Access to Behavioral Health Task Force
“Integration of Physical and Behavioral Health” Recommendations

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.
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.
FINAL (Approved by Commission August 18)

**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.
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.
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
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.
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.
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.
**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
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.
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.
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.
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.
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.
The Four Quadrant Clinical Integration Model

**Quadrant II**

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

**Quadrant IV**

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

**Quadrant I**

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

**Quadrant III**

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment