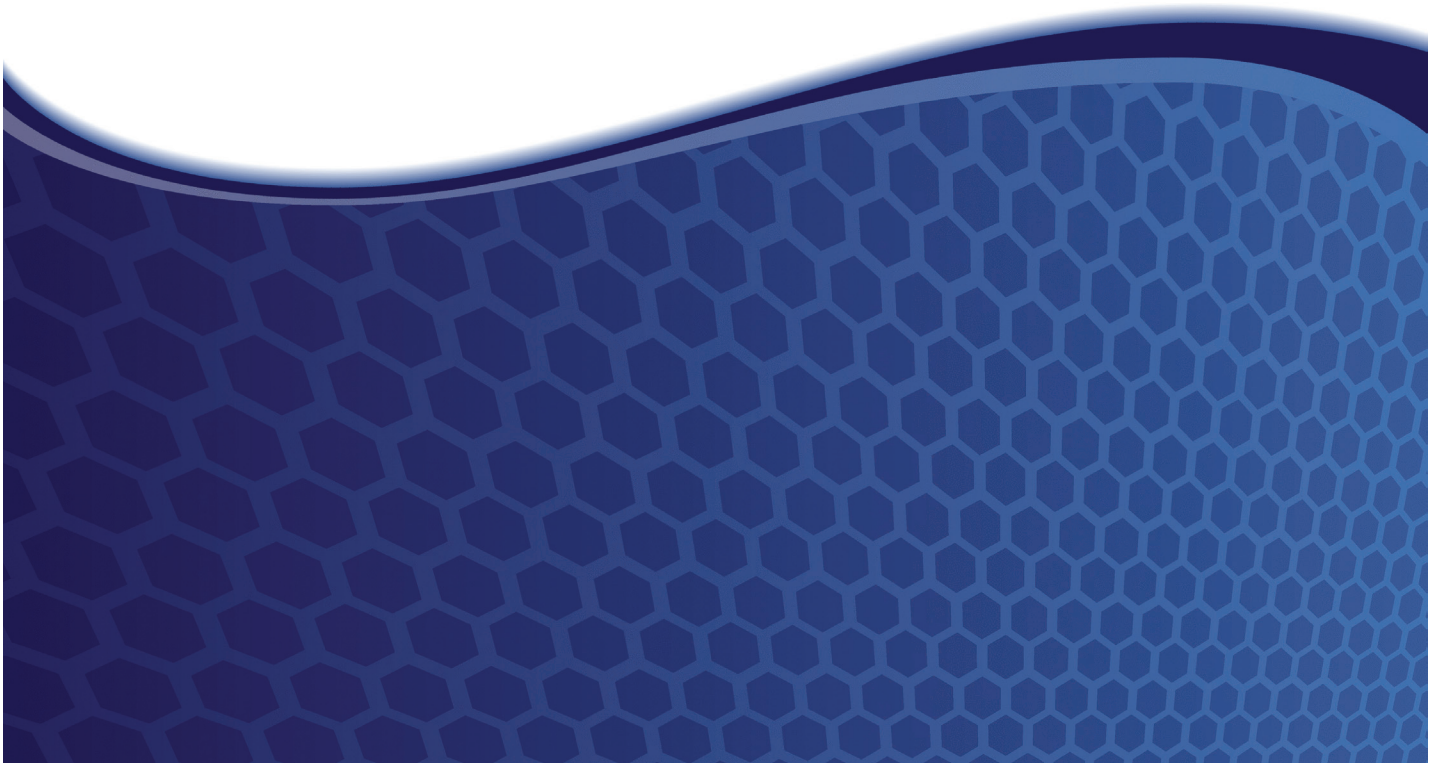
- (N) North — 1, 13, 14
- (C/NC) Central/North Center — 11, 12, 15
- (SL) St. Louis — 16, 22, 23, 24, 25
- (SE) Southeast — 17B, 19, 20, 21
- (KC) Kansas City — 2, 3, 4, 5, 6, 7
- (SW) Southwest — 8A, 8B, 9, 10
- (SC) South Central — 18, 17A

Appendix B

Hospital Diversion Initiative, Initial Results 2011 Summary

The Behavioral Health Network of St. Louis Hospital-Community Linkages Project
General Provisions and Requirements for Implementation 1/20/2010

Southeast Community Planning Inpatient Redesign Workgroup
Missouri Department of Mental Health Three-Year Service Plan
and Allocation Recommendations July, 2010



Summary

Hospital Diversion Initiative
ReDiscover

In January 2010, through a grant from the Health Care Foundation of Greater Kansas City, a collaboration of safety net providers agreed to divert persons with psychiatric and addiction disorders from hospitals to alternative services.

The target population includes uninsured and underinsured Jackson County and Kansas City adult residents with co-occurring conditions who frequent emergency rooms and inpatient services. They are below the federal poverty level and many are homeless. Over 350 people have received services to date.

Hospital Diversion Teams provide an immediate response to hospitals' requests for service including short-term, intensive response (stabilization, respite care, intensive case management) and longer-term supports that promote self-sufficiency (disease management, recovery, aftercare planning, housing, and transportation). Treatment retention strategies will include outreach, assertive engagement, support services and family member involvement.

ReDiscover leads the initiative. Collaboration involves: KC area CMHCs, area hospitals, ancillary providers, policy makers and funders including MO Department of Mental Health, and several County funders.

Outcomes include: reduced hospital and/or psychiatric inpatient recidivism rates; cost reduction; improved engagement into community treatment; and decreased mental illness symptoms.

Results show significant impact

- Over 350 high utilizers of emergency services have been referred and successfully connected with treatment
- Average savings per referral was $17,814 for each 6 month period in community care
- Reduction of ER services went from 3.6 visits to 0.9 once in community care
- Key contributors to success were identified
- Estimated cost savings during the grant period is $13,700,000 (19 months of service)

Referrals (1/2010-8/2011) = 350

Cost to Hospitals for Clients referred to HDI

Table 1: Hospital Costs for Clients Before and After HDI Engagement					
	6 months Pre-HDI	Post-HDI**	Difference	Projected 6 months Post-HDI	Projected Difference
Total (n=66)	$1,785,971.89	$261,908.10	$1,524,063.79	$610,245.87	$1,175,726.02
St Luke's (n=40)	$1,012,158.79	$221,274.80	$790,883.99	$515,570.28	$496,588.51
Truman (n=47)	$773,813.10	$40,633.30	$773,179.80	$94,675.59	$679,137.51
Avg Cost Per Client (n=66)	$27,060.18	$3,968.30	$23,091.88	$9,246.14	$17,814.04
St Luke's (n=40)	$25,303.97	$5,531.87	$19,772.10	$12,889.26	$12,414.71
Truman (n=47)	$16,464.11	$864.54	$15,599.57	$2,014.38	$14,449.73

Overall annual cost savings for all clients served in 2010: $8,301,343

Estimated savings during entire grant= $13,700,000

Table 2: Total and Average Number of Visits		
	6 months Pre-HDI	Post-HDI
Total Visits (n=66)	238	61
St Luke's (n=40)	106	39
Truman (n=47)	132	22
Average Visits per Client (n=66)	3.6	0.9
St Luke's (n=40)	2.7	1.0
Truman (n=47)	2.8	0.5

100% of referrals frequented hospital emergency services prior to referral. After referral, 23% returned.

Medicaid Enrollment: 55% at referral. Either Medicaid or pending: 96% after referral.

Key Success Factors:

- Collaboration between hospital and community provider
  - Teamwork on identifying and connecting with clients
- Timely Referral
  - Quick response from community provider to accept and track referral into treatment agency
- Assertive community engagement
  - Locate and develop trusting relationship to connect as main contact for client
- Temporary "flexible" services to meet client need
  - Services that can engage client into connection – medication, housing, etc
- On-going mental health services
  - Community mental health services – psychiatric, case management, etc
- Active staff involvement to ensure community follow-through
  - Continued assertive community engagement, as needed

Sustainability Plan

Due to the success, ReDiscover is looking for ways to continue project through collaboration of community providers and hospitals.

- Mental Health Centers can prioritize on-going mental health services for hospital referrals, as long as State & County funding remains

Needed additional resources:

- Community contact for timely referrals
- Temporary flexible services package
- Assertive community engagement at referral and as needed later

Notes:

- Project funded by Health Care Foundation of Greater Kansas City
- Program is a collaborative project of Kansas City area Community Mental Health Centers and local hospitals
- Funding for ongoing mental health treatment has been provided through the Missouri Department of Mental Health and Jackson County Mental Health Fund

Draft: August 28, 2011

Behavioral Health Network of Greater St. Louis

Hospital-Community Linkages Project Update April, 2012

Overview – Increasing Coordination; Accessing Follow-up Care

The Behavioral Health Network established the Hospital-Community Linkages Project (HCL) to improve care coordination between hospitals and community behavioral health service providers throughout Missouri's eastern region. The project helps get people quickly and effectively linked with a community-based behavioral healthcare home upon hospital discharge, so they can continue their path to recovery. This is accomplished by designated liaisons that visit patients prior to hospital discharge and provide transitional care coordination service until the time of the appointment with a community provider.

The project addresses a long-standing need in the community for better coordination between area hospitals and community providers in serving persons with significant behavioral health needs. It was created as part of a regional response to the April 2010 closure of Metropolitan St. Louis Psychiatric Center, which provided acute and emergency behavioral health services. To help the region respond to the closure, the Department of Mental Health pledged money to the region which included funds for treatment at community behavioral health sites for a certain number of patients after they were discharged from inpatient care.

A Focus on Persons with the Most Need

The project's target population is adults being discharged from acute care behavioral health units of hospitals whom have ongoing behavioral health needs and meet the following criteria:

- Are uninsured or have regular Medicaid insurance coverage.
- Are not currently linked with a service provider who can coordinate care for them.
- Have a qualifying behavioral health diagnosis (serious mental illness).

> *"I had been hospitalized 4 times since this June, and am finally feeling stable. For the first time in a long time, I have hope, and know that there is a plan in place for me and people to help me".*
>
> *~Lorie D.*

Initial Results are Promising

Community and hospital providers have said that the HCL is already a huge success. Many cite that the coordination among all 20 participating hospitals and behavioral health service providers is unprecedented in our region. Behavioral Health Network reviewed data from the project's first year of operations and found:

- The **number of patients referred far exceeds the number of slots available**. This shows that the project is beginning to address a very high level of need for community behavioral health services in the region.
- A **56% show-rate for appointments**, which is higher than the 35% and 36% show-rates demonstrated in two significant studies on similar patient populations (*Compton, et al., 2006; Boyer, et al., 2000*).
- For those patients who kept their appointment with a community provider, there was a **40% reduction in psychiatric inpatient days and 12% reduction in ED visits** based upon a review of state Medicaid claims for the 12 month period preceding the referral and a 3 month period post-referral (annualized). Hospital costs decreased by 42% (*$5,079 avg. per patient per year)* while all other psychiatric costs (outpatient and pharmacy) increased by 180% (*$3,128 avg. per patient per year).* **This resulted in a 14% *($1,951 avg. per patient per year*) total overall psychiatric healthcare cost savings.**

The HCL Project has sparked a marked increase in communication between hospitals and community providers in the Eastern Region. The increase in communication has ultimately resulted in better access to community services for people needing on-going care when they leave the hospital. The positive results of this project would not have been possible without the firm commitment and skills of the professional staff, and their supervisors, who are on the frontline.

Hospital-Community Linkages Project Participating Providers
Barnes-Jewish Hospital
BJC Behavioral Health
Bridgeway Behavioral Health
Christian Hospital
Comtrea
Crider Health Center
Hopewell Center
Independence Center
Jefferson Regional Medical Center
Mercy Health
Places for People
Preferred Family Healthcare
Queen of Peace Center
St. Alexius Hospital
St. Anthony's Medical Center
St. Louis Regional Psychiatric Stabilization Center
SSM DePaul Health Center
SSM St. Joseph's Health Center
SSM St. Joseph's-Wentzville
SSM St. Mary's Health Center

Next Steps Focused on Sharing Best Practices, Expansion

The HCL Project is guided by a Steering Workgroup and Liaison Committee. Members meet regularly to review data, address overall coordination issues and identify best practices in follow-up care coordination that can be implemented across providers.

The Behavioral Health Network has developed a 2012 work plan that includes coordinating the project with other providers doing similar work, including substance abuse providers, Behavioral Health Response and the St. Louis Integrated Health Network. In addition, a dedicated number of referral slots have been set aside to facilitate community linkage for those discharged from the new St. Louis Regional Psychiatric Stabilization Center.

Although much work remains, the project's initial results and the commitment of those involved are compelling indicators that a new and better way of managing the behavioral health service delivery system is taking root in the region.

About the Behavioral Health Network

Behavioral Health Network of Greater St. Louis is a non-profit organization formed in 2010 based on the recommendation of the St. Louis Regional Health Commission to establish a permanent structure for on-going region-wide behavioral health system planning and coordination. The organization is a collaborative effort of providers, advocacy organizations, government leaders and community members dedicated to developing an accessible and coordinated system of behavioral healthcare throughout the eastern region of Missouri, with emphasis on services to the uninsured and underinsured citizens of St. Louis City and the counties of Franklin, Jefferson, Lincoln, St. Charles, St. Louis and Warren. For more information and access to the full report, visit www.bhnstl.org.

References

C. Boyer, Ph.D., D. McAlpine, M.A., K. Pottick, Ph.D., and M. Olfson, M.D., M.P.H. Identifying Risk Factors and Key Strategies in Linkage to Outpatient Psychiatric Care. Am J Psychiatry 157:1592-1598, October 2000.

M. Compton, M.D., M.P.H. , B. Rudisch, M.D., J. Craw, M.P.H, Tina Thompson, B.A., and D. Owens, M.D. Predictors of Missed First appointment at Community Mental Health Centers After Psychiatric Hospitalization. Psychiatr Serv 57:531-537, April 2006.

Southeast Community Planning Inpatient Redesign Workgroup
Missouri Department of Mental Health
Three-Year Service Plan and Allocation Recommendations
July, 2010

Background and Context

In the spring of 2010, it became apparent that state projected budget cuts for the coming fiscal year were to have serious impacts on the Missouri Department of Mental Health's (DMH) ability to continue to offer acute inpatient services for the citizens of Missouri. In order to address the consequences of this budget cut, DMH convened regional workgroups, consisting of the administrative agents and other service providers from the respective region. Each regional group was directed to devise a multi-year plan designed to address the mental health needs of the region without the availability of state-sponsored acute inpatient services and emergency rooms. This report outlines the plan of action recommended by the Southeast Regional Workgroup.

The Southeast Region consists of 31 counties covering approximately 2.000 square miles in the Southeast portion of the state. The region is considered primarily rural. The population of the region served is approximately 660,000. The largest community in the region is Cape Girardeau, which has a population near 40,000. Twelve of the counties in the region have populations under 15,000.

Mental health services are provided through six Administrative Agents (community mental health centers) and two affiliates. The Administrative Agents each have outpatient services to persons with serious mental illness within their service areas and crisis intervention services through the ACI system. The unique characteristics of the communities within each service area have led to differences in the service delivery system. There are private psychiatric units within the community hospitals in most service areas and the Administrative Agents have developed working relationships with them. The location of Southeast Missouri Mental Health Center has led to fewer inpatient beds available in Farmington, until recently.

Southeast Missouri Mental Health Center serves approximately 1600 persons in the Emergency Room annually and has approximately 1300 acute care admissions annually. Approximately 57% of admissions are from the Services Area 17 which consists of Iron County, St. Francois County, and Washington County. This is, in part, a function of the residential care industry that has been established in the communities surrounding SMMHC.

The direct impact of the State budget cuts on service provision in the Southeast Region is the closure of the State Mental Health Emergency Room and Acute Services in Farmington and peripherally in St. Louis which result in the direct "loss" of an emergency room dedicated to patients presenting with mental health issues and the "loss" of 38 inpatient, acute, locked ward beds in the regional system that are available to patients that need immediate protection, as they are deemed as a danger to themselves or the community, including the indigent and uninsured.

The Southeast Regional Workgroup was informed by DMH that it would have $3 million annually, to allocate across the 31 counties that comprise the region to address the new reality of mental health service provision. A map of the Southeast Region can be found in Appendix E. This report is the result of numerous planning meetings held during a 3 month period in 2010. It represents the results of a consensus-driven, facilitated process and is agreed to as an acceptable starting point and roadmap for the next three years.

Consensus on Need for Continued Planning and Evaluation

All members of the group agree that the Department of Mental Health and its service providers are entering a new service reality and that this plan represents a concerted effort at creative thinking in tight economic times. Group members also recognize that this plan will have to be flexible and responsive to new data and feedback and that this planning process was only the first step in an on-going evaluation and implementation effort that must continue throughout the next three years.

The time allotted was sufficient to articulate goals, initial directions and allocations and to create a set of solid foundational agreements on which to build a new process. However, in order to ensure that the goals and strategies outlined here meaningfully fulfill needs and to ensure proper implementation; continued conversations and work will be imperative.

Future conversations will need to include not only the administrative agents, other service providers, and the MDMH but also the private hospitals across the region who will now be the sole provider of inpatient, acute, locked beds, in addition to law enforcement officials, court officials, and guardians responsible for involuntary admissions as well as many other mental health and community stakeholders.

Farmington Service Area in the Short-Term

The workgroup also recognized the special, short-term challenges faced by service providers in Farmington, due to the closure of the State Mental Health Facility and has made funding recommendations to mitigate the immediate effects of the budget cuts. It has also recommended an approach that, over time, equalizes Farmington with the rest of the region. Specific strategies will have to be implemented to ensure that by the end of Year 2, Farmington is prepared to be funded on a per client basis. Continued review and evaluation of the impacts of the hospital closing in Farmington will be necessary to ensure that service providers are successfully redistributing their caseload over time to handle the recommended incremental funding decreases.

The Farmington hospitals are especially concerned that the short –term impact of the immediate closure of the State Mental Health Facility and Emergency Room in Farmington will cause great difficulties for patients and the existing hospitals in the area. The hospitals requested workgroup support for a proposal to continue offering Mental Health Stabilization Services up to a six-month period at the State facility location or another location in the Farmington area in order to support a more smooth transition to the system outlined in the workgroup plan.

The workgroup agreed to support this proposal but noted an unwillingness to allocate any of the $3 million for this goal. The following issues would need to be resolved for service to be kept open: an alternative source of funding would need to be found for this purpose; an Emergency Room operator would need to be identified as DMH has stated that they will not fund or staff this service; DMH agrees to leave the ER space open for up to six months if a plan is developed and agreed upon for this service.

Defining Regional Principles and Goals

Workgroup members realized early on that splitting the money "evenly" among the service areas in the region would take them only so far. While each service area is different and requires some level of allocation that could be used to fulfill individual needs, most of the money was going to need to be programmed regionally and services available across service area boundaries. Without the creation of such regional efficiencies, potential solutions became financially infeasible.

Continued planning must recognize the following realities and embrace the overall goal of moving mental health service provision in the Southeast region and across the state forward. Whereas budget cuts often result in regressive policies, workgroup members chose to view this as an opportunity to "Rethink the System."

To this end, workgroup members agreed to the following guiding principles:

- It is imperative to address public safety needs and the need of those with severe mental illness.
- Culture change with regard to Mental Health is needed and progress toward the de-stigmatization of mental illness is a constant motivator.
- All stakeholders must be involved and be part of the solution.
- Continued planning is necessary and should be goal driven using constant data analysis to evaluate and reevaluate needs, actions and policy adjustments.
- Sustainability must be a criterion for policies and programs. Whatever is created, even in a hurry, should have the potential to be built upon and maintained.

After much initial discussion, workgroup members narrowed their discussion to two sets of goals. The primary goals are designed to guide how the $3,000,000 regional allocation will be prioritized and supported. The secondary goals are longer term policy goals that must be addressed through continued planning and collaboration with the Department of Mental Health and statewide with other regions.

Primary Regional Goals

- Create a continuum of care model that, if clearly articulated, supported and followed, will effectively mitigate the loss of inpatient, acute care, locked and unlocked beds through improved urgent care services, and intensive community based services.

- Ensure a safe, regional continuum of care for those in need where the immediate need and goal is stabilization, recognizing that hospitalization is not always necessary. This continuum must be identified and linked to a visible, understood mechanism for stabilizing clients so they can continue to be treated in the community.

- Create opportunities and resources for people to be treated in the community (not in the hospital) through the use of strategically located new programs and resources, strengthening or expanding existing resources or adapting existing resources for new use. This will require that some services be provided across jurisdictional boundaries to create efficiencies.

- Create a service area allocation for each of the six service areas in the Southeast region (to be managed by the Administrative Agent) that will be targeted toward creating or strengthening short-term, urgent care capabilities and intensive services available in the local community.

- Ensure the incremental redistribution of Farmington's current caseload. Need to support allocations for a strategic adjustment period to the state hospital closure in order to manage the closure impacts on the entire Southeast region.

- As part of the on-going planning effort, create understandable, visible decision tree/protocols for each community stakeholder responsible for assigning, moving and caring for clients.

    - This goal is designed to underscore alternative patient options using the entire continuum of care, since hospitalization and/or the use of inpatient emergency space cannot be the primary response, except where absolutely necessary. These protocols must consider the clients assessed needs, articulate primary and backup alternatives and options envisioned by the Southeast region continuum of care model, identify the location and type of resources available, and envision and recommend the appropriate use of resources based on prevalent scenarios. A regional asset map should be created.

    - Currently, referrals for both inpatient and outpatient services originate from many sources including emergency rooms, walk-ins, community mental health centers, agency referrals, immediate law enforcement holds, crisis hotlines, families, probate courts, residential care facilities, private hospitals and substance abuse facilities. All of these stakeholders need to be involved in the protocols discussion.

- Ensure continued sharing of ideas and best practices, evaluation and review.

Secondary Regional and Statewide Goals

- Create outreach and training strategies and tools for use with community leaders, individuals and county and local government officials. This might include: local print and television media campaigns, fact sheets for elected officials, stakeholder meetings, letters to law enforcement officials and judges, guardian training, or educational materials and training on protocols for appropriate agencies and organizations.
    - Specific strategies will need to be provider and geography appropriate, so MDMH should partner with the Administrative Agents to sponsor and develop an offering of educational resources from which to choose.

- Identify Medicaid match/Alternative funding options. Partner with DMH and MOHealth Net to explore potential changes in rapid Medicaid eligibility. Identify alternative sources for funding match (Medicaid or other). Identify potential alternative sources of local funding; local government contributions or existing funding streams that used more creatively can cover some costs.

- Explore issues surrounding the lack of available resources and need to create more supervised, long-term housing. (In line with the DMH Transformation Workgroup on Housing Report)

- Work towards goal of funding following the client. (In line with DMH Transformation Workgroup on Housing Report)

- Initiate, through DMH, a statewide discussion about the need for client transportation plans and policies in light of need to move to regional service models. The need for a regional model causes secondary questions on how far will the police take an individual who needs emergency service or stabilization and how far a voluntary client will drive to receive service.

- Initiate, through DMH, a statewide discussion of the continued problem of inadequate funding of medications for indigent and uninsured mental health clients.

Creating a Regional Continuum of Mental Health Care

Workgroup discussions led to the consensus that there really is not a shortage of acute care hospital beds in the region, assuming you can appropriately divert unnecessary referrals or provide an alternative accommodation for patients who no longer need that level of care.

To the degree that patients can be treated in the community as an appropriate alternative to hospitalization, more acute care beds will be available for those clients who need them when they need them. To the extent that a mental health continuum of care can be created that supports clients at all levels, the problem created by the elimination of beds due to budget cuts attenuates.

Priority One: Creating Safe Beds – The appropriate services (on a continuum) must be available. Everyone must be guaranteed the minimum required to keep them safe. In order for the continuum of care model to work, all the levels of the continuum must be adequately funded. In any strategy for addressing this challenge, public safety has to remain the number one priority so ensuring that there are spaces available for involuntary admissions requiring locked ward accommodations is crucial.

The other crucial piece of this puzzle is the need for emergency space to house a patient that needs to be stabilized quickly but doesn't need hospitalization. As members of the workgroup agreed, "If I have time, I can find a bed. The issue is if I don't have time."

Also recommended is the consideration of the use of existing beds. For example, Administrative Agents should work with the RCF's in their area to move appropriate clients to affiliated independent housing thus freeing up RCF beds for individuals in need of congregate care and 24/7 supervision.

Continuum of Care:
Entire continuum must be supported for the model to work.

Short-Term →	**Emergency/Immed.** →	**Long Term** →	**Acute**
Urgent M.H. Services	Diversion/Stepdown	Non-Acute	In-Patient
Intensive Wraparound	IRTS Beds	IRTS	Locked
Stabilization	Stabilization	Not this plan	

Short Term – In the Community

- *Urgent Mental Health Services*

This part of the continuum is dedicated to expanding face-to-face outreach and urgent care in the community as an alternative to emergency room services. It builds on the current ACI system. If appropriate urgent care services are provided dispositions other than emergency room services and inpatient admission can be created and can direct future treatment, services and housing choices. If not, clients are inappropriately placed and the system breaks down. Visible, Accessible Urgent Mental Health Services will be supported in the community to help fulfill the short term, urgent need. Each service area will provide the Service. The Administrative Agent can modify the staffing model as the volume and acuity within the service area changes. Other funding streams may be leveraged for specific community services.

Most Intensive Urgent Mental Health Model: Needed in more dense population areas to successfully divert consumers from emergency room presentation

- Qualified staff available every day (master's degrees) on location and mobile
- High staffing level (3 and a 60% time nurse practitioner) 8am-5pm
- 2 staff on call to emergency room at night and other sub-acute locations (completely dedicated to this task)
- Collaboration with Courts, Local Law Enforcement and DHSS
- Extended walk-in hours and after hours services
- Options for same day/next day appointments, and on-call availability during evenings, nights and weekends.

Less intensive Urgent Mental Health Model: Appropriate for heavily rural regions, and is less likely to divert consumers from presentation to the emergency rooms during off hours.

- Lower staffing level during the day
- Staff dedicated to this and other tasks.
- Less walk-in hours
- Contract out the night on-call duties
- Private emergency rooms contract with their own people

Funding allocations to create or enhance Urgent Mental Health Services might include: expanding qualified mental health professionals, specialty caseworkers and outreach staff, more Peer Specialists to help cover the gap from discharge to first doctor's appointment, expanded Peer-to-Peer training, Crisis Hotline enhancement, expanded walk-in hours, creation of crisis teams to get persons in jeopardy assessed (and treated) so we know where that person needs to go. By offering these alternative services in the community, we divert people from the Emergency Room.

- ❖ *Intensive Wraparound Stabilization*

This is a disposition from urgent care services, and involves the provision of intensive, short-term, wrap-around stabilization services on an outpatient basis for consumers with substantial mental health needs who might otherwise be candidates for inpatient admission. Service is provided for multiple hours over multiple days and is designed to prevent reactivation of a mental health crisis. It can be provided in either one of two formats: (a) in the consumer's home and work environment; or (b) in a clinic location. Either option provides increased availability of day and evening services with a higher level of credentialed staff. It can also include additional therapists, more nursing time, more psychiatric time.

Utilizing Intensive CPR will leverage Medicaid, provided that terminology and documentation demonstrate medical necessity and reimbursable under Medicaid.

<u>Emergency/Immediate – In the Region</u>

- ❖ *IRTS – Diversion/Step Down*

Creating Intensive Residential Treatment Services (IRTS) beds (not locked but alarmed) fulfills the regional need for high quality, emergency diversion options and also fulfills the need for step-down beds for those leaving the hospital, thus providing additional community preparation while awaiting a more permanent community placement.

The IRTS model creates "Safe" sub-acute beds with the 24/7 oversight services necessary to keep someone safe and makes use of intensive CPR and the existing catalog of Rehab Plan services as the funding strategy for clients and psycho-social support. In order to be successful, the workgroup members concluded that IRTS facilities needed to be supported throughout the Southeast region because while step down from a hospital may not be geographically limited, emergency diversion and crisis prevention need to be more local. The diversion model must be strengthened and supported for the continuum goals to work. IRTS must have highly trained staff given the consumers' potential danger to self or others. These beds must be made available throughout the region.

IRTS beds are also likely to include Long Term Non-Acute beds, funded through the separate Voluntary by Guardian initiative (see below), thus leveraging another funding stream for this section of the continuum.

Long Term Supported Housing with Intensive Treatment– In the Region

14 beds are allotted for Southeast Region as part of the Voluntary by Guardian (VbG initiative). Although these beds are not formally part of this plan, they could comprise a portion of an IRTS facility, with the long term nature of such beds providing some measure of financial stability, thereby anchoring the more volatile IRTS beds associated with inpatient diversion and step down.

Acute -Hospitalization

- *In-patient*

Private Hospitals with acute care beds are listed in Appendix C. The need for these beds would be diminished if the continuum above was supported to adequate levels. The workgroup believes that if the continuum is fully used, there will be no shortage of these beds in the system. Locked Wards must be available for involuntary, dangerous clients.

Recommended Funding Allocations

The Southeast Regional Workgroup is recommending the following allocations for its six service areas:

Short Term/Urgent Care

- $200,000 per service area, for a total of $1.2 million, to support the creation or enhancement of "Urgent Mental Health Care Services" (site-based and mobile community based services).
    - Service Area Allocation plans for each service area's $200,000 allocation can be found in Appendix G

Short Term/Urgent Care

- $750,000 for the creation or enhancement of "Intensive Wrap-around Stabilization Community-based Services".
    - This allocation recommendation factors in the incremental client caseload changes for the Farmington Service Area over a three-year period. It also assumes the possibility for a Medicaid match for approximately half the clients served, making the total amount potentially $1.3 million.

- Year 1: Farmington Service Area $250,000, Remaining areas $100,000 each.
- Year 2: Farmington Service Area $200,000, Remaining areas $110,000 each.
- Year 3: Allocation based on actual, adult population served in each service area.

Regional Emergency Diversion and Hospital Step Down

- $1,050,000 to fund 17 IRTS beds, potentially in six locations, to serve the immediate regional need for emergency diversion and hospital step-down beds.

- This allocation assumes the possibility for match. The workgroup started with a regional vision for 6 beds in each of four locations but quickly realized the financial challenges of creating new beds so settled on regional funding model that identifies and supports existing beds across the region that can be designated for this purpose. Several locations can make more beds available if more money becomes available and one service area is checking on its ability to make beds available. It is also important to remember that there are fixed costs associated with operating infrastructure that have to be covered even when the beds are unoccupied.

Kennett:	4 IRTS beds	(up to 4 additional beds are possible if funding permits)
Farmington:	3 IRTS beds	(a 4th bed might be possible)
West Plains:	4 IRTS beds	(a 5th and 6th bed might be possible)
Rolla:	2 IRTS beds	(not currently available)
Cape:	3 IRTS beds	(a 4th bed can be made available)
Sikeston:	1 IRTS bed	(to be identified - a 2nd bed if funding is available)

TOTAL ALLOCATION:

$1,200,000 – Short Term: Urgent Mental Health Care Clinics
$750,000 – Short Term: Intensive Wrap-around Stabilization Services
$1,050,000 - Regional Emergency Diversion and Hospital Step Down

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$3,000,000 – Creating support for Regional Continuum of Care

Implementation Recommendations

Upon approval of the plan, a Southeast Region Implementation Steering Committee will be immediately formed. The Steering Committee will include representation from the Administrative Agents, DMH and others who will meet on a regular basis to discuss regional implementation strategies, share best practices and monitor and continually assess progress toward creating a successful continuum of care. In addition, Service Area Implementation Teams will also be identified. These teams will report to the Steering Committee. Each will include all the local, community stakeholders who can work together to move through successful plan implementation including partnership building, program creation, problem solving and education and outreach efforts. Advance implementation work at the service area level has already begun in anticipation of plan approval.

Appendix B
NAMES AND AFFILIATIONS OF WORKGROUP MEMBERS

Organization	Name	Title
Southeast Missouri Behavioral Health Care	Clif Johnson	Director of Clinical Compliance
Mineral Area CPRC (affiliated agency)	Vicki Winick	CEO
Mineral Area CPRC (affiliated agency)	Karen Ferrell	Services Coordinator
Mineral Area CPRC (affiliated agency)	Vickey Belknap	Adm. Assistant
Ozarks Medical Center	Carol Eck	Exec. Director
Ozarks Medical Center	Sharon Head	DMH, CPRC Manager
Community Counseling Center	John Hudak	Exec. Director
Community Counseling Center	Tim Schwent	CFO
Community Counseling Center	Audrey Burger	Regional Director
Community Counseling Center	Dinia Jenkins	Supervisor Outpatient and Crisis Services
Community Counseling Center	Judith Johnson	Clinical Director
Community Counseling Center	Dr. Bob McCool	Medical Director
Bootheel Counseling Services	Cheryl Jones	CEO
Bootheel Counseling Services	Taryn LeGrand-Lovett	Clinical Director
Bootheel Counseling Services	Karen Evans	Fiscal Director
Bootheel Counseling Services	David Terrell	CPR Program Director
Bootheel Counseling Services	Angela Lutmer	Clinical/Crisis Therapist
BJC BH	Mark Stansberry	Executive Director
BJC BH	Karen Miller	Associate Director
BJC BH	Will Letterman	Clinical Supervisor of Admissions
BJC BH	Rob Millette	CFO
Pathways	David Duncan	Exec. Director
Pathways	Linda Grgurich	President
Family Counseling Center	Myra Callahan	CEO
Family Counseling Center	Shawn Sando	CFO
Family Counseling Center	Randy Ray	COO
DMH-CPS	Scott Giovanetti	Chief of Adult Community Operations-Eastern & Southeast Region
DMH-CPS Southeast Region	Julie Inman	Regional Executive Officer
DMH-Southeast Missouri Mental Health Center	Melissa Ring	Chief Operating Officer-APS

DMH-CPS	Larry Fletcher	SCL Director-Eastern & SE Region
DMH-CPS	Tom Kimbro	Program Specialist
DMH-CPS	James Womack	SCL Supervisor-SE Region
DMH-CPS	Felix Vincenz	Chief Operating Officer for the Division of Comprehensive Psychiatric Services
Facilitator-East West Gateway	Julie Stone	Director