



**EASTERN REGION PUBLIC
MENTAL HEALTH
PLANNING PROJECT**

**ALTERNATIVE
MODELS ANALYSIS**

AUGUST 2006

INTRODUCTION

The Eastern Region of Missouri¹ has a long-standing commitment to provide healthcare services to individuals and families affected by substance abuse and mental illness. In April 2006, the Eastern Region Community Mental Health Centers, Missouri Department of Mental Health Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse and the St. Louis Regional Health Commission partnered and began a first phase of strategic planning to improve access to and service delivery of behavioral health services.^{2 3}

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

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

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

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

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

² See **Appendix 1** for committee structure and steering committee composition.

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

ORGANIZATIONAL STRUCTURES

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

These include:

1. **Facility or Hospital-based** – This structure is typical in large organizations such as hospitals or comprehensive health centers where primary care and behavioral health departments are owned and operated by one corporate structure. Health systems made up of multiple hospital sites often have arrangements for behavioral health in one or two of their operating locations.
2. **Co-Location** – Health and mental health facilities may be in adjoining geographic locations or even in the same building. However, they are owned and operated by two different corporate owners.
3. **Networked or Purchased Services** – The integration of primary care and behavioral health care may be accomplished through the purchase of care in private for-profit or non-profit settings. Typically, a large integrated health system might outsource specialty mental health interventions by creating a provider network or contracting with a local Community Mental Health Center and/or Alcohol and Drug Abuse provider organization.
4. **Hybrid System** – In this system, a staffed and networked agency is created to broker contracts, deliver direct care and manage area-wide utilization of public, safety net services. The blending of internal staff provided and external purchased services is created to conserve resources while expanding the locations and array of available care.

OPERATIONAL STRUCTURES

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

- ∞ Political and organizational
- ∞ Core program philosophy
- ∞ Financing strategy
- ∞ Program mission, scope, and tactics
- ∞ Administrative infrastructure
- ∞ Staff training
- ∞ Performance indicators

In addition to the above criteria, stakeholders in the Eastern Region project determined that an effective crisis management system and a “collaborative care” approach to service delivery was important when considering program effectiveness. Stakeholders defined “collaborative care” as:

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

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

SITE VISITS

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

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

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

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

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

Stakeholders visited Burrell Behavioral Health in Springfield, Missouri; Detroit-Wayne County Community Mental Health Agency in Detroit, Michigan; Johnson County Mental

Health Center in Mission, Kansas; Swope Health Services in Kansas City, Missouri; Waccamaw Mental Health Center in Conway, South Carolina; and, Washtenaw Community Health Organization in Ypsilanti, Michigan. Based on the interview guide, information from each site visit is summarized in this document.

BURRELL BEHAVIORAL HEALTH, SPRINGFIELD, MISSOURI

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

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

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

Addressing Eastern Region Goals:

1. *Crisis intervention and case management functions:* Burrell assigns case managers to all seriously mentally ill clients in treatment. These staff coordinate all service needs with the client. The agency crisis system includes rapid assessment and a free-standing 10-bed “stabilization” unit which prevents unnecessary hospitalization. The “crisis intervention team” reported more than 4,700 contacts in 2005. Patients may be seen for initial screening at office locations and the hospital emergency departments. Less than half of the patients seen for crisis intake require hospitalization.
2. *Access to an array of behavioral health & health services:* The agency offers a broad continuum of behavioral health interventions including prevention, outpatient, residential, community based and inpatient care services. The client can enter “any door” to the system as dictated by initial screening results. Once in the system, they may move easily between services with guidance from case managers, as needed. Staff provide on-site services at 21 school district locations, Division of Family Services offices and at juvenile courts.

3. *Integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care:* The full array of behavioral health services are managed under the single administration of the Burrell program. This structure minimizes barriers to care for clients with dual disorders associated with mental illness and substance abuse. The program is also an integral part of the Cox Health system, which affords easy access to medical interventions. The system includes a 40 bed adult inpatient unit as well as a geriatric unit. Burrell staff also provide behavioral health services in the local Federally Qualified Health Center offices.
4. *Integrated funding streams to increase resources:* Burrell has diversified its program income to include private and public resources. While 19 percent of its operating budget comes from the Department of Mental health, an additional 16 percent is received from private pay, including commercial insurance.

DETROIT - WAYNE COUNTY COMMUNITY MENTAL HEALTH AGENCY

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

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

Addressing Eastern Region Goals:

1. *Triage, crisis intervention and case management functions:* The Wayne County area benefits from the operations of a crisis screening unit, crisis residential facilities, 24-hour mobile crisis response and 23-hour crisis respite beds. Multiple treatment sites and co-location of services with law enforcement, and social service settings are available. Case management service is clearly defined and widely available.
2. *Access to an array of behavioral health & health services:* The system affords easy access to care because it operates with links to medical and psychiatric emergency settings that are responsive to centralized assessment and triage. Programs are joined by a “common vision” to serve the client by working under the Gateway Community Health

collaboration. An administrative service organization (ASO) model is used effectively to allow sharing of client information as client is seeking care.

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

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

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

JOHNSON COUNTY MENTAL HEALTH CENTER, MISSION, KANSAS

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

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

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

- ∞ An array of integrated mental health and substance abuse services, including outpatient, residential, group home and crisis response capacity,
- ∞ Blended funding streams which maximize local, state and federal resources to support healthcare,
- ∞ An agency that continues to operate an active prevention program delivering more than 1,770 hours of community education and prevention.

Addressing Eastern Region Goals:

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

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

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

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

5. *Integrate information systems to improve service coordination for the client:* Information systems at Johnson County are integrated and allow data-sharing with the state facilities. Legislation was created as a result of mental health reform to legally

permit necessary clinical data to follow the patient, even in the absence of a signed release. The agency also is working to fully develop an electronic medical record. Progress notes and admitting information are now available in the electronic medical record format.

SWOPE HEALTH SERVICES, KANSAS CITY, MISSOURI

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

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

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

Addressing Eastern Region Goals:

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

2. *Access to an array of behavioral health & health services:* Swope Health Services is a comprehensive health and mental health center which spends more than 40 percent of its

operating budget on behavioral health care. The center operates a 30-bed residential drug abuse facility (Imani House) on the campus and relies on community and state hospital beds for acute inpatient needs. The agency also developed a comprehensive unique outreach program serving large homeless populations in Kansas City.

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

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

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

WACCAMAW MENTAL HEALTH CENTER, CONWAY, SOUTH CAROLINA

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

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

- ∞ A county/state based system which relies on multiple fund streams to support a full array of health and behavioral health interventions,

- ∞ Effective inter-agency collaborative agreements which allow each respective agency to operate independently, but in a coordinated approach to enhance client access,
- ∞ A strong commitment and history of serving minority populations,
- ∞ Established contracts with local hospitals that provide purchase agreements for inpatient care,
- ∞ Solutions to unique service demands created by a rural setting.

Addressing Eastern Region Goals:

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

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

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

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

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

WASHTENAW COMMUNITY HEALTH ORGANIZATION, YPSILANTI, MI.

With a budget of \$100 million for an integrated health care delivery system, \$44 million is designated for mental health and substance abuse services. The organization contracts with qualified providers, providing consistent, high-quality health care for the 331,000 citizens of Washtenaw County. Approximately 80,000 patients are seen annually. WCHO is a member of the Community Health Partnership of Southeastern Michigan, a collaborative effort between four Michigan counties established in 2002.

WCHO also benefits from a strong working relationship with the University Medical Center at Ann Arbor. The linkage with the psychiatric emergency services at the center and the related training opportunities with the University of Michigan help create a broad service platform for the area. Special features of the Washtenaw County program include:

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

Addressing Eastern Region Goals

1. *Strengthen triage, crisis intervention and case management functions:* Case management services are clearly defined, and form the basis for staff training for clinicians in addictions and mental health programs. Emergency room services at the medical center offer quick access for crisis management and referral. The system includes contract service providers to expand capacity.
2. *Improve access to an array of behavioral health & health services:* Washtenaw County collaborates with Oakland and Macomb counties to deliver a comprehensive array of services. Clients are included on the system advisory board to ensure attention to access issues. The area is well funded with \$40 million being spent last year for the population being served.
3. *Increase integration between a) mental health and substance abuse services, and b) increase integration between health and behavioral health care:* The system operates with a concept of providing a “medical home” for all patients seeking care. This concept fosters close cooperation between providers in the area, including primary care. A “single team” approach is used for each patient. The university health plan is included in the delivery approach. Behavioral health staff members are “imbedded in health care facilities.”
4. *Create an integrated funding stream and increase resources:* The partnering agencies in this area have considerable “clout” to ensure that a variety of fund sources are available. Major health plans, state, federal and local funds all contribute to the support of behavioral health and integrated health services. System coordination is the key to making the funding work. Agency leadership has worked with the state legislators to create a funding base which allows support for substance abuse, mental health and health services in a process that is “seamless to the client.”
5. *Integrate information systems to improve service coordination:* The local agency has developed, and is using, electronic medical records. The ENCOMPASS system is considered easy to use by providers and is being made available to other systems around

the country. The record format and content is designed to meet the needs of area stakeholders/providers.

SITE VISIT SUMMARY

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

Site Visit Summary

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

SITE VISIT CONCLUSIONS

- ∞ Service delivery challenges differ across programs for many reasons. Clearly, a successful program in Detroit, Kansas City or Springfield may not exactly fit the needs of people in the St. Louis region. The context of the program sites differs and definitely affects approaches to service. The size of the city, available transportation, demographics of the region, funding levels and cultural differences of the population are just a few examples of “contextual variables” that alter what and how services are delivered. These differences were noted as we visited sites and explored solutions. Although dissimilarity cannot be ignored, it should not limit discussions of how programs handle **access, quality and cost** parameters.
- ∞ The site visits also included discussion of best practice and evidence-based practice (EBP). Because these concepts are often applied in medical practice settings, they are more difficult to apply in behavioral health and social service agency structures where philosophies of care and intervention strategies vary widely. However, it is incumbent upon us to learn about treatment or recovery protocols which consistently produce good results as documented by replicated research findings. Site visits included some discussions of the EBP approach, the agency’s experience with it, and whether it could be successfully replicated in St. Louis.
- ∞ It is apparent that programs visited for this review represent high levels of coordination and integration that is largely the result of single entity administrative structures. When one agency (or a single county) is “in charge” of many functions, the burden of integration may be lighter. However, the St. Louis regional providers may never be united under one county, regional or state administrative entity. This suggests that promoting service coordination, integration and collaboration in the region will require a fresh approach to create a “networked” structure which can standardize key functions across all partner organizations. This might be accomplished using a common electronic data platform for entering clients into the system and tracking their service needs.

APPENDIX 1

Site Visit Questionnaire

I. Core Program Philosophy

- Briefly describe the agency mission and values:

- Is the system “seamless,” allowing the consumer to enter “any door?”
- How does the agency promote integrated or collaborative services?
 - i. Between physical and behavioral health
 - ii. Between mental health and substance abuse
- Does the agency have a well-documented administrative process and structure? Describe:

- How does the agency support cultural competence among services & providers?
- How does the system offer core services to specified population with evidenced-base approach?
- Does the agency follow a defined clinical practice model for behavioral health (BH) and primary care (PC)?
- How does the system focus resources on community interventions taking place in helping networks outside of traditional behavioral health settings (examples – schools, churches, legal system, etc.)?
- How does the system track:
 - i. Where individuals are receiving services
 - ii. Whatever state the individual is in e.g. crisis situation?

II. Financing Strategy

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

- Does the agency have a sustainable budget? How is this achieved?
- How does the agency maximize private insurance revenues?
- Does the agency have mechanisms for risk sharing with partners? What are they?
- Does the agency have agreements for distribution of cost savings (to partners)? How do they operate?

III. Program Scope and Tactics

- Is there a single case manager actively tracking the individual across all services?
- Is the scope of service clearly defined? Identify types of services provided:

- Describe clinical and team role expectations:

- Who are the target population(s) served?
- What are the triage and referral criteria for outside services? Examples?
- Is the system focused on alternatives to hospitalization? What are they?

IV. Staff Training

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

V. Performance Indicators

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

Other comments or observations:

Date: _____

RESOURCES

Feldman, Mitchell D., Christensen, John F., (2003) Behavioral Medicine in Primary Care, A Practical Guide, 2nd Ed., New York: McGraw-Hill.

McCombs, Harriet, DHHS Bureau of Primary Care

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

Sampson, Neil at US DHHS Bureau of Primary Care

GENERAL COMMENTS

Advantages of this system:

Disadvantages of this system:

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

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

Other Key Observations/Takeaways”