



Access to Behavioral Health Task Force 2009 Behavioral Health Recommendations

Executive Summary

BACKGROUND

In the first two phases of the St. Louis Regional Health Commission's (RHC's) behavioral health initiative (April 2006- March 2009), efforts were focused on improving the service, integration and coordination of the behavioral health system providers. Although much progress was achieved in improving entry, reducing stigma, and coordinating care for the highest utilizers of the health care system in the Eastern region, these efforts did not directly address core structure and financing issues that restrict access to behavioral health services in the Eastern region. In April 2009 (phase three), the RHC appointed a Task Force to develop recommendations to address these core structural and financial issues, for the State of Missouri, health care providers, and stakeholders of the behavioral health system to implement post-March 2010.

In order to address the structural and financial barriers to access behavioral health services, the Access to Behavioral Health Task Force adopted guiding principles for the framing of current and future implementation efforts to expand access to behavioral health services with emphasis on the uninsured and underserved individuals in the region and confirmed five focus areas for recommendation development:

1. Integration of physical and behavioral health services
2. Psychiatric Acute Care Transformation
3. Existing service area structure
4. Funding
5. Provider Capacity

RECOMMENDATION SUMMARY

The Task Force developed a total of twenty-six recommendations. For the purposes of this summary, the recommendations will be discussed in the following three categories:

1. Increase consumer choice when seeking behavioral health services.
2. Utilize community health centers as new access points for behavioral health services.
3. Reorganize behavioral health system to enhance efficiency and leverage additional resources.

1. Increase consumer choice when seeking behavioral health services.

In the Eastern Region, there is widespread perception that individuals are limited to accessing services from a community mental health center on the basis of complex residential requirements that consequently limit patient choice of provider when seeking behavioral health services.

The Task Force recommends that processes, procedures and other barriers to freedom of access be removed so individuals may seek services from any Eastern Region community behavioral health agency regardless of where they live in the Eastern Region.

2. Utilize community health centers as new access points for behavioral health services.

Assessment data and feedback from provider and consumer focus groups indicate capacity constraints severely limit treatment options for individuals without a severe and persistent mental health illness, or who cannot access the public behavioral health system in the Eastern Region. Therefore, it is anticipated that developing access points at community health centers for behavioral health services will increase capacity by allowing primary care and mental health providers to meet those needs within the same facilities.

In addition, the integration of physical and behavioral health services has been shown to: improve clinical coordination of care, increase access to behavioral health services to allow for the appropriate treatment of behavioral health conditions and reduce stigma associated with receiving treatment for a behavioral health illness.

The Access to Behavioral Health Task Force has recommended the development of “comprehensive health centers” through the exploration of collaborations, partnerships, affiliations, or mergers between community behavioral health organizations and community health centers in conjunction with the appropriate linkage of consumers and patients to healthcare homes that best fit their complete health needs.

3. Reorganize behavioral health system to enhance efficiency and leverage additional resources.

In anticipation of resources generated from Psychiatric Acute Care Transformation (PACT), an initiative to transfer the current inpatient acute care beds owned and operated by the Missouri Department of Mental Health (DMH) at Metropolitan St. Louis Psychiatric Center (MPC) to a community hospital provider, Community Mental Health Centers and behavioral health stakeholders collaborated to develop a plan for a regional access system and enhanced community-based services with redirected State dollars.

The Access to Behavioral Health Task Force supports PACT and recommends that State dollars be redirected to support the consensus-based plan generated by the Eastern Region Community Mental Health Centers and behavioral health stakeholders. This plan is to develop a regional access system and enhance community-based services to prevent unnecessary inpatient hospitalizations and reduce length of stay in acute care settings. The Task Force also recognizes that the regional planning efforts of behavioral health providers should explore opportunities to develop collaborations, affiliations and partnerships between Comprehensive Psychiatric Services (CPS) Division and Alcohol and Drug Abuse (ADA) Division providers/services in the Eastern Region.

The Task Force also recommends an ongoing assessment of all potential funding sources for behavioral health services in the Eastern Region in order to identify total availability of resources, leverage additional funds and ensure efficient use of resources to meet the needs of the community. The Task Force also supports any initiatives to redesign the State disability process in the Eastern Region that causes a delay in Medicaid eligibility determinations.

PRIORITY AREAS

The Task Force concluded by confirming priority recommendations with input from the Behavioral Health Steering Committee and Advisory Board. The top five priorities are:

1. Individuals may seek services from any Eastern Region administrative agent or affiliate regardless of where they live in the Eastern Region.
2. Advocate for increased funding to support behavioral health services for the uninsured.
3. The St Louis Regional Administrative Agents and Affiliates should pilot an initiative with MO-Health Net, DMH and Family Support Division for rapid Medicaid eligibility determinations.
4. Utilize the St. Louis Integrated Health Network (IHN) Network Master Patient Index (NMPI) information systems project as single integrated clinical sharing system for physical and behavioral health providers to access clinical data.
5. Develop additional physical and behavioral health services within the entire criminal justice system , including increased exchange of information with physical and behavioral health providers at point of arrest or while incarcerated (esp. pre-trial), and with follow-up appointment scheduling to appropriate healthcare home upon release and ensure continuity of care with follow-up within 30 days of being released.

RECOMMENDATIONS

Integration of Physical and Behavioral Health

Combine services into "one stop shop"

1. Increase services through collaborations, partnerships, affiliations or mergers between Comprehensive Psychiatric Services (CPS) Division and Alcohol and Drug Abuse (ADA) Division providers/services in the Eastern Region.
2. Physically locate behavioral health professionals at each community health center (CHC) in the region and primary care providers at each behavioral health organization, as appropriate, to meet the needs of the entire population served at the agency, including children.
3. Seek mutually beneficial relationships to increase integration, including the exploration of collaborations, partnerships, affiliations, or mergers, between community behavioral health organizations and community health centers.
4. Ensure consumers and patients are linked to a healthcare home that best fits their complete health needs.
5. Establish standardized referral guidelines and develop a "warm hand-off" process between physical and behavioral health providers to improve the coordination of care.
6. Coordinate clinical care planning between physical and behavioral health providers, with a unified care path development and frequent communication between providers.
7. Coordinate (or centralize) scheduling functions, with same day appointments with physical and behavioral health professionals.
8. Develop additional physical and behavioral health services within the entire criminal justice system , including increased exchange of information with physical and behavioral health providers at point of arrest or while incarcerated (esp. pre-trial), and with follow-up appointment scheduling to appropriate healthcare home upon release and ensure continuity of care with follow-up within 30 days of being released.

Plan regionally

9. Develop a permanent network of behavioral health providers that includes all public mental health and alcohol and drug abuse service providers and a non-voting representative from the St. Louis Integrated Health Network (IHN).
10. The St. Louis Integrated Health Network (IHN) should include a representative of the behavioral health network (BHN) as a non-voting advisory member.

Train jointly

11. Hold joint, coordinated training and educational programs across both behavioral health and physical health organizations in Eastern Region to impart knowledge that will enhance the quality of care for individuals with physical and behavioral health needs.

Share information

12. Identify, collect and publicly report metrics to assess effectiveness of integration efforts.
13. Consider utilizing the St. Louis Integrated Health Network (IHN) Network Master Patient Index (NMPI) information systems project as single integrated clinical sharing system for physical and behavioral health providers to access clinical data.
14. Consider expanding NMPI functionality over time to be able to use the system as a mechanism to collect longitudinal health data (including behavioral health metrics) to report aggregated process and outcome measures.

Psychiatric Acute Care Transformation

15. Support the current plans for the Eastern Region Psychiatric Acute Care Transformation (PACT) initiative, including the transfer of operations of acute psychiatric services at Metropolitan St. Louis Psychiatric Center (MPC) to a private community hospital system; ensure this process improves access to behavioral health services in the Eastern Region during implementation.
16. State dollars and other resources generated from PACT process must be redirected for enhanced community based services within the Eastern Region.

Existing Service Area Structure Recommendations

17. Individuals may seek services from any Eastern Region administrative agent or affiliate regardless of where they live in the Eastern Region.
18. Encourage more efficient utilization of the expertise of all behavioral health service providers in the Eastern Region, especially as it relates to, special populations, specialized services and the integration of physical and behavioral health services.

Funding

Approved by Regional Health Commission December 16, 2009

19. The St Louis Regional Administrative Agents and Affiliates should pilot an initiative with MO Health Net, DMH and Family Support Division for rapid Medicaid eligibility determinations.
20. Redirect funds generated as a result of the proposed Psychiatric Acute Care Transformation (PACT) initiative to develop enhanced community-based services including a strong regional access system, stabilization services and enhanced community services to prevent unnecessary inpatient hospitalizations and reduce length of stay in acute care settings.
21. Expand funds for psychiatric, including alcohol and drug abuse, medication services to individuals in the Eastern Region.
22. Assess on an ongoing basis, all potential resources available for behavioral health services in the Eastern Region, including DMH, federal grants, county tax sources and private sources to identify total availability of resources, leverage additional funds and ensure efficient use of resources to meet the needs of the community.
23. Develop systems to provide incentives to providers through the development and annual public reporting of access, utilization and outcome metrics for mental health and substance abuse services.
24. Provide training and technical assistance to providers on integration and partnerships of physical health and behavioral health in order to fully maximize federal, state and local funds.
25. Advocate for increased funding to support behavioral health services for the uninsured.
26. Advocate for increased Medicaid rates and service coverage for behavioral health services.

Provider Capacity

The Task Force notes that increasing provider capacity is important and has captured recommendations for this topic under the other focus areas.

Focus Area 1: Integration of Physical and Behavioral Health

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 1: Increase services through collaborations, partnerships, affiliations or mergers between Comprehensive Psychiatric Services (CPS) Division and Alcohol and Drug Abuse (ADA) Division providers/services in the Eastern Region.

Timeframe: Short-term (1 – 3 years)

Background/Objective(s): Building on the success of the Eastern Region Behavioral Health Initiative (RHC) in 2006 and the Missouri Foundation for Health (MFH) Priority Area Grant: Improving Access to Integrated Treatment for Adults with Co-Occurring Disorders in 2006, it is recommended that all existing Comprehensive Psychiatric Services (CPS) Division and Alcohol and Drug Abuse (ADA) Division providers/services in the Eastern Region will become co-occurring capable (with some programming becoming co-occurring enhanced) within each service provider's mission, defined responsibilities and resources while co-occurring service capacity limitations and non-existing necessary services will be addressed. The system of care, programs, and services will continue to be reorganized around a set of best practice treatment principles to improve services for individuals with co-occurring psychiatric and substance use disorders. Evidence-based/best practices will be utilized to ensure all agency programs and staff become "welcoming, recovery focused and co-occurring capable" while inter-agency collaborations and partnerships will be developed within/across the quadrants of care to assist one another in becoming co-occurring capable/enhanced and to coordinate care. Inter-agency collaborations and partnerships can be the mechanisms to integrate physical and behavioral health thus establishing learning communities within and across the quadrants of care for all physical and behavioral health issues challenging our system of care, programs, services and ultimately our consumers.)

Responsible/Lead Agency: MO Department of Mental Health (DMH), community behavioral health providers, Missouri Cadre for Co-Occurring Excellence, consumers of behavioral health services and their families.

Action Steps: Identify best practices for improving co-occurring services and programming. Consider consultation from Dr. Minkoff and Dr. Cline. Provide funding to support agencies work to become co-occurring capable and incentives for programs producing deliverables, achieving benchmarks and improving health outcomes.

Funding Strategy: TBD

Challenges: Traditional separation of mental health and substance abuse services and funding across our country's systems of care which have lead to ineffective sequential and parallel treatment approaches that are not welcoming, accessible, integrated, continuous and comprehensive.

FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 2: Physically locate behavioral health professionals at each community health center (CHC) in the region and primary care providers at each behavioral health organization, as appropriate, to meet the needs of the entire population served at the agency, including children.

Timeframe: Short-term (1-3 years)

Background/Objective(s): For patients without a severe and persistent mental health illness, or who cannot access the public behavioral health system in the Eastern Region due to capacity constraints, treatment options are severely limited, per feedback from primary care and behavioral health providers, patient focus groups, and assessment data provided to the St. Louis Regional Health Commission (RHC). National and State best practices indicate that co-location of a psychiatrist or other behavioral health professional within a community health center and primary care providers within community behavioral health organizations increases the ability of primary care physicians and behavioral health providers to appropriately treat behavioral health conditions and reduces the stigma associated with receiving treatment for a behavioral health illness. Initial pilot programs re: integration in implementation stages within the State of MO have proven successful and should be enhanced, expanded, and replicated. May be implemented in conjunction with Focus Area 1, Recommendation 3.

Responsible/Lead Agency: State of Missouri, St. Louis Integrated Health Network (IHN) members, community behavioral health providers, Missouri Primary Care Association, Missouri Coalition of Mental Health Centers.

Action Steps: 1. Create briefing on fiscal impact/reimbursement strategies to ensure financial viability 2. Develop briefing to IHN members and community behavioral health center leaders on integration strategies, and operational considerations. 3. Create timeline for co-location options by community health center and community behavioral health organization sites in region

Funding Strategy: TBD, pending financing briefing

Challenges: Operational complexity of blending practice models; funding, staff training at CHCs; scarcity of behavioral health providers; physical plant capacity limitations (at a limited number of CHC sites).

FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 3: Seek mutually beneficial relationships to increase integration, including the exploration of collaborations, partnerships, affiliations, or mergers, between community behavioral health organizations and community health centers in order to:

- Increase clinical integration
- Maximize regional, state and federal benefits (including, but not limited to, Section 330 benefits and cost-based reimbursement for Medicaid, foundations/philanthropic funds, etc.)
- Achieve organizational economies of scale
- Reduce the stigma of behavioral health illness

Timeframe: Short-term (1-3 years)

Background/Objective(s): In order to enhance integration, maximize revenues into the Eastern Region for public behavioral health services, improve service delivery, achieve cost efficiencies, and reduce the reported stigma of receiving behavioral health services, current providers should explore the potential for formal affiliations, which may or may not include a full merger of organizations, in order to achieve these goals.

Responsible/Lead Agency: State of Missouri (MO Department of Social Services, MO Department of Mental Health and other state agencies as applicable), IHN members, community behavioral health organizations, MO Primary Care Association

Action Steps: State of Missouri should develop incentives to encourage affiliations. Joint presentation to IHN members and community behavioral health organizations leadership on affiliation/merger concept. IHN/behavioral health leaders to consider recommendation and develop next steps. State of MO should develop incentives to encourage affiliations and expansion of services. Develop a “one stop shop” for services.

Funding Strategy: TBD

Challenges: Current organizational autonomy within safety net system limits impetus for strategic inter-organizational changes.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 4: Ensure consumers and patients are linked to a healthcare home that best fits their complete health needs.

Timeframe: Short-term (1-3 years)

Background/Objective(s):

- Improves continuity of care by promoting sustained relationships between physicians and patients (Grumbach and Bodenheimer).
- Reduces non-emergent use of Emergency Departments (District of Columbia Department of Health, Health Care Safety Net Admin.).
- “Promoting a stable physician-patient relationship can improve patients’ timely receipt of preventive health care. For certain preventive services, having a regular doctor is more effective than having a regular site” (Sarver JH, Cydulka RK, Barker DW).
- Research indicates that “most people in the United States desire a primary care home to provide for and coordinate their health care needs” (Grumbach and Bodenheimer).
- Right treatment at right setting is provided – comprehensive services through community behavioral health organizations are provided to those with severe and persistent behavioral health needs, while behavioral health services for those with other needs are provided at CHCs

Responsible/Lead Agency: State of Missouri (MO Department of Social Services, MO Department of Mental Health and other state agencies as applicable), St. Louis Integrated Health Network (IHN) members, Eastern Region community behavioral health organizations

Action Steps: Develop designated healthcare home model with community behavioral health organizations designed as healthcare home for Quadrants II and IV (severe mental illness), and community health centers (CHCs) as healthcare home for Quadrant I and III (see attached model). Each Medicaid or uninsured person chooses (or is assigned) a physical or behavioral health provider as a healthcare home, depending on medical need. Assignment is tracked electronically by shared information systems under development (IHN NMPI, MO HealthNet). Develop specific processes for linkage of patients to specific provider.

Funding Strategy: TBD

Challenges: May increase administrative burden to link patients to a single provider. Limited availability of needed primary care services at community behavioral health providers and behavioral health services at primary care sites (current state). Frequent turnover of providers within safety net setting. Organizations current inability to interface electronically with shared information systems.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 5: Establish standardized referral guidelines and develop a “warm hand-off” process between physical and behavioral health providers to improve the coordination of care.

Timeframe: Short-term (1-3 years)

Background/Objective(s): Established standardized referral guidelines between primary care physicians and behavioral health professionals will improve the coordination of care for individuals with physical and behavioral health needs. A “warm hand-off” includes identifying the best available resource/provider agency for the individual, assisting the individual in contacting the referral source and overcoming any barriers to accessing the care, and following up with the individual to make sure connections are made with the appropriate resource/provider agency.

Responsible/Lead Agency: Behavioral Health Network (TBD)

Action Steps: Adopt national referral guidelines to streamline process for behavioral and physical health referrals.

Funding Strategy: Funds must be available to the IHN and BHN to coordinate these activities.

Challenges: N/A

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 6: Coordinate clinical care planning between physical and behavioral health providers, with a unified care path development and frequent communication between providers.

Timeframe: Mid-term (3-5 years)

Background/Objective(s): Currently, a high degree of fragmentation is reported to exist between primary care providers and behavioral health providers in the Eastern Region, with reported uncoordinated treatment plans and infrequent communication between providers. Along with co-location, comprehensive and unified clinical planning can occur. Enhances communication, productivity and integration between outpatient and inpatient behavioral health service providers, and across the behavioral and physical health systems. Assists lead clinician with information to assess the patient's medical condition and optimize care. Reduces risk of medication errors and adverse drug reactions. Improves clinical outcomes by improving availability of information regarding compliance with clinical care protocols and the results of clinically important metrics.

Responsible/Lead Agency: St. Louis Integrated Health Network (IHN) members, behavioral health providers

Action Steps: Convene team of IHN clinical representatives with community behavioral health organizations to assess national best practices and develop protocols for care path development within each organization. Explore tele-health options.

Funding Strategy: Seek one-time grant to support protocol development.

Challenges: Time and funding required of clinical staff for increased care planning activities. Scarcity of behavioral health providers. High turnover of safety net providers requires constant retraining.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 7: Coordinate (or centralize) scheduling functions, with same day appointments with physical and behavioral health professionals.

Timeframe: Mid-term (3-5 years) - Remove administrative billing barriers

Longer-term (greater than 5 years) - Coordinate scheduling functions

Background/Objective(s): Combined scheduling functions, with same day appointments, would improve patient satisfaction, reduce no-show rates, and foster provider collaboration.

Responsible/Lead Agency: MO Department of Social Services, MO Department of Mental Health, IHN members, community behavioral health organizations.

Action Steps: TBD, once integrated efforts are completed.

Funding Strategy: n/a

Challenges: MO HealthNet FQHC billing guidelines do not currently assure reimbursement for primary care and behavioral health visits on the same day. Administrative complexity of scheduling coordination if separate primary care/behavioral health organizations are maintained.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 8: Develop additional physical and behavioral health services within the entire criminal justice system , including increased exchange of information with physical and behavioral health providers at point of arrest or while incarcerated (esp. pre-trial), and with follow-up appointment scheduling to appropriate healthcare home upon release and ensure continuity of care with follow-up within 30 days of being released.

Timeframe: Mid-term (3-5 years)

Background/Objective(s): Explore opportunities to improve access to and the availability of behavioral health services for those within the criminal justice system. Develop a transition program to assist the criminal justice system behavioral health services in linking individuals to community behavioral health services upon their release from the criminal justice system. Coordinate with Department of Corrections to develop a transitional accountability plan for health services as part of release plans. The provision of ongoing behavioral health services may reduce recidivism.

Responsible/Lead Agency: Community behavioral health providers, Criminal Justice System (including but not limited to: State of MO prison system, MO Department of Corrections, jail settings in (including but not limited to): St. Louis City, St. Louis County, St. Charles County, Jefferson County, Lincoln County, Franklin County, and Warren County), Specialty courts (i.e. drug courts, mental health courts, etc.), juvenile detention courts, probation officers, and additional agencies as appropriate

Action Steps: Educate providers on the behavioral health services provided by the criminal justice system. Identify local and national best practices in improving access to behavioral health services for those within and discharged from the criminal justice system. Secure funding.

Funding Strategy: Criminal justice system, including specialty courts. Community behavioral health organizations pooled funds.

Challenges: Requires funding. Limited communication and coordination between the criminal justice system and healthcare providers. Legal issues.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 9: Develop a permanent network of behavioral health providers that includes all public mental health and alcohol and drug abuse service providers and a non-voting representative from the St. Louis Integrated Health Network (IHN).

Timeframe: Short-term (1-3 years)

Background/Objective(s): The RHC's Behavioral Health Steering Committee has proposed forming a permanent organization in order to coordinate and integrate the delivery of safety net behavioral and physical health services in the Eastern Region. The behavioral health network (in collaboration/ coordination with the IHN) will be responsible for improving integration and delivery of safety net behavioral health services, including but not limited to the RHC recommendations. The Task Force recommends that this step be taken; however, instead of forming a new organization, the board of BHR should consider expanding to include other behavioral health providers and a representative of the IHN, in order to reduce duplication of coordinating bodies, and build upon existing infrastructure.

Benefits:

- Provides a lead entity responsible for the coordination and integration of the behavioral health system.
- Provides opportunities for collaboration among behavioral health safety net providers.
- Provides a lead organization to coordinate regional integration efforts in collaboration with the St. Louis Integrated Health Network (IHN).

Responsible/Lead Agency: Behavioral health organizations, St. Louis Integrated Health Network, Department of Mental Health

Action Steps: Explore the possibility of Behavioral Health Response (BHR) becoming the permanent regional coordinating body for behavioral health providers.

Funding Strategy: None needed.

Challenges: Limited

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 10: The St. Louis Integrated Health Network (IHN) should include a representative of the behavioral health network (BHN) as a non-voting advisory member.

Timeframe: Short-term (1-3 years)

Background/Objective(s): The RHC's Behavioral Health Steering Committee has proposed forming a permanent organization in order to coordinate and integrate the delivery of safety net behavioral and physical health services in the Eastern Region. The behavioral health network (in collaboration/ coordination with the IHN) will be responsible for improving integration and the delivery of safety net behavioral health services, including but not limited to the RHC recommendations. The Task Force recommends that once the formation of this organization occurs, it should be included as a non-voting advisor of the IHN, per IHN membership bylaws. This membership will provide opportunities for permanent, ongoing collaboration among primary/specialty care providers and behavioral health safety net providers.

Responsible/Lead Agency: St. Louis Integrated Health Network, Behavioral Health Network (TBD)

Action Steps: Formalize the structure for a regional network of behavioral health providers. Board representatives meet to ratify.

Funding Strategy: None required.

Challenges: Limited.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 11: Hold joint, coordinated training and educational programs across both behavioral health and physical health organizations in Eastern Region to impart knowledge that will enhance the quality of care for individuals with physical and behavioral health needs.

Timeframe: Mid-term (3-5 years)

Background/Objective(s): Hold joint, coordinated training programs across behavioral and physical health organizations to encourage collaboration and improve communication across systems. Training should include information on the differences in culture among the behavioral and physical health systems and techniques to generate “buy-in” across the organization, effective screening and referral processes and billing for integrated care.

As part of these trainings, hold Continuing Medical Education (CME) trainings and conferences on the integration of physical and behavioral health services. Include information on national and state best practices for the integration of services, current local efforts to integrate physical and behavioral health services, delivery of culturally competent care and mechanisms to improve the communication to multiple populations (including immigrant/refugee populations), referral processes across systems, trauma-informed care, and domestic violence. Emphasize the importance of ongoing communication and coordination between physical and behavioral health providers. Provide CME credit to participating providers. The trainings will:

- Reduce stigma associated with a behavioral health illness.
- Improve communication between physical and behavioral health providers.

Responsible/Lead Agency: St. Louis Integrated Health Network Members (as expanded with BHN representation, see recommendation #6) in collaboration with local medical schools (including college and universities), community behavioral health organizations, MO Institute of Mental Health, MO Primary Care Association, MO Coalition of Mental Health Centers, National Alliance on Mental Illness St. Louis, Mental Health America of Eastern MO, MO Recovery Network, Criminal Justice System, St. Louis Board of Education, and others as appropriate.

Action Steps: Identify opportunities for expansion of existing training efforts. Identify specific barriers that discourage physical health providers from conducting behavioral health screenings and providing referrals. Develop training to provide techniques for removing primary care providers’ barriers to screening and providing referrals for behavioral health needs and improving communication among providers.

Ensure behavioral health topics are included in CME rotation schedule. Develop and publicize CME conference schedule.

Funding Strategy: TBD, pending financing briefing.

Challenges: Existing time constraints on participating providers.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 12: Identify, collect and publicly report metrics to assess effectiveness of integration efforts.

Timeframe: Short-term (1-3 years) - Identify baseline measures

Mid-term (3-5 years) - full evaluation

Background/Objective(s): Identify, collect and publicly report metrics on the effectiveness of integration efforts to encourage collaborative, long-term improvements in the quality of care for individuals in the safety net population in need of physical and behavioral health services.

Responsible/Lead Agency: Regional Health Commission, in collaboration with Eastern Region behavioral health providers, St. Louis Integrated Health Network (IHN), and local universities

Action Steps: Identify metrics to measure successful implementation of integration efforts. Develop a survey for the collection of data. Collect baseline measurements. Publicly report outcomes.

Funding Strategy: TBD.

Challenges: Limited funding. Identify measures for behavioral health services.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 13: Consider utilizing the St. Louis Integrated Health Network (IHN) Network Master Patient Index (NMPI) information systems project as single integrated clinical sharing system for physical and behavioral health providers to access clinical data.

Timeframe: Mid-term (3-5 years)

Background/Objective(s): The IHN's NMPI project will link providers across the safety net, enabling clinicians to have immediate access to patient medical information (including medical history, physical exam findings, comprehensive list of current medical problems and medications, recent treatments, results of diagnostic tests, hospital discharge summaries and emergency room visits). The NMPI can also incorporate clinical guidelines and care protocols and track compliance and clinical outcomes. Behavioral Health providers such as community mental health providers and alcohol and drug providers with a critical mass of encounters will be able to "push" behavioral health clinical information such as diagnoses and prescription data into this system, and be able to view clinical data, under IHN developed guidelines for system usage.

Responsible/Lead Agency: St. Louis Integrated Health Network,

Action Steps: Planning for behavioral health data integration with selected pilot sites by NMPI Steering Committee, Planning Group pending successful resolution of funding strategies. Explore options to link with CIMOR and CyberAccess.

Funding Strategy: Cost per organization model for one-time integration and ongoing license fees developed. Organizational determination of cost/benefits for data utilization once fee structure made available.

Challenges: Complexity of data integration of behavioral health data. Additional cost per organization added to NMPI. Time/resources needed for system integration and provider training. Potential confidentiality issues regarding patients with behavioral health illnesses. Organizations capabilities to interface with NMPI, due to limited availability of electronic medical records within many behavioral health organizations.

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FOCUS AREA 1: Integration of physical and behavioral health.

Recommendation 14: Consider expanding NMPI functionality over time to be able to use the system as a mechanism to collect longitudinal health data (including behavioral health metrics) to report aggregated process and outcome measures.

Timeframe: Longer-term (greater than 5 years)

Background/Objective(s): A region-wide, integrated health database allowing for the aggregation of clinical outcome metrics would improve the ability to target public health interventions, prioritize resource allocations, and assist in ongoing clinical improvement efforts for physical and behavioral health conditions.

Responsible/Lead Agency: St. Louis Integrated Health Network (IHN)

Action Steps: IHN assesses feasibility and cost implications of additional functionality. IHN privacy/security committee assesses privacy, security, and community acceptance considerations.

Funding Strategy: TBD, pending community acceptance and cost analysis.

Challenges: Cost may be prohibitive, potential privacy/security/community acceptance concerns.

Focus Area 2: Psychiatric Acute Care Transformation

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 2: Psychiatric Acute Care Transformation

RECOMMENDATION 1: Support the current plans for the Eastern Region Psychiatric Acute Care Transformation (PACT) initiative, including the transfer of operations of acute psychiatric services at Metropolitan St. Louis Psychiatric Center (MPC) to a private community hospital system; ensure this process improves access to behavioral health services in the Eastern Region during implementation.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S):

- The Eastern Region Psychiatric Acute Care Transformation (PACT) initiative is a project to transfer the current inpatient acute care beds owned and operated by the Missouri Department of Mental Health (DMH) at MPC to a community hospital provider. A similar process has occurred in the Western and Central portions of the State already – in 2009, DMH has announced plans for the Eastern Region as well. DMH is undertaking this project for the following reasons:
 - Reimbursement for the adult Medicaid population is maximized if the acute psychiatric care is delivered under a medical-surgical license. (The IMD rule does not apply).
 - DMH will be able to generate funds by leveraging these beds and eliminating direct service costs associated with these facilities. The funds must be used to enhance care in other parts of the system (i.e. community).
 - The current fragmentation between the hospital services and community-based services can be reduced.
 - This project reinforces the Department's belief that their efforts and resources should be devoted toward the long-term population.
- Key elements of this project include:
 - Transfer of approximately 50 beds to a private inpatient provider
 - Addition of Modified Medical Detoxification beds at MPC under the management of Bridgeway
 - Development of urgent care “hand-offs” and additional community services in lieu of inpatient stays
 - Development of a regional Access Center

RESPONSIBLE/LEAD PARTY: MO Department of Mental Health, community behavioral health providers, community hospital partner

ACTION STEPS:

1. Consider critical organizational issues when planning for operational transfer. These issues include, but are not necessarily limited to, the following:
 - a. Assess available psychiatric resources compared to demand for inpatient services to ensure accessibility is not compromised
 - b. Complete detailed patient flow scenarios, esp. for patients with acute drug and alcohol problems
 - c. Provide appropriate financial incentives to promote and support maintenance/development of privately administered inpatient beds long-term.
 - d. Ensure medical screenings are available to all individuals in need of services at the new regional Access Center.

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2. Develop clear protocols and procedures to ensure referrals in and out of the Regional Access Center are accurate and efficient.
 - a. Develop communication systems with community providers, EMS providers, and law enforcement agencies to provide current information on the capacity of the access center.
 - b. Identify alternative options for the community providers to utilize when the access center is at capacity.
 - c. Develop clear protocols for referrals into Access Center from other acute care providers.
 - d. Clarify and communicate the services provided by “secure Modified Medical detox” so community providers appropriately utilize the new services @ MPC.
3. Involve impacted organizations into the planning process for new operations on the front-end, including:
 - a. All regional organizations providing acute psychiatric care
 - b. Representatives of law enforcement, esp. police
 - c. Family/consumers
4. Ensure the Eastern Region Behavioral Health Steering Committee Principles Regarding the Privatization of a State-Operated Mental Health Facility are followed in the transition period (see attached).

FUNDING STRATEGY: TBD

CHALLENGES: Identifying a community hospital partner to operate acute psychiatric services. Ensuring services are not reduced due to budgetary pressures during process.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 2: Psychiatric Acute Care Transformation

RECOMMENDATION 2: State dollars and other resources generated from PACT process must be redirected for enhanced community based services within the Eastern Region.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): Utilizing appropriated State dollars and other resources from MPC transfer process into enhanced community based services within the Eastern Region will allow for an expanded array of community services that will lead to a reduction in acute care length of stay at MPC, a reduction in re-hospitalizations, and improved service coordination between hospital and community providers.

RESPONSIBLE/LEAD PARTY: MO Department of Mental Health, community behavioral health providers, community hospital partner

ACTION STEPS: Work with MO Department of Mental Health to develop an agreement for the reinvestment of funds to support and enhance community-based services. Develop a process for identifying which services need to be enhanced to effectively serve this community with input from key stakeholders in the Eastern Region. Develop anticipated outcomes from enhanced community services prior to implementation.

FUNDING STRATEGY: TBD

CHALLENGES: Generating support within Eastern Region to ensure services and associated funds are preserved within the Eastern Region's behavioral health system.

Eastern Region Behavioral Health Steering Committee
Principles Regarding the Privatization of a State-Operated Mental Health Facility

1. Patient care cannot be compromised. Patients should be treated with the appropriate amount of care, at the right time, in the least restrictive clinical setting, so as to provide optimal care with the available resources.
2. Services must be culturally competent and sensitive and should respect the dignity of each patient and his/her family.
3. Privatization is not the goal; rather it is a means to achieve the goal of increasing access and capacity to high quality and cost effective services for patients. Services for each patient should be delivered in the most appropriate clinical setting for that particular patient.
4. To the extent the private sector is able and willing to provide appropriate services to persons who otherwise would receive them in the public sector; it is a cost-effective alternative that encourages creative use of scarce resources, and offers more clinical options from which patients and families can choose.
5. Current financial resources committed to delivering services in a state-operated facility must be reserved for services used by these patients, albeit in different settings. The state must demonstrate its commitment to preserving and enhancing resources for patients, not shifting the financial responsibility onto providers or families.
6. The Missouri Department of Mental Health retains the ultimate responsibility to establish performance standards and to monitor performance, a responsibility that is not diminished under a privatized system. These functions, however, should involve collaboration between government, families, consumers, advocates, and providers.
7. Outcomes must be measured against these performance measures, by an objective party. A process must be in place to monitor progress and guide improvement if performance measures are not achieved.
8. The private partner must not reduce access to acute psychiatric hospitalization.
9. Involvement of traditional and non-traditional family is critical to the success of therapy and the patient's long-term health. The services provided must include families.
10. A continuum of services should be available to patients to allow for an appropriate match of needs and services. Providers, must therefore, be able to offer a range of clinical services, including, but not limited to inpatient, partial, outpatient, and support services. Where a single provider entity is unable to offer the spectrum of services a patient needs, providers should collaborate to insure such access is available.
11. The state should remove existing barriers to collaboration or those which prevent flexibility in programming or training.

Focus Area 3: Existing Service Area Structure

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 3: Service Area Structure

RECOMMENDATION 1: Individuals may seek services from any Eastern Region administrative agent or affiliate regardless of where they live in the Eastern Region.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): Currently, there is a widespread perception that individuals in the Eastern Region are limited to obtaining services to one specific community mental health center on the sole basis of where they live, thereby limiting patient choice of which provider they may be able to see for mental health services. It is recommended that policies, procedures, and other barriers to freedom of access be removed, so that any Department of Mental Health (DMH)-eligible individual may seek services from any behavioral health provider in the Eastern Region, and that place of residence will no longer be a criterion for limiting or denying services to a particular individual. The service area structure should also support and encourage integration efforts among physical and behavioral health providers in the Eastern Region. To prevent unanticipated outcomes, incentives to maintain a “fair” payer and service mix between providers, and disincentives to prevent the “creaming” of the most lucrative and/or “easy to serve” clients by providers, should be designed and implemented.

RESPONSIBLE/LEAD PARTY: DMH, State of Missouri; Coalition of Community Mental Health Centers

ACTION STEPS: A team convened by DMH should be created to examine current DMH policies, state statutes and contracts that may exist that outline or imply a geographic restriction to access, and recommend regulatory or statutory changes as needed. The team should also develop incentives to maintain a “fair” payer and service mix between providers, and disincentives to prevent the “creaming” of the most lucrative and/or easy to serve clients by providers.

FUNDING STRATEGY: TBD, deferred to funding recommendations.

CHALLENGES: Administrative time allocation to assess regulatory/legislative barriers.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 3: Service Area Structure

RECOMMENDATION 2: Encourage more efficient utilization of the expertise of all behavioral health service providers in the Eastern Region, especially as it relates to, special populations, specialized services and the integration of physical and behavioral health services.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): Currently, over 30 behavioral health providers operate in the Eastern Region, including administrative agents, administrative agents' subcontractors, affiliate DMH providers and alcohol and drug abuse (ADA) providers. In many cases, significant service overlaps and gaps may exist due to the multiplicity of providers and the absence of a plan for these services that strategically aligns capacity in the Eastern Region. For example, affiliations or mergers of some of these providers should be encouraged where appropriate (see Focus Area 1: Integration, Recommendation 1).

RESPONSIBLE/LEAD PARTY: DMH, State of Missouri; Coalition of Community Mental Health Centers, Integrated Health Network, MO Primary Care Association

ACTION STEPS: A team convened by DMH should be created to examine the current service configuration in the Eastern Region, and determine if organizational or service line reconfiguration is beneficial among DMH-funded behavioral health organizations. The team charge may be combined with implementation steps of Focus Area 3: Service Area Structure, Recommendation #1. As part of this team's work, a comprehensive assessment of need, capacity, existing provider configuration, and the degree of variation in access between the Administrative Agent service areas should be undertaken, with specific recommendations for potential realignment included. It is recommended this assessment be completed on a periodic basis.

FUNDING STRATEGY: TBD.

CHALLENGES: Administrative time allocation to create service plan configuration. Political challenges re: realignment between providers if significant gaps or variations in access are identified.

Focus Area 4: Funding

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 1: The St Louis Regional Administrative Agents and Affiliates should pilot an initiative with MO Health Net, DMH and Family Support Division for rapid Medicaid eligibility determinations.

TIMEFRAME: Short-term (1-3 years)

Mid-term (3-5 years) - Proactively enroll individuals into Medicaid.

BACKGROUND/OBJECTIVE(S): Many consumers of public behavioral health services in the Eastern Region are Medicaid eligible but due to the disability determinations process do not obtain Medicaid for long periods of time causing the consumer to either not get services or for the services to be 100% State funds or provider uncompensated care.

RESPONSIBLE/LEAD PARTY: Department of Mental Health, Family Support Division, MO Health Net, Eastern Region Behavioral Health Network (TBD)

ACTION STEPS:

1. DMH should propose a process to decrease the amount of time it takes for disabled individuals to enroll in Medicaid and submit their proposal to MO Health Net.
2. DMH, Family Support Division and MO Health Net should pilot the initiative with eligible consumers of public behavioral health services in the Eastern Region.

FUNDING STRATEGY: TBD

CHALLENGES: Altering procedures that are well embedded in the eligibility process.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 2: Redirect funds generated as a result of the proposed Psychiatric Acute Care Transformation (PACT) initiative to develop enhanced community-based services including a strong regional access system, stabilization services and enhanced community services to prevent unnecessary inpatient hospitalizations and reduce length of stay in acute care settings.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): The current system of care is challenging to access, and emergency departments and inpatient beds are over-utilized due to the lack of effective community-based alternative stabilization services that could prevent unnecessary inpatient hospitalizations. Utilizing appropriated State dollars and other resources from MPC transfer process into enhanced community based services within the Eastern Region will allow for an expanded array of community services that will lead to a reduction in acute care length of stay at inpatient hospitals, a reduction in re-hospitalizations, and improved service coordination between hospital and community providers.

RESPONSIBLE/LEAD PARTY: Missouri Department of Mental Health, Behavioral Health Response, Eastern Region Behavioral Health Network (TBD), Community Access Transformation Team (CATT)

ACTION STEPS:

1. Develop and submit CATT proposal to DMH.
2. Advocate that funds made available through PACT initiative are utilized for community based services.
3. Develop utilization review mechanism.
4. Develop evaluation mechanism in order to institute quality improvement process to ensure desired outcomes.

FUNDING STRATEGY: Transfer funds currently utilized for acute inpatient care for effective triage/access and the development of effective community-based options to acute inpatient care.

CHALLENGES: N/A

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 3: Expand funds for psychiatric, including alcohol and drug abuse, medication services to individuals in the Eastern Region.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): Due to the state of our current economy, many individuals have recently lost health insurance or simply do not have health insurance and are unable to purchase medication for their mental health disorder. The inability to purchase medications may result in the individuals' condition worsening and ultimately needing more intensive services at additional cost to the system.

RESPONSIBLE/LEAD PARTY: Missouri Department of Mental Health, MO Health Net, Eastern Region Behavioral Health Network (TBD),

ACTION STEPS:

1. Addition or transfer of funds that would be specifically dedicated to medication services for individuals who lack insurance and are unable to access necessary medication services.
2. Collaborate with pharmaceutical retailers, manufacturers and the MO Pharmacy Association, as appropriate, to expand the availability and affordability of medications.

FUNDING STRATEGY: Ensure appropriations of funds made available through PACT are flexible and advocate for a budget item that would provide fund for this purpose.

CHALLENGES: Securing additional funds in short-term due to challenging budgetary environment.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 4: Assess on an ongoing basis, all potential resources available for behavioral health services in the Eastern Region, including DMH, federal grants, county tax sources and private sources to identify total availability of resources, leverage additional funds and ensure efficient use of resources to meet the needs of the community.

TIMEFRAME: Short-term (1-3 years) - Initiate actions steps.
Longer-term (greater than 5 years)- Ongoing

BACKGROUND/OBJECTIVE(S): Currently, variation exists in the availability of fiscal resources for behavioral health services across the Eastern Region. For example, some Counties in the Eastern Region collect a “mill tax” per State statute to specifically fund mental health services, while others do not. Also, the United Way of Greater St. Louis distributes funds totaling several million dollars to some administrative agents and other behavioral health providers in some parts of the Eastern Region, while other behavioral health services, providers, and parts of the region receive little or no funding. This variation in funding availability is not necessarily driven by service need or provider performance.

RESPONSIBLE/LEAD PARTY: Missouri Department of Mental Health, Eastern Region Behavioral Health Network (TBD), Missouri Hospital Association, area universities, United Way and other existing and/or potential funders

ACTION STEPS:

1. Maintain a thorough inventory of all public funding available for behavioral health services in the Eastern Region.
2. Periodically conduct a thorough, scientific assessment of the service needs, including service gaps, in the Eastern Region.
3. Identify a mechanism to measure provider performance.
4. Based on the assessment, recommend measures to increase funding sources, or reduce variation in funding, where appropriate.
5. This assessment may be combined with implementation steps of Focus Area 3: Existing Service Area Structure, Recommendation #2.
6. Annually report outcomes and findings to the community.

FUNDING STRATEGY: TBD.

CHALLENGES: Significant changes to current funding infrastructure which could result in significant resistance from provider community. Significant challenges exist in collecting data due to lack of standardized reporting mechanisms current state. Due to limited resources, it may be difficult to conduct a thorough needs assessment on an ongoing basis.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 5: Develop systems to provide incentives to providers through the development and annual public reporting of access, utilization and outcome metrics for mental health and substance abuse services.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): It is recommended that behavioral health organizations in the Eastern Region establish outcome and quality measures and require organizations to submit data utilizing the established measures. Some suggested outcome and quality measures include: housing, employment, law enforcement contacts, hospital admissions, substance abuse use, placement in behavioral health agency upon release from hospital or jail, physical health (e.g. diabetic screenings), number of people served, and cost per encounter. Fiscal incentives should be provided to agencies based on productivity, patient satisfaction, and other performance-based metrics. The collected data will also help support advocacy efforts to attract additional funding for the Eastern Region. Health disparities should also be monitored and training should be provided appropriately.

RESPONSIBLE/LEAD PARTY: DMH, behavioral health organizations

ACTION STEPS:

1. Identify evidence-based and best practice service models and implement programs in behavioral health organizations.
2. Develop standardized regional outcome and quality measures for annual reporting.
3. Annually collect and publically report data from behavioral health organizations.
4. Define fiscal incentives for providers.
5. Utilize information for expanded advocacy efforts to attract additional funding.

FUNDING STRATEGY: TBD.

CHALLENGES: Given the emerging science of behavioral health, performance-based metrics may be difficult to establish. Current capabilities of provider agencies to collect and report data is limited in many circumstances.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 6: Provide training and technical assistance to providers on integration and partnerships of physical health and behavioral health in order to fully maximize federal, state and local funds.

TIMEFRAME: Mid-term (3-5 years)

BACKGROUND/OBJECTIVE(S): If psychiatry, counseling and other specialized services administered by behavioral health providers to Medicaid clients were billed under the community health center (CHC) umbrella, Medicaid match dollars currently required by behavioral health providers to fund these services would be freed up to provide more services. In addition, under this model, a behavioral health provider could serve every single Medicaid patient requiring psychiatry, counseling or other services that came to its doors including every community health center Medicaid referral. In addition, Department of Mental Health (DMH) funds could be appropriately leveraged by CHCs to enhance behavioral health services provided on-site.

RESPONSIBLE/LEAD PARTY: DMH, MO Health Net, CMHCs, CHCs and area universities, as appropriate.

ACTION STEPS:

1. Provide regional training and technical assistance to CHCs and CMHCs to understand how to maximize funding sources through partnership opportunities.
2. Assess and remove legislative and regulatory barriers, if and as they exist, at the State level to fully incent integration of community health centers and community mental health centers.

FUNDING STRATEGY: TBD.

CHALLENGES: None.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 7: Advocate for increased funding to support behavioral health services for the uninsured.

TIMEFRAME: Short-term (1-3 years)

BACKGROUND/OBJECTIVE(S): The Governor recently announced significant restrictions on the state spending for the remainder of the fiscal year which reduced MO Department of Health (DMH) community programs budget by \$3 million. Due to these restrictions, DMH providers will continue to serve existing clients, but will no longer accept new clients not covered by Medicaid, private insurance or other non-DMH funds from December 1, 2009 through June 30, 2010. This restriction has an even greater effect on the Eastern Region of MO because the extensive disability process causes a delay for consumers in this region to obtain Medicaid (Focus Area 4, Recommendation 1). The Task Force recommends advocacy efforts be targeted for funding behavioral health services for the uninsured at least 200% of the poverty level.

RESPONSIBLE/LEAD PARTY: Eastern Region behavioral health providers, Advocacy groups (e.g. NAMI St. Louis and Mental Health America of Eastern MO), Coalition of Community Mental Health Centers

ACTION STEPS:

1. Obtain data to show the effects the new restrictions will have on access to behavioral health services.
2. Develop and distribute key talking points to key advocacy groups.

FUNDING STRATEGY: TBD.

CHALLENGES: Budgetary restrictions in the State of MO.

Approved by Regional Health Commission December 16, 2009

FOCUS AREA 4: Funding

RECOMMENDATION 8: Advocate for increased Medicaid rates and service coverage for behavioral health services.

TIMEFRAME: Long-term (greater than 5 years)

BACKGROUND/OBJECTIVE(S): Increase current Medicaid payment schedules for behavioral health providers to equal Medicare rates for services provided in the Eastern Region. This may increase number of behavioral health providers willing to care for safety net patients, which would reduce the excessive wait times for behavioral health services in the Eastern Region.

RESPONSIBLE/LEAD PARTY: DMH, MO Health Net, Eastern Region behavioral health providers, Community Health Centers (CHCs) and area universities, as appropriate.

ACTION STEPS:

1. Model gap between Medicaid and Medicare rates and determine estimated total cost for increasing Medicaid rates, based upon assumed volume projections.
2. Identify funding stream as part of financing recommendation process.
3. Increase Medicaid service coverage to include recovery-oriented services, such as case management, employment, housing and other support services.

FUNDING STRATEGY: TBD.

CHALLENGES: Identifying ongoing funding stream for such payments.

Approved by Regional Health Commission December 16, 2009

Access to Behavioral Health Task Force Roster

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