MISSOURI HOSPITAL ASSOCIATION
PSYCHIATRIC NETWORK TASK FORCE MEETING
10 a.m. Tuesday, July 14, 2015
4712 Country Club Drive
Jefferson City, Missouri

AGENDA

I. Welcome, Introductions and Agenda Review* — Marsha Morgan, Chair

II. Review and Approve of Minutes* — Marsha Morgan

III. MHA, MO HealthNet, Department of Mental Health Updates

A. Medicaid Update — Joe Parks, M.D. MO HealthNet and Steve Renne
B. Legislative Update — Daniel Landon
C. DMH Update — Mark Stringer, DMH
D. Medicare Update — Andrew Wheeler
E. Regulatory Update — Sharon Burnett
F. Enacted Community Mental Health Liaison Bill, SB426 Implications for Hospitals — Rick Gowdy, DMH

IV. Old Business

A. Review and Approval of Operating Rules* — Marsha Morgan

V. New Business

A. Overview of Needs Assessment and Emergency Department Boarding Surveys* — Sharon Burnett
B. Develop Goals and Objectives for the Network — Marsha Morgan
C. Nominations for Committee Chair and Steering Committee — Marsha Morgan

VI. Next Steps — Marsha Morgan

*Indicates written agenda material included.

MISSOURI HOSPITAL ASSOCIATION
PSYCHIATRIC NETWORK
MINUTES OF MEETING
10 a.m. Tuesday, July 14, 2015
Missouri Hospital Association
4712 Country Club Drive
Jefferson City, Missouri

MEMBERS PRESENT	OTHERS PRESENT
Laura Festa	Sharon Burnett
Al Greimann	Rick Gowdy
Dayna Harbin	Daniel Landon
Alyson Harder	Joe Parks
Cara Macaleer (via phone)	Steve Renne
Susan Mathis (via phone)	Mark Stringer
Richard McGee	Andy Wheeler
Patty Morrow	Joe Parks
Mike Motte	Christine Patterson
Bob Reitz	
Gayle Reneer	
Marla Smith	
Lisa St. Aubyn	
Tom Stalf	
Lesa Stock	
Tracie Walker	

WELCOME AND INTRODUCTIONS

Marsha Morgan opened the meeting at 10:05 a.m.

MEDICAID UPDATE

Dr. Joe Parks, Director of MO HealthNet, spoke about the new contract requirements in the Medicaid Managed Care RFP. They include pay for performance, medical home and disease management components, performance benchmarks, and patient access requirements. He reported that MC plans are currently bound to the same mental health parity rules applicable to commercial payors.

Dr. Parks spoke about how MHN's procurement and implementation of the Medicaid Management Information System is consuming enormous staff resources and the state will be required to run the new and old systems in parallel for five years. Because of this and staff resources being focused on the Department of Mental Health's 1115 waiver application, MHN has put on hold the 1115 waiver request to continue the IMD demonstration project and MHA's request for SNF level payment for behavioral health patients boarded for extended periods beyond authorized bed payment days.

Dr. Parks also spoke about the legislative requirement to expand Medicaid Managed Care statewide in 2016. He indicated the division would keep three state plans and they would be operational in all areas of the state in 2016. He cautioned that regional plans proposed by some hospitals would take much longer to implement due to MMIS constraints.

Members expressed the following concerns:

- Unavailability of provider coverage for children in FFS Medicaid transferred to MC areas of the state.
- Payments for children in residential settings in FFS Medicaid are not comparable to MC payments.
- MC health plans are using psychiatrist for case review that do not live in Missouri and are unfamiliar with the state patient access issues. Dr. Parks recommended that hospitals request MC to have a case manager assist with access issues.
- Only one of three MC plans allows provisionally licensed psychologists to be credentialed and privileged. Because of severe state shortage of psychiatrists, members requested MHN require MC plans to allow provisionally licensed psychologists.

Dr. Parks reported that on October 1 when ICD-10 goes into effect, MHN will no longer be able to accept ICD-9 billing. He strongly encouraged hospitals to send batch test files through the MHN portal.

Steve Renne reviewed the current statistics of Missourians who are insured as a result of enrolling in the federal marketplace plan.

LEGISLATIVE UPDATE

Daniel Landon reviewed several federal legislative proposals affecting psychiatric treatment. Legislation (S. 599) to reauthorize and extend the lapsed Medicaid Emergency Psychiatric Demonstration Project has been approved by a U.S. Senate committee. Several bills are being considered regarding the prevention of and response to opioid abuse (S. 1134, S. 1654, H.R. 2850), with one specifically targeted to prenatal and post-natal implications (H.R. 1462). The Helping Families in Mental Health Crisis Act (H.R. 2646 is being debated by a House legislative committee but likely will need to resolve cost and policy concerns.

Landon also reviewed several state legislative proposals which were not enacted in 2015 but are expected to return for 2016. Various bills (House Bills 319, 1014, 340 and others) related to the expansion of telemedicine and telemonitoring capacity advanced with minimal controversy in 2015. House Bills 1148 and 868 would have changed standards for EMS transport of behavioral health patients. House Bill 538 would have expanded access to naloxone for use in responding to opioid overdoses.

DMH UPDATE

Mark Stringer, the new director of DMH, spoke about the Excellence in Mental Health Act under which Missouri has applied for and is well positioned to be one of eight demonstration states. Stringer also spoke about the success of the Community Mental Health Liaison and Emergency

Room Enhancements Initiatives over the past 18 months. Stringer reported that DMH is working with MHN to apply for a CMS 1115 waiver that would expand Medicaid coverage to a small group of individuals age 18 to 25 who experience their first serious mental illness episode. Goal is to demonstrate cost neutrality by getting them into early intervention and ultimately employed and off Medicaid.

MEDICARE UPDATE

Andy Wheeler reported that the FY 2016 inpatient psych PPS final rules should be implemented any day and an MHA Issue Brief on the proposed rule is available. Wheeler reviewed the following payment and policy updates for FY 2016:

- migration to 2010 OMB CBSA delineations
- quality reporting parameters continue to be refined
- IPF payments will be reduced if facilities do not report quality data. The marketbasket update will be reduced by 2 percent for those facilities.

REGULATORY AND QUALITY UPDATE

See MHA Regulatory and Quality Report for details. Members discussed the staffing and education variance request that freestanding psychiatric hospitals have submitted to DHSS. **Action Item: Psychiatric hospitals share a copy of the variances granted with MHA. MHA will then compile and send out to psychiatric hospitals.**

Members recommended Dr. Scott Zeller conduct a webinar for ED physicians. **Action Item: MHA will contact Dr. Zeller.**

Members requested the psychiatrist's workforce data be further analyzed to determine age range, how many are employed by VA, number of child psychiatrists and if data is by county of residence or work location. **Action Item: MHA will provide additional analysis.**

Members discussed the lack of Psychiatric Mental Health Advanced Practice Registered Nurses and R.N.s interested in working in behavioral health. **Action Item: MHA to discuss efforts to recruit nurses into psychiatric nursing.**

ENACTED COMMUNITY MENTAL HEALTH LIAISON BILL, SENATE BILL 426 IMPLICATIONS FOR HOSPITALS

Rick Gowdy, newly appointed DMH's Director of the Division of Behavioral Health, and Christine Patterson, Community Mental Health Liaison Coordinator with the Coalition of Community Behavioral Healthcare, provided an overview of Senate Bill 426 enacted in 2015 and effective on August 28. The bill adds Community Mental Health Liaisons to the list of individuals who can receive confidential information from mental health programs and facilities and from the courts about individuals who have been civilly committed for the purpose of care and service coordination. They also reviewed the role of CMH Liaisons in civil commitments emphasizing that their primary role is to assist law enforcement and courts thus avoiding unnecessary ED visits, admissions and incarcerations and to assist in aftercare planning for

civilly committed individuals. Community Mental Health Liaisons are qualified mental health professionals with a Master's Degree who are employed by the Community Mental Health Centers and designated by the DMH. **Action Item: Gowdy to provide overview for member distribution of what CMH liaisons and ACI coordinators can and cannot do.**

REVIEW AND APPROVAL OF MINUTES

The minutes from the April 17 meeting were reviewed and approved.

REVIEW AND APPROVAL OF OPERATING RULES

Members reviewed and approved the draft operating rules with one change — Section IV B. Attendance by at least 30 percent of the [*membership]* **hospitals in the Network** at any duly called meeting shall constitute a quorum. Members agreed to limit the member representatives to two per hospital or system if a system decides to be represented at a system level only as specified under Section III B. **Action Item: Member hospitals with more than two representatives shall notify MHA which two will represent their hospital.**

OVERVIEW OF NEEDS ASSESSMENT AND EMERGENCY DEPARTMENT BOARDING SURVEYS

Sharon Burnett provided an overview of the April 2015 ED boarding survey as well as the survey trend for the past five years. She also provided the group with a copy of the needs assessment completed by network members in late April.

DEVELOP GOALS AND OBJECTIVES FOR THE NETWORK

Morgan led the members in a discussion of their top concerns and issues. The top issues and recommendations made were the following:

- Managed care issues — Schedule a face-to-face meeting with MC companies and their subcontracted or MH carve out providers, hospitals and MHN officials. Members reported that the Coalition of CBH was planning on scheduling a similar meeting. **Action Items: MHA to contact Brent McGinty at the Coalition and arrange for the meeting. MHA to send members joint legislative managed care committee hearing schedule when it is known. Alyson Wysong-Harder and Al Greimann volunteered to develop a one-page overview of the managed care issues.**
- Throughput issues — Members reported that PASRR delays at DHSS and Level II screening continue to cause significant discharge delays. They recommended that DMH contractor conduct screening using telecommunication whenever possible and that MHA investigate the reasons that the PASRR process is experiencing significant delays again. **Action Item: MHA to discuss with DMH and DHSS.**

Members also discussed their inability to discharge patients back to sending facilities/homes and the inability to find suitable discharge placement for SMI and/or DD patients with significant behavioral problems or co-occurring medical conditions. They reported increasing problems placing children. Members recommended having a meeting with representatives from DSS,

DHSS, DFS, DMH's Division of Behavioral Health and DD and the Coalition at the November meeting at Tan-Tar-A. **Action Items: MHA to explore scheduling a meeting. Patti Morrow and Cara Macaleer volunteered to develop a one-page overview of the placement issues.**

- Survey Issues — Members believe that psychiatric hospital and units are disproportionally surveyed more frequently and that surveyors do not understand the complexities of caring for this population.
- Psychiatric provider representation and voice on the MHA Board of Trustees — Members recommended that a member of the Psychiatric Network be appointed to the MHA board to represent psychiatric provider's needs and interests.

NOMINATIONS FOR COMMITTEE CHAIR AND STEERING COMMITTEE

Morgan and Burnett discussed how the first year's election would be conducted to meet the requirements of the operating rules Section V. B. Morgan would remain as chair representing psych units through 2016. An election will be conducted by electronic vote prior to the November meeting to elect the co-chair representing psychiatric hospitals and that co-chair would serve in 2016 and 2017. As this is an odd year, steering committee representatives from MHA districts 1, 3 and 5 would be elected for two years and representatives from districts 2, 4 and 6 would be elected for a one year term prior to the November meeting. **Action Item: MHA to send out requests for co-chair and steering committee representatives and then send out electronic ballots to the network members.**

NEXT STEPS AND ADJOURNMENT

Morgan reviewed identified action items and adjourned the meeting at 2 p.m.

MHA REGULATORY AND QUALITY REPORT
July 14, 2015

REGULATORY UPDATE

MHA is creating a Survey Manual for hospitals, a guide to the licensing and survey process in Missouri. This comprehensive manual is intended to help hospital leaders prepare for and understand the survey process. The manual should be available for download by September 1. At a recent meeting of the MHA Survey and Licensure Advisory Committee, the Department of Health and Senior Services reported no progress on the proposed psychiatric rule revisions but offered that they are accepting variance requests to the staffing and training requirements.

CMS Proposes Mental Health Parity Rule for Medicaid & CHIP Plans

On April 6, 2015, CMS released a proposed rule that applies the provisions of the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, Medicaid alternative benefit plans, and Children's Health Insurance Program plans. The goal is to align as much as possible with the approach taken in the final MHPAEA regulation to create consistency between the commercial and Medicaid markets. The MHPAEA requires that health plans provide behavioral health benefits at parity with medical/surgical benefits of the same class. Treatment limitations for any behavioral health benefit class must be no more restrictive than those applied to "substantially all" (or at least two-thirds) medical/surgical benefits in the same classification.

MHA submitted comments emphasizing the need for transparency in documenting mental health parity and eliminate the IMD exclusion as it runs contradictory to the MHPAEA.

CMS Overhauls Medicaid Managed Care Regulations; Proposes End to IMD Exclusion for 15-Day Stays

On May 26, 2015, CMS released a proposed rule on Medicaid and Children's Health Insurance Program managed care regulations, which focuses on network standards and quality measures, medical loss ratio standards, and rate setting transparency. The rule also includes a provision to end the reimbursement exclusion of services provided to adults by an institution for mental disease for 15 days or less. CMS defines an IMD as any inpatient or residential psychiatric treatment setting with more than 16 beds.

The provisions of the proposed rule, Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability, are intended to update the programs' rules and strengthen the delivery of quality care for beneficiaries. It is the first major update to Medicaid and CHIP managed care regulations since 2003. A key goal is to better align Medicaid and CHIP managed care rules and practices with those of other payers. MHA is drafting comments on the proposed rule which are due July 27, 2015.

QUALITY UPDATE

MHA Submits Comments On Proposed Rule Outlining FY 2016 Inpatient Psychiatric PPS Update And Quality Measures

MHA submitted comments on a CMS proposed rule outlining the Medicare program's Inpatient Psychiatric Facilities Prospective Payment System update for fiscal year 2016

July 15 Webinar Scheduled on Keys to Successful FY 2016 IPF Quality Reporting

Outreach and Education webinar for participants in the Inpatient Psychiatric Facility Quality Reporting Program is scheduled for July 15 at 12 p.m. noon. "Keys to Successful FY 2016 Reporting" will summarize the IPFQR Fiscal Year 2016 data submission requirements, provide best practice guidelines for successful reporting, as well as guidance on how to confirm data accuracy. Slides and recording are archived and available at http://www.qualityreportingcenter.com/inpatient/ipf/events/.

OTHER NEWS OF INTEREST

Psychiatric Readmissions In Community Hospitals

A statistical brief (#189) from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project found that 30-day readmission rates in 2012 were 15.7 percent when the primary diagnosis was schizophrenia and 9 percent when the primary diagnosis involved mood disorders. This compares with a 30-day readmission rate of 3.8 percent for all other non-mental health/substance abuse conditions. Alcoholism/chemical dependency hospitals are excluded. Hospital Readmissions Involving Psychiatric Disorders, 2012 is based on data from the HCUP Nationwide Readmissions Database and the HCUP National (Nationwide) Inpatient Sample, which includes Missouri data. The national report is available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb191-Hospitalization-Mental-Substance-Use-Disorders-2012.jsp. We are working on getting a Missouri specific report.

In Case You Missed It

AHA member archived webinars are available http://www.aha.org/hospital-members/advocacy-issues/mentalhealth/confcalls.shtml. You will need an AHA member log in to access.

- July 7, 2015 Community-Based Behavioral Health Solutions
- June 4, 2015 Psychiatric Patient Boarding Problems in the Emergency Department by Scott Zeller, MD.
- May 27, 2015 Improving 24/7 Access to Behavioral Health – Via an Outpatient Assessment Center, ED Telehealth, & Video Home Visits

Workforce News

2014 data from the DHSS Office of Primary Care and Rural Health shows that the shortage of psychiatrists has worsened in Missouri since 2005. In 2014, there were on 636 psychiatrists serving 5,988,927 Missourians or one for every 11,194 people and there were 72 counties

without a single psychiatrist. In 2005, there were 616 psychiatrists serving 5,595,211 Missourians or one every 9,083 people and 71 counties without a psychiatrist. Data from the Missouri State Board of Healing Arts which contributes data to the OPCRH was used for the report.

Good news is that the 2015 County Health Rankings shows that Missouri has significantly more mental health providers than the national average. Data is available at www.countyhealthrankings.org/missouri.

Measure	Description	US Median	MO Overall	Minimum MO	Maximum MO
Mental Health Providers	Ratio of population to mental health providers	1128:1	632:1	13688:1	272:1

Missouri Hospital Association Psychiatric Network

Operating Rules

Approved July 14, 2015

I. NAME

The network shall be known as the Missouri Hospital Association Psychiatric Network.

II. PURPOSE AND OBJECTIVES

A. Purpose.

The purpose of the Missouri Hospital Association Psychiatric Network is to serve as a forum for collaboration among psychiatric hospitals and units, including the promotion of activities regarding:

1. Sharing of best practices
2. Continuing education
3. Performance improvement
4. Identifying and addressing common issues
5. Providing guidance to MHA on legislative and regulatory issues
6. Sharing information and common resources
7. Grants and other funding resources

B. Objectives.

The network shall provide direction and leadership in shaping the effective and efficient delivery of behavioral health care in communities throughout Missouri. Specifically, the network provides:

1. A mechanism for the interchange of ideas and dissemination of information relative to behavioral health.
2. A platform from which psychiatric hospitals and units executives may speak.
3. Educational programs and activities to strengthen the performance of psychiatric hospitals and units.
4. Recommendations regarding policies, programs and activities affecting psychiatric hospitals and units to MHA, the Missouri Department of Mental Health, and other appropriate organizations.

III. MEMBERSHIP

A. Membership.

Each hospital, as defined by 197.020 RSMo, providing inpatient psychiatric services within Missouri and a member of the Missouri Hospital Association, is a member of the network. MHA will provide staff as an ex-officio member.

B. Representation.

Each hospital or system with hospitals as defined in Article III, Section A, shall be represented in the network by its chief executive officer or his/her designee. Each hospital or system shall be limited to two members per organization. Other individuals or organizations including, for example, the Missouri DMH, may be invited to participate in network activities but shall not be members of the network.

C. Termination.

An entity which is no longer providing inpatient psychiatric service or is no longer a member of MHA, may be terminated from the network.

D. Membership Fees.

There shall be no additional MHA fees or dues for membership in the network, unless the network chooses to assess a fee for a specific activity.

IV. MEMBERSHIP MEETINGS

A. Membership Meetings.

Meetings shall be held at least three times each year. In-person meetings will be held in conjunction with the MHA Annual Behavioral Health Conference in April, the MHA Annual Meeting and Trade Show in November and at one other time during the year. Additional meetings by teleconference may be held at the discretion of the Steering Committee. The membership shall be notified of in person membership meetings at least two months in advance.

B. Quorum.

Attendance by at least 30 percent of the hospitals in the Network at any duly called meeting shall constitute a quorum.

C. Rules of Procedure.

The order of business for meetings shall be as provided by the Steering Committee or by Robert's Rules of Order.

D. Voting.

On all issues requiring a vote of the membership, each member of the Psychiatric Network shall be entitled to one (1) vote. Voting by proxy shall not be permitted. Voting by acclamation may be used at assembly or conference call meetings. Any member present during the meeting may request a roll call vote be taken.

V. STEERING COMMITTEE AND OFFICERS

A. Steering Committee.

There shall be a Steering Committee for the network consisting of the Chair, Co-Chair and one (1) representative from each of the six MHA districts.

B. Eligibility.

The Chair and Co-Chair shall be a chief executive officer of a psychiatric hospital and the executive director/senior leader of a psychiatric unit or hospital system with behavioral health inpatient units in Missouri. The Chair shall be elected in even years and the co-chair in odd years. The term of each shall be for two years. Each district representative shall be a chief executive officer of a psychiatric hospital or the executive director/senior leader of a psychiatric unit/hospital system or his/her designee located in the MHA district they are representing. Term of office shall be for two years; even numbered districts elected on even year cycles and odd numbered districts on odd year cycles.

C. Selection of Chair, Co-Chair and District Representatives.

The selection of the Chair, Co-Chair and District Representatives shall be held at the November membership meeting each year. The newly elected Steering Committee members shall assume their duties at the close of the November meeting.

D. Termination and Vacancies.

The Chair, Co-Chair or any District Representatives may resign at any time by giving written notice to the Chair or Co-Chair. The resignation shall become effective upon the date specified or, if no date is specified, upon the receipt of such resignation. The term of the Chair, Co-Chair or a District Representatives shall automatically terminate when the individual is no longer employed as chief executive officer of a psychiatric hospital or the executive director/senior leader of a psychiatric unit or hospital system with behavioral health units located in the MHA district they represent. A vacancy of the Steering Committee shall be filled by appointment by the Steering Committee until the next membership meeting.

E. Duties of Steering Committee, Chair and Co-Chair.

1. Steering Committee

   The duties of the Steering Committee shall be as follows:

   a. develop and implement annual goals and objectives for the network
   b. direct and oversee the business of the network
   c. represent the membership of the network
   d. encourage participation in the network
   e. review committee reports, if any, and determine recommendation to make to MHA staff and/or the MHA Board of Trustees
   f. foster growth and development of the network
   g. develop long-range planning for the network
   h. act as a liaison with other organizations

2. Chair and Co-Chair

   The Chair and/or Co-Chair shall arrange for and preside at all membership meetings of the network and of the Steering Committee. The Chair and Co-Chair shall supervise the activities of the network, present appropriate reports at meetings, represent the network as appropriate, and perform such other duties as authorized by the Steering Committee.

F. Meeting of the Steering Committee.

The Steering Committee shall meet at least three times each year. Interim meetings may be called by the Chair or Co-Chair.

G. Committees.

The Steering Committee may designate additional ad hoc committees as needed. Members of these committees and their duties shall be approved by the Steering Committee.

VI. STAFFING

The Missouri Hospital Association Psychiatric Network shall be provided staffing from MHA, and shall work collaboratively with MHA and other entities with interests in psychiatric hospitals and units as deemed appropriate by MHA and the Steering Committee.

VII. ADOPTION AND AMENDMENTS

These Operating Rules may be adopted, altered, amended or repealed by a two-thirds vote of the members present at any membership meeting. Notice of proposed changes shall be communicated to all members at least seven days in advance of the meeting. Amendments may be proposed by the Steering Committee or any network member.

Approved by Membership of the Network:

_____
Network Chair

_____
Date

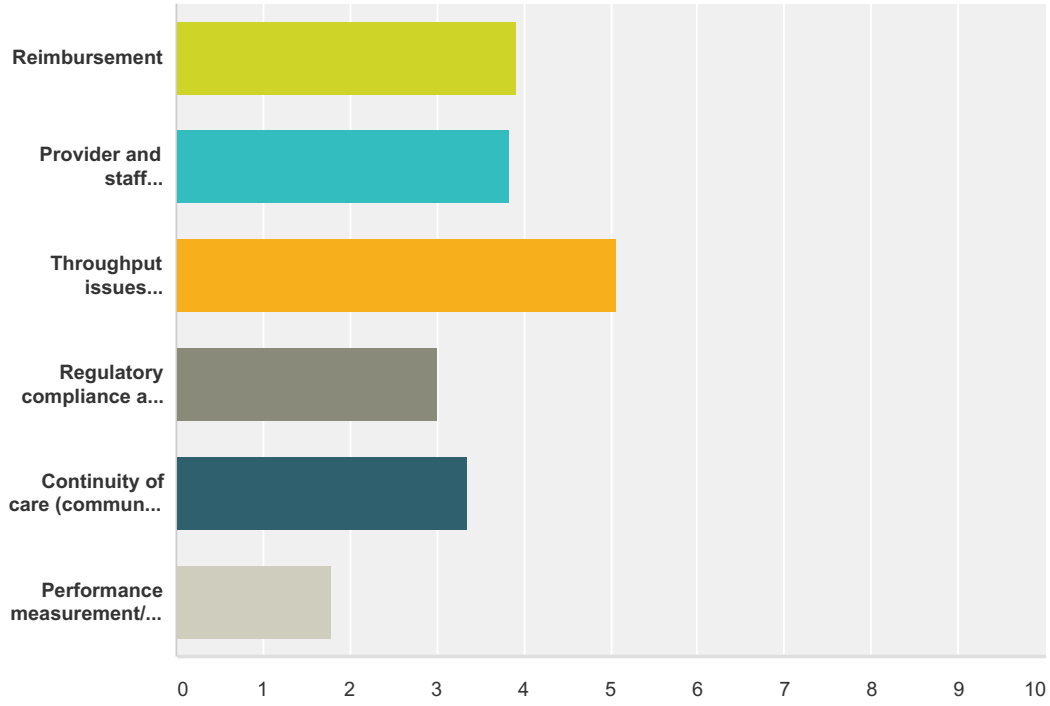
Accepted by MHA:

_____
President and CEO

_____
Date

Q1 Identify the most challenging issues impacting your inpatient behavioral health unit/hospital by ranking the following from 1 - most challenging/pressing issue, to 6 - least challenging issue.

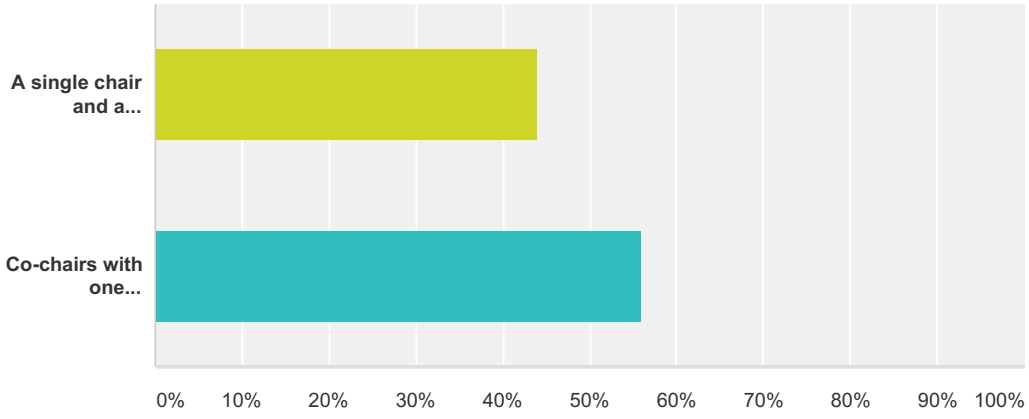
Answered: 25 Skipped: 0



	1	2	3	4	5	6	Total	Score
Reimbursement	16.00% 4	36.00% 9	8.00% 2	16.00% 4	12.00% 3	12.00% 3	25	3.92
Provider and staff recruitment	28.00% 7	20.00% 5	16.00% 4	4.00% 1	8.00% 2	24.00% 6	25	3.84
Throughput issues (difficult-to-place patients, ED boarding)	52.00% 13	24.00% 6	12.00% 3	4.00% 1	8.00% 2	0.00% 0	25	5.08
Regulatory compliance and safety (suicide, elopement, abuse, violence, etc.)	0.00% 0	4.00% 1	28.00% 7	40.00% 10	20.00% 5	8.00% 2	25	3.00
Continuity of care (community and OP resources, readmissions)	4.00% 1	16.00% 4	32.00% 8	12.00% 3	32.00% 8	4.00% 1	25	3.36
Performance measurement/improvement (HBIPS, falls, restraints, injuries)	0.00% 0	0.00% 0	4.00% 1	24.00% 6	20.00% 5	52.00% 13	25	1.80

Q2 For committee chair, indicate your preference.

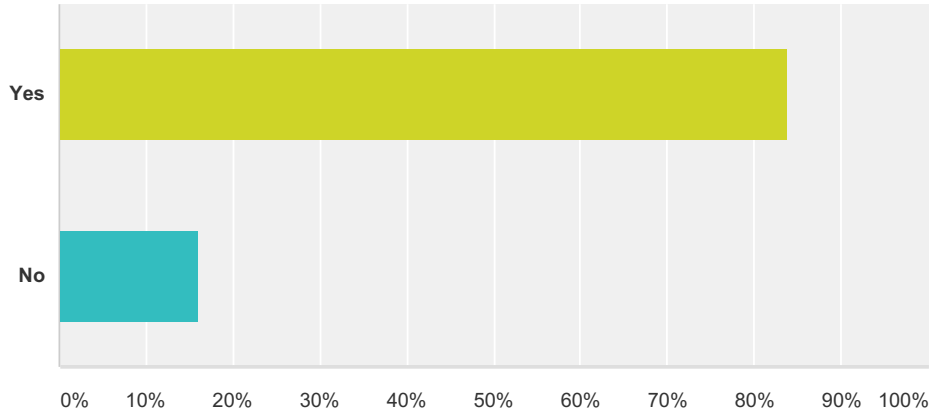
Answered: 25 Skipped: 0



Answer Choices	Responses	
A single chair and a chair-elect selected by the members each year	**44.00%**	11
Co-chairs with one representing psych units and one representing psychiatric hospitals	**56.00%**	14
Total		**25**

Q3 Are you interested in participating in a learning and performance improvement collaborative focused on the unique needs of psychiatric providers?

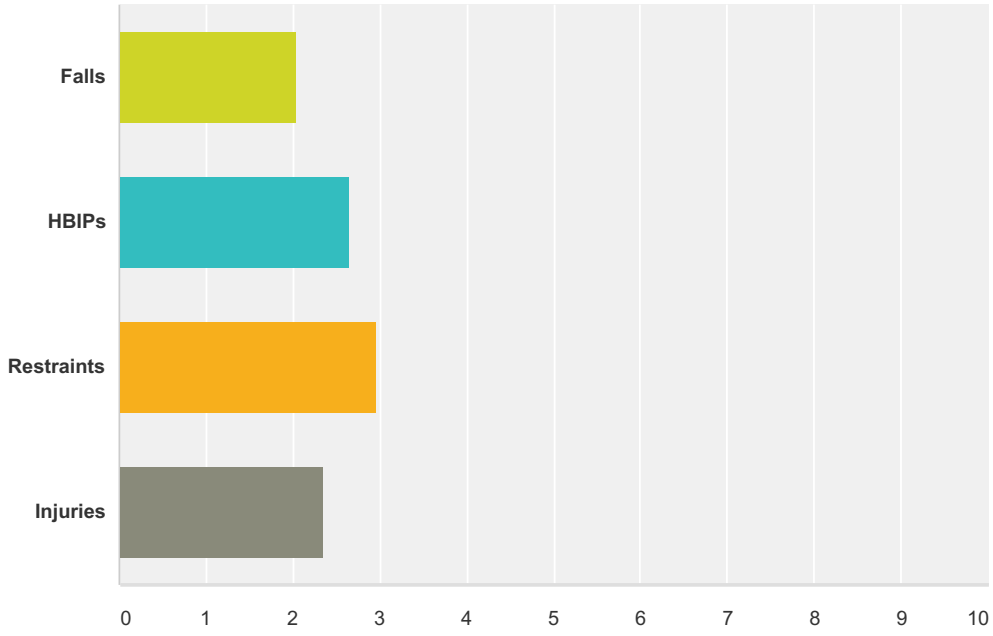
Answered: 25 Skipped: 0



Answer Choices	Responses	
Yes	**84.00%**	21
No	**16.00%**	4
Total		**25**

Q4 If yes, rank area of greatest interest.

Answered: 23 Skipped: 2



	1	2	3	4	Total	Score
Falls	**17.39%** 4	**13.04%** 3	**26.09%** 6	**43.48%** 10	23	2.04
HBIPs	**34.78%** 8	**21.74%** 5	**17.39%** 4	**26.09%** 6	23	2.65
Restraints	**34.78%** 8	**39.13%** 9	**13.04%** 3	**13.04%** 3	23	2.96
Injuries	**13.04%** 3	**26.09%** 6	**43.48%** 10	**17.39%** 4	23	2.35

Other Challenging Issues or Improvement Collaborative Areas of Interest
Discontinuation of the Medicaid IMD
I want to be sure injuries includes injuries to staff and the increased violence/aggression experienced
Handoff communication
Staying abreast of the legal and political arena for the mental health area.
Licensing reviews/surveys
Trauma-Informed Clinical Care Models and applicability in the inpatient setting
ER Boarding, lack of community resources available to indigent patients through Community Mental Health Centers
Self-pay
Creating a network of physician, professional, and staff recruitment. Also learning of best practices within pysch in Missouri.
Medical Necessity Denials for inpatient care
Level 2 approval process takes two or more weeks. Violent patients with forensic history, placement back into state facility treatment options for MR/DD patients not appropriate for inpatient psych units.
Readmission rates Acute medical-psychiatric environment needs
Availability of beds for MMRD patients in the state. Seeing more of this type of patient on unit and very distributive to groups as well as challenging for staff. Increasing number of patients with violent tendencies as well as though coming from our jails. Difficulty to transferring these patients across the State-lack of available ambulances-cause increased los in our ED's as well as transferring patients back to their county of origin is expensive for the hospital. More educational opportunities for nurses.
Patient placement and continuum of care issues post discharge

PSYCHIATRIC BOARDING SURVEY
April 12 – 18, 2015

87 hospitals answered the survey. 60 reported boarding during the week (49 acute and 11 CAHs; 32 with psych beds and 28 without psych beds). 83 identified their hospital by name.

Of those 60 hospitals who boarded. Total of 690 patients boarded. 609 were from hospitals with psych services and 81 from hospitals without psych services.

District	Hospitals Reporting	Boarding Hospitals	Patients Boarded	Pts/Reporting Hospital	Pts/Boarding Hospital
1	8	4	14	1.78	3.5
2	10	8	75	7.5	9.4
3	21	11	54	2.6	4.9
4	19	17	264	13.9	15
5*****	14	12	242	17.3	20.2
6	11	8	41	3.7	5.1
Totals	**83**	**60**	**690**	**8.3**	**11.5**

*****CoxHealth reported for all hospitals in system

123 patients boarded were less than 21 years of age. Most were boarded for 4 to 8 or 8 to 24 hours only one reported greater than 24 hours.

527 patients boarded were 21 to 64 and fairly 17 evenly distributed over the 2-4, 4-8 and 8–24 hour range with 4 hospitals reporting boarding longer than 24 hours.

40 patients boarded were 65 or older and fairly evenly distributed over the 2-4, 4–8 and 8–24 hour range with no hospitals reporting boarding more than 24 hours.

42 patients were admitted to non-psych beds because no psych beds were available (excludes those admitted for medical stabilization). On hospital admitted 19 psychiatric patients to a medical bed during this time period.

Three hospitals reported discharging patients to home or community setting after holding them in the ED for longer than 24 hours.

Top Reasons for boarding:

1. 49 - lack of accepting facility psych beds
2. 32 - lack of in-house psych beds
3. 13 - lack of accepting facility due to patients condition/needs
4. 10 - length of time for eval by psych personnel
5. 10 - waiting for additional lab and x-ray results
6. 8 - lack of appropriate transport services

51 hospitals completed the point-in-time survey done on morning of April 13. Only 13 reported boarding a total of 46 patients.

Five Year ED Boarding Survey Summary

Year	Hospitals Reporting	Boarding Hospitals	Patients Boarded	Pts/Reporting Hospital	Pts/Boarding Hospital
2011 (Aug)	89	67	530	6	7.9
2012 (Aug)+	64	46	575	9	12.5
2013 (April)	64	55	355	5.5	6.4
2014 (April)	47	38	223	4.7	5.9
2015 (April)*	83	60	690	8.3	11.5

+IMD demo started Sept. 202

*IMD demo ended March 2015

2014			
County	Psychiatrist	Population	Psychiatrist/Population
Adair	1	25,607	
Andrew	3	17,291	
Atchison		5,685	
Audrain	2	25,529	
Barry		35,597	
Barton		12,402	
Bates		17,049	
Benton	1	19,056	
Bollinger		12,363	
Boone	34	162,642	
Buchanan	8	89,201	
Butler	4	42,794	
Caldwell		9,424	
Callaway	4	44,332	
Camden		44,002	
Cape Girardeau	4	75,674	
Carroll		9,295	
Carter		6,265	
Cass	3	99,478	
Cedar		13,982	
Chariton		7,831	
Christian	2	77,422	
Clark		7,139	
Clay	8	221,939	
Clinton		20,743	
Cole	7	75,990	
Cooper		17,601	
Crawford	1	24,696	
Dade		7,883	
Dallas		16,777	
Daviess		8,433	
DeKalb		12,892	
Dent		15,657	
Douglas		13,684	
Dunklin	1	31,953	
Franklin	6	101,492	
Gasconade		15,222	
Gentry		6,738	
Greene	30	275,174	
Grundy		10,261	
Harrison		8,957	
Henry	4	22,272	
Hickory		9,627	
Holt		4,912	
Howard		10,144	
Howell	2	40,400	
Iron		10,630	
Jackson	71	674,158	
Jasper	15	117,404	
Jefferson	5	218,733	
Johnson	2	52,595	
Knox		4,131	
Laclede		35,571	
Lafayette		33,381	
Lawrence	2	38,634	

2014			
County	Psychiatrist	Population	Psychiatrist/Population
Lewis		10,211	
Lincoln	1	52,566	
Linn		12,761	
Livingston	1	15,195	
Macon	1	15,566	
Madison		12,226	
Maries		9,176	
Marion	5	28,781	
McDonald		23,083	
Mercer		3,785	
Miller		24,748	
Mississippi	1	14,358	
Moniteau		15,607	
Monroe		8,840	
Montgomery		12,236	
Morgan		20,565	
New Madrid		18,956	
Newton		58,114	
Nodaway	3	23,370	
Oregon	2	10,881	
Osage		13,878	
Ozark		9,723	
Pemiscot		18,296	
Perry		18,971	
Pettis	3	42,201	
Phelps		45,156	
Pike		18,516	
Platte	4	89,322	
Polk	2	31,137	
Pulaski	2	52,274	
Putnam		4,979	
Ralls		10,167	
Randolph		25,414	
Ray		23,494	
Reynolds		6,696	
Ripley		14,100	
Saline		23,370	
Schuyler		4,431	
Scotland		4,843	
Scott		39,191	
Shannon		8,441	
Shelby		6,373	
St. Charles	13	360,485	
St. Clair, MO		9,805	
St. Francois	10	65,359	
St. Louis City	84	319,294	
St. Louis County	175	998,954	
Ste. Genevieve		18,145	
Stoddard		29,968	
Stone	1	32,202	
Sullivan		6,714	
Taney	2	51,675	
Texas		26,008	
Vernon	3	21,159	
Warren		32,513	

2014			
County	Psychiatrist	Population	Psychiatrist/Population
Washington	2	25,195	
Wayne		13,521	
Webster		36,202	
Worth		2,171	
Wright		18,815	
Missouri 2014	535	5,988,927	11194
			72 counties w/o psychiatrist
2014 data from DHSS Office of Primary Care and Rural Health			
Missouri 2005	616	5,595,211	9083
2005 Data from Healing Arts			71 counties w/o psychiatrist
Unknown/Out of State	360		
2005 based on 2000 census data			

Assistance from the Missouri Foundation for Health and the Health Care Foundation of Greater Kansas City

Developing an Early Intervention Medicaid Waiver for Young Adults in Behavioral Health Crisis

DBH
Division of Behavioral Health

July 1, 2015

Holiday Inn Executive Center
Columbia MO

Strengthening Missouri's Public Mental Health System

Governor Nixon's FY 2014 Initiative:

- **Community Mental Health Liaisons (CMHL)**
- **Emergency Room Enhancements (ERE)**
- **Mental Health First Aid Training (MHFA)**
- **Crisis Intervention Team Training (CIT)**
- **NAMI Family Programs**

Division of Behavioral Health

The CMHL Experience: The First 18 Months

31 Community Mental Health Liaisons:

- **11,000 total referrals**
- **8,250 referrals engaged in services**
- **3,300 ages 18-35**
  - **2,475 (75%) SMI and SMI/SUD**
  - **825 (25%) SUD only**

NOV-13 TO APR-15

Division of Behavioral Health

The ERE Experience: The First 18 Months

7 Regions, 60 Hospitals, ER's, Medical Clinics:

- **1,974 total referrals**
- **1,927 referrals engaged in services**
- **934 ages 18-35**
  - **698 (75%) SMI and SMI/SUD**
  - **236 (25%) SUD only**

Division of Behavioral Health

1115 Waiver for Young Adults in Behavioral Health Crisis

- **CMHL and ERE have identified large numbers of persons who need a comprehensive package of behavioral health and medical services**
- **Many are uninsured and capacity for CMHC's to serve them is limited**
- **Many are experiencing first major mental illness episodes**
- **18-35 population has unique needs and may not respond well to traditional DMH/Medicaid programs**
- **Early intervention and ongoing services can minimize the impact of disabling conditions at a lower cost to the state**
- **DMH has had initial success with early intervention service models for young adults**

Division of Behavioral Health

Key Waiver Timeline Goals

<u>July 1, 2015</u>:
Engaging key contractors for waiver writing, technical assistance and budget neutrality (Health Management Associates, Mercer)

<u>October 1-31, 2015</u>:
Public comment period, including statewide public hearing forums

<u>December 1, 2015</u>:
Submission of 1115 Waiver request to CMS

<u>July 1, 2016</u>:
Effective date of 1115 Waiver for young adults in behavioral health crisis

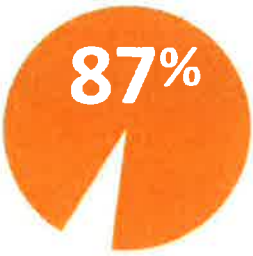
Division of Behavioral Health

THE MISSOURI HEALTH INSURANCE MARKETPLACE
2015 Results

COVER MISSOURI

Overall Enrollment:

253,430 Signed up for a Marketplace Plan



219,953 **Effectuated Coverage** *(paid their first bill)*

Of the 50 states and D.C., **Missouri ranked 12th highest in the number of enrollees.**

59% *(128,846)* Received a cost-sharing reduction for out-of-pocket costs

90% *(197,663)* Received a premium assistance tax credit

For those who received a premium assistance tax credit:

$363 Average monthly premium before tax credit

$278 Average monthly tax credit

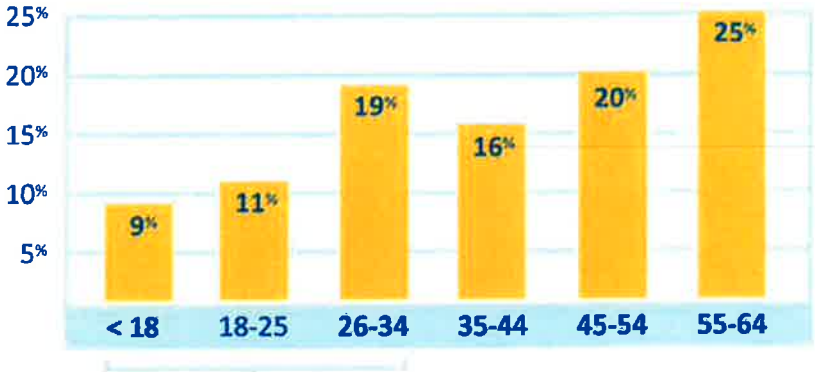
$85 Average monthly premium after tax credit

77% Average reduction in premium after tax credit

Plan Levels of Missouri Enrollees with Effectuated Coverage

Plan Level	Enrollees	Percentage
Catastrophic	486	0.2%
Bronze	56,661	26%
Silver	145,369	66%
Gold	16,652	8%
Platinum	785	0.4%

Percentage of Marketplace Enrollees by Age

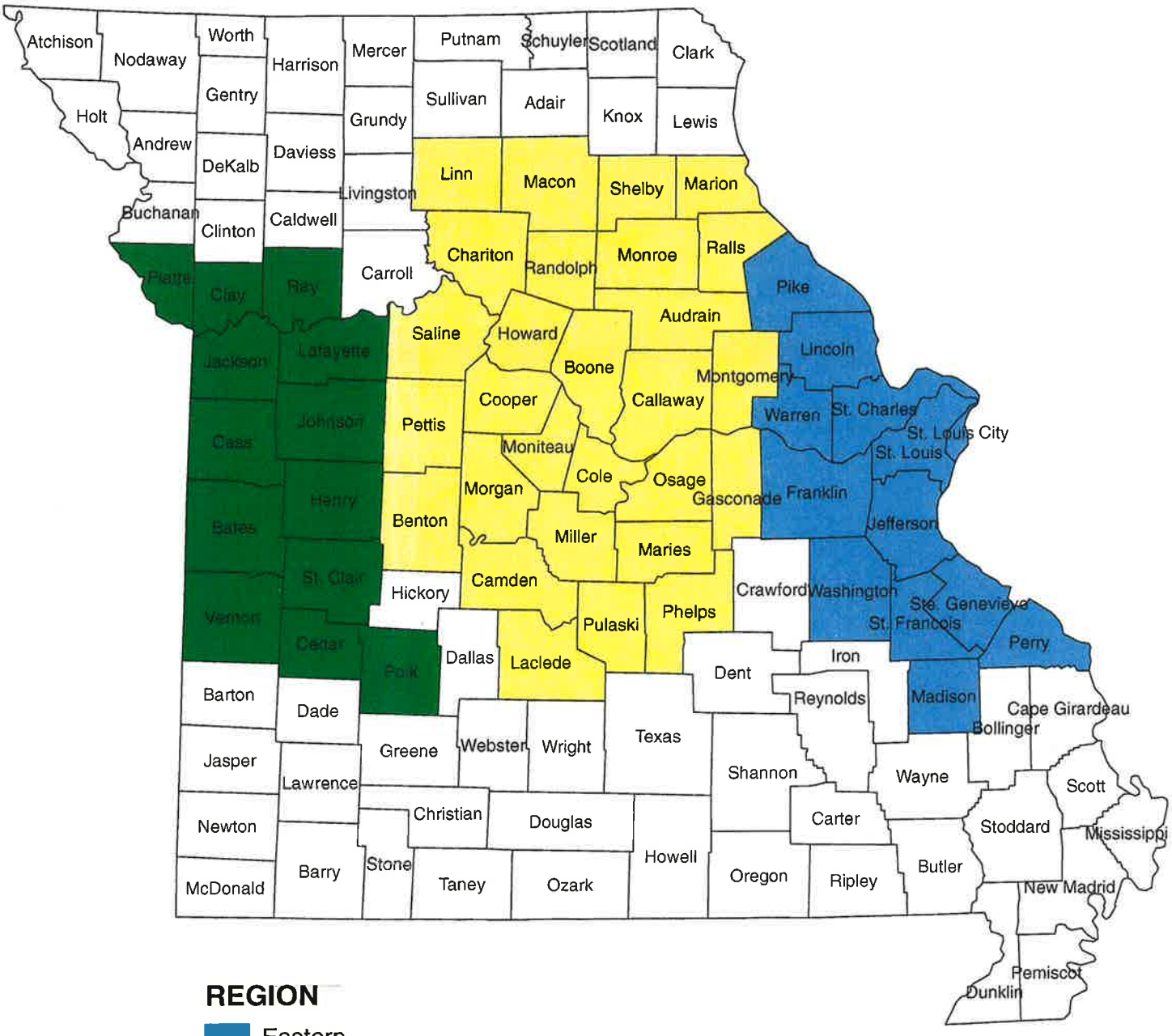


39% of enrollees are under age 35.

Of the 54 largest metropolitan areas (in the 37 states using the healthcare.gov platform), **St. Louis ranked 14th with 112,118 enrollees. Kansas City ranked 17th with 85,785 enrollees.**

Note: Results as of March 2015

MO HealthNet Managed Care



REGION

- Eastern
- Central
- Western
- Fee for Service

Community Mental Health Liaisons

The new Community Mental Health Liaison (CMHL) program is part of the Strengthening Mental Health Initiative. Thirty-one CMHLs work across the state to assist law enforcement and courts.

The goal is to form better community partnerships between Community Mental Health Centers, law enforcement, and courts to **save** valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays and to **improve outcomes** for individuals with behavioral health issues. Liaisons also follow-up with Missourians referred to them in order to track progress and ensure success. Through the CMHL program, people with behavioral health issues who have frequent interaction with law enforcement and the courts will have improved access to behavioral health treatment.

Role of the Community Mental Health Liaison:

- Answer general questions about mental health conditions and co-occurring disorders (including mental health disorders, substance use disorders, and developmental disabilities).
- Answer questions about the available CMHC resources and services to address behavioral health issues.
- Assist law enforcement and the courts in locating inpatient psychiatric beds for court-ordered involuntary detentions.
- Work to facilitate access to behavioral health resources for potential and existing clients.
- Upon request: Screen potential and existing clients for behavioral health needs and follow their cases to monitor treatment.
- For people with repeat involvement: Consult with case managers to improve coordination of care.
- Explore opportunities for use of outpatient commitments.
- Provide/coordinate training on the following topics: (mental health disorders, civil commitment procedures, suicide prevention, mental health first aid training, etc.).
- Identify and address structural barriers, miscommunications, and consistent patterns that reduce access to services.
- Participate in/consider developing with local law enforcement Crisis Intervention Teams (CIT) or other initiatives that assist law enforcement in dealing with individuals with behavioral health needs.
- Collaborate with local partners in Mental Health Courts, Treatment Courts, Veterans Courts, other specialty/diversion courts dealing with behavioral health issues.
- Where appropriate, participate in monthly or bi-monthly meetings for other court initiatives, such as Juvenile Detention Alternatives Initiative (JDAI), Crossover Youth Initiative (COYI), etc. to improve access to behavioral health services.
- Collect data about behavioral health issues that impact law enforcement and the courts.

Community Mental Health Liaisons and Civil Commitment Information

- Senate Bill 426 adds Community Mental Health Liaisons to the list of individuals who can receive information from facilities and the courts about individuals who have been civilly committed. The information is disclosed for the purpose of coordination of care and services.

- Community Mental Health Liaisons are qualified mental health professionals with a Master's degree who are employed by a local Community Mental Health Center and designated by the Department of Mental Health as Community Mental Health Liaisons.

- Community Mental Health Liaisons assist law enforcement and the courts with individuals who are experiencing behavioral health issues. The role of Community Mental Health Liaisons is to improve outcomes for individuals who come into contact with the criminal justice system and to avoid unnecessary emergency room visits, hospital admissions and incarceration.

- Community Mental Health Liaisons assist in aftercare planning and care coordination for individuals who have been civilly committed in an effort to ensure such individuals are connected to services and to improve outcomes.

- Requests for information from facilities for coordination of care and services as allowed by SB 426 will occur as permitted by HIPAA and section 630.140.3(2), RSMo. Community Mental Health Centers are HIPAA compliant agencies.

- Many facilities are already working with Community Mental Health Liaisons to coordinate care and services and arrange for aftercare. Often, Community Mental Health Liaisons only require verbal information for the referral process.

- Community Mental Health Liaisons can be identified by their employee badge issued by the Community Mental Health Center. Their status as a Community Mental Health Liaison designated by the Department of Mental Health can be confirmed by checking the current Community Mental Health Liaison list on the website of the Missouri Coalition for Community Behavioral Healthcare http://www.mocoalition.org/#!community-mental-health-liasion/cvzg.
    - This list will remain current and up-to-date at all times.

- If you have any questions about the Community Mental Health Liaison Initiative, please contact Christine Patterson, Ph.D. at 573.634.4626 ext. 106 or via email at cpatterson@mocoalition.org.

July 9, 2015

MISSOURI HOSPITAL ASSOCIATION

Medicare IPF Base Per Diem Rate

	FY 2015 – Per Diem	Proposed FY 2016 – Per Diem	FY 2016 – ECT	Proposed FY 2016 - ECT
IPFs who submit quality data	$728.31	$745.19	$313.55	$320.82
IPFs who do not submit quality data	$713.19	$730.56	$307.41	$314.52

Percent Change – 2015 to Proposed 2016	Per Diem	ECT
Submit quality data affecting 2015 and 2016	2.3%	2.3%
Did not submit quality data affecting 2015 and 2016	2.4%	2.3%
Did not submit quality data affecting 2015 and submitted quality data effecting 2016	4.5%	4.4%
Submitted quality data affecting 2015 and did not submit quality data effecting 2016	0.3%	0.3%

MISSOURI HOSPITAL ASSOCIATION

Adoption of Revised Core Based Statistical Area (CBSA) Delineations

CBSA	FY 2015	Proposed FY 2016	Percent Change
26 – Rural Missouri	0.7725	0.7725	0%
16020 – Cape Girardeau, MO-IL	0.9094	0.9094	0%
17860 – Columbia, MO	0.8319	0.8319	0%
22220 – Fayetteville, Springdale, Rogers, AR-MO	0.8598	0.8598	0%
27620 – Jefferson City, MO	0.8359	0.8359	0%
27900 – Joplin, MO	0.8306	0.8306	0%
28140 – Kansas City, MO-KS	0.9430	0.9425	-0.05%
41140 – St. Joseph, MO-KS	0.9837	0.9837	0%
41180 – St. Louis, MO-IL	0.9366	0.9366	0%
44180 – Springfield, MO	0.8334	0.8334	0%

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MISSOURI HOSPITAL ASSOCIATION

Adoption of Revised CBSA Delineations

County	FY 2015	Proposed FY 2016	Percent Change
Crawford – change from rural to urban	0.7725	0.8546	10.63%
Howard – change from rural to urban	0.7725	0.8022	3.85%
Washington – change from rural to urban	0.7725	0.8546	10.63%

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