Emergency Department Enhancement Project

General Provisions and Requirements for Participating Providers

WORKING DRAFT

1/10/2014 UPDATE
I. **Overview**

The Behavioral Health Network (BHN) Emergency Department Enhancement Project was established to improve referrals and care coordination for consumers between local hospitals, community mental health providers and substance use treatment providers in the Eastern Region\(^1\). The project is an expansion of the Hospital-Community Linkage Project model and is designed to incorporate referrals directly from emergency rooms.

As part of Governor Nixon’s *Strengthening Missouri’s Mental Health System* initiative, $1.2 million funding has been allocated annually by the Missouri Department of Mental Health’s (DMH) Division of Behavioral Health (DBH) to implement this project. The purpose of this funding is to develop a model of effective intervention for people with multiple/complex needs and limited resources experiencing a mental health crisis and seeking care at local hospital emergency rooms.

This document provides an overview of the basic provisions and requirements for participating providers as per the Emergency Department Project Proposal developed by the BHN and approved by the Missouri Department of Mental Health on August 30, 2013. This document and other required forms and information can be accessed on the BHN website at [www.bhnstl.org](http://www.bhnstl.org). For additional information you can contact Hillary Katsin, BHN Project Coordinator at hkatsin@bhrworldwide.com or 314-703-3653.

II. **General Provisions**

A. Community hospitals that operate behavioral health inpatient units and Emergency Departments *and* accept both voluntary and involuntary admissions will be allocated a number of treatment "slots" with community behavioral health providers to facilitate referral and linkage to community services for eligible consumers.

B. Each participating provider (hospital and community) will assign a liaison who will be the primary contact for the project and be responsible for project coordination and communications. Liaisons will be required to participate in regular liaison meetings held by the BHN for the purposes of information sharing, mutual problem-solving and performance improvement.

C. All providers will be required to directly participate in required project evaluation and data collection activities.

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\(^1\) The Eastern Region includes the City of St. Louis and the Missouri Counties of Franklin, Jefferson, Lincoln, St. Charles, St. Louis and Warren.
III. **Eligibility Criteria**

A. The primary target population for this project are adult consumers who present to the Emergency Department, are not admitted to an inpatient psychiatric unit, have ongoing behavioral health needs, and meet the following criteria:

1. Uninsured or regular Medicaid Insurance Status
2. Age 18 or older
3. Residents of the Eastern Region or homeless presenting in this region
4. Not currently linked with a service provider who can oversee/coordinate care
5. One (or more) of the following provisional diagnoses:
   a. Schizophrenia
   b. Delusional Disorder
   c. Bipolar I Disorders (I & II)
   d. Psychotic Disorders NOS
   e. Major Depressive Disorder-Recurent
   f. Major Depressive Disorder-Single Episode(Age 60 and older only)
   g. Obsessive-Compulsive Disorder
   h. Post Traumatic Stress Disorder
   i. Borderline Personality Disorder
   j. Anxiety Disorders

B. Given the limited availability of community treatment slots, priority will be given to individuals who are considered “high users.” This includes individuals:

1. With multiple ER visits in a relatively short period of time
2. With co-occurring mental illness and substance abuse disorders
3. That are not engaged in community behavioral health care and who are unlikely to easily engage in traditional services
4. With chronic medical conditions including Chronic Obstructive Pulmonary Disease (COPD)/Asthma; Diabetes Mellitus; Hypertension; Congestive Heart Failure (CHF); and Coronary Artery Disease, etc.
5. Who are below the federal poverty level
6. Who are homeless or have very unstable housing situations

D. Basic Exclusion Criteria includes the following:

1. Private Medical Insurance
2. Medicaid MC+ Insurance with Behavioral Health MCO
3. Veteran’s Benefits Eligible
4. DM 3700 Project identified consumers (can be referred but not assigned project slot)
5. Admitted to Inpatient Services (referrals should be made directly to liaisons assigned to work with hospital inpatient units as per HCL inpatient project guidelines)
IV. Referral Process

A. Hospital ED staff will evaluate consumer eligibility for referrals to allocated project slots based upon the eligibility criteria outlined in Section II. The attached Pre-eligibility Screening Form can be completed for this purpose.

B. If a decision is made to use an available slot, staff will contact the Community Referral Coordinator (CRC) when available on-site. If a CRC is not present, then staff will contact Behavioral Health Response (BHR) at 314-469-6644 or 800-811-4760 to make the referral.

C. BHR staff will verify consumer eligibility and schedule an appointment with a community mental health center (CMHC) for those eligible. If a consumer is also being referred for substance abuse treatment services, the Consent for Release of Confidential Information and/or Authorization to Discuss Form (attached) must be completed to facilitate communication and care coordination between the CMHC and the substance abuse treatment provider. If not signed, BHR will only schedule an appointment with the CMHC at that time.

D. BHR will provide the contact and appointment information to the referring hospital and forward the referral and appointment information to the community providers.

E. Hospital staff will forward relevant treatment information and a copy of any consent forms directly to the community treatment providers.

F. The assigned community mental health liaison will review the information received and initiate outreach and engagement services with each consumer until they are engaged in treatment. If the referral is made after business hours or over the weekend, BHR will provide phone and face-to-face outreach as needed until the consumer is connected with the community liaison.

G. The outreach and engagement process shall be initiated within 24-hours of the initial referral call to BHR for eligible consumers. This will be performed through a variety of methods as indicated (face-to-face, phone, mail/email).

1. An immediate face-to-face outreach at the hospital location should be made when possible and must be attempted if a client lacks any contact information, such as a phone number, location, or a family/friend support contact at the time of referral.

2. During business hours (8AM-5PM; M-F), the outreach will be initiated by the CMHC liaison, and by BHR all other times.

H. If the client misses his or her first appointment, the CMHC liaison shall continue the outreach and engagement process with a minimum of three attempts to contact, in-person when possible, and a 30-day follow-up where appropriate.

A flowchart is included on the following page that illustrates the referral process steps.
Hospital-Community Linkages ED Enhancement Referral Flow Chart

Hospital Staff complete pre-eligibility screening and makes determination on slot utilization.

Hospital Staff or on-site CRC calls BHR. The ADA “Consent for Release Confidential Information and/or Authorization to Discuss” is signed and faxed for SUD treatment referrals.

BHR verifies eligibility and determines need for immediate outreach as per guidelines.

BHR provides hospital staff appointment date and time and contact information for liaison(s).

BHR notifies CMH/ADA liaison(s) of referral by phone or email, and faxes case/consent. For ADA referrals, BHR also contacts ADA site manager by phone.

Hospital Staff secure releases and fax medical record documents to designated CMHC/ADA providers.

Business Hours (8AM-5PM M-F)

BHR notifies CMH/ADA liaison(s) of referral by phone or email, and faxes case/consent.

Outreach and Engagement initiated by CMHC liaison as per guidelines.

After Hours

BHR follows-up next day with provider(s) to confirm information was received. ADA liaison will contact CMHC liaison directly to initiate care coordination.

Outreach and Engagement initiated by BHR as per guidelines.
V. Data Collection, Reporting & Evaluation

The Department of Mental Health has contracted with the Missouri Institute of Mental Health (MIMH) to conduct the project evaluation. MIMH has been asked to report on changes in the following:

- Changes in ER utilization/hospital lengths of stay
- Incremental data on post-engagement ER utilization/hospital lengths of stay
- Enrollments in treatment programs (i.e., CPR, CSTAR, etc.)
- Diagnostic information
- Housing
- Employment
- Involvement with law enforcement

Data Collection is required for the purposes of this evaluation and will be collected at three points in time as follows:

A. **Referral:** Referring Hospitals will provide basic demographic, diagnostic and other data to BHR for each client they refer. BHR will enter this data into their Call-PRO System at the time of referral. The data will then be transferred daily to the Efforts to Outcomes (ETO) System for access by community providers.

B. **Initial Intake:** Community Mental Health Liaisons will access the referral data in the ETO system and complete the required intake questions at the time of their first contact with the client.

C. **3 Months Post-Intake:** Community Mental Health staff will complete a 3 month follow-up questionnaire with enrolled clients and enter this information to the ETO system.

Specific data requirements and instructions for completion are contained in the MIMH Evaluation QXQ Manual. Some additional data elements are also required by BHN. In addition, MIMH plans to evaluate the following:

A. **Stakeholder Collaboration:** All participating providers will be requested to complete a web-based questionnaire to measure the level of perceived collaboration.

B. **Focus Groups:** a series of focus groups will be held to assess participants’ experience of their ED care and discharge/community integration. Each focus group will include approximately 4-6 participants and last approximately 90 minutes. Participants will be compensated for their time and input.
PRE-ELIGIBILITY SCREENING
BEHAVIORAL HEALTH NETWORK ED ENHANCEMENT PROJECT REFERRAL

yes ☐ no ☐  1) Presence of Severe Mental Illness (SMI)
☐ Schizophrenia  ☐ Delusional D/O  ☐ Bipolar D/O  ☐ Psychotic D/O NOS  ☐ Anxiety D/O
☐ Major Depressive D/O Recurrent  ☐ OCD  ☐ PTSD  ☐ Borderline PD
☐ Major Depressive D/O Single Episode (age 60 and older ONLY)
☐ One of the above diagnoses AND Co-occurring Substance Use Disorder

yes ☐ no ☐  2) Insurance Status
Must be: Medicaid (not MC+) ☐     OR     Uninsured ☐

yes ☐ no ☐  3) Age
Must be 18 years of age or older

yes ☐ no ☐  4) Residency
Must be resident of one of the following counties:
☐ St. Louis City  ☐ Franklin  ☐ Warren
☐ St. Louis County  ☐ Jefferson  ☐ Lincoln
     OR
☐ Homeless and presenting in one of the above counties

yes ☐ no ☐  5) Community Treatment
Must not be currently enrolled with an outpatient behavioral health treatment provider

If able to answer “Yes” to all categories, consumer has met pre-eligibility requirements.

DISPOSITION:
☐ Referred to Community Referral Coordinator (CRC) when available on-site*
   CRC name: ____________________________________________
☐ Contacted Behavioral Health Response (BHR) if CRC is not available. BHR is available 24/7 (314-469-6644 or 800-811-4760). Inform the Call Center that you are making a referral to the ED Enhancement Project*
   BHR contact name: ____________________________________
☐ Other: ____________________________________________________________

*NOTE: If patient is also being referred for Substance Use Disorder (SUD) treatment the “Bridgeway Behavioral Health, Preferred Family Healthcare, Queen of Peace Center Consent for Release of Confidential Information and/or Authorization to Discuss Form” MUST be signed and either provided to the CRC or faxed to BHR before a SUD appointment can be made.

If answered “No” to ANY of the above categories, patient does not meet pre-eligibility requirements.
• Follow existing hospital discharge planning procedures

Place Patient Label Here

_________________________  _______________________
Staff completing Pre-eligibility Screening     Date/Time
Bridgeway Behavioral Health, Preferred Family Healthcare, Queen of Peace Center

Consent for Release of Confidential Information and/or Authorization to Discuss Form

This document is a:

□ Consent for Release of Confidential Information and/or Authorization to Discuss Form

I, Full Name: ____________________________ Date of Birth: ________________, authorize the organizations/agencies indicated below to disclose and discuss information from my records (as listed below).

Discharging Hospital: ____________________________ Phone: ____________________________

ADA provider:

□ Bridgeway Behavioral Health On Call Service Provider (OCSP) Phone: ____________________________

□ Preferred Family Healthcare (OCSP) Phone: ____________________________

□ Queen of Peace Center (OCSP) Phone: ____________________________

CMHC:

□ Adapt of Missouri Phone: ____________________________

□ Hopewell Center Phone: ____________________________

□ BJC Behavioral Health Phone: ____________________________

□ Independence Center Phone: ____________________________

□ Comtre Phone: ____________________________

□ Places for People Phone: ____________________________

□ Crider Health Center Phone: ____________________________

The following information from my records (specify the nature and extent of the information to be disclosed):

________________________________________________________________________________________

________________________________________________________________________________________

The purpose of need for such disclosure (List purpose, be as specific as possible)

________________________________________________________________________________________

________________________________________________________________________________________

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished per written request and may be for specific items or the entire release.

This consent will automatically expire 1 year from date of signature unless there is a different specification of date, event, or condition noted. ____________________________

Would you like a copy of this authorization? Please initial: ( ) YES ( ) NO

If yes, copies will be mailed to you if not provided immediately.

Signature of Patient: ____________________________ Date: ____________________________

Signature of Witness: ____________________________ Date: ____________________________

Signature of Parent/Guardian/Legal Rep: ____________________________ Date: ____________________________

(Specify relationship to patient: ____________________________)