Emergency Room Enhancement Procedural Summary by Site							
Site	**Eligibility Criteria**	**Initial Screen**	**Hospital Readmissions**	**ER Utilization and Lengths of Stay Data**	**Warm Handoff?**	**Transportation Offered?**	**How Are Appointments Made?**
1. Pathways Rolla	Clients are referred through the ER, law enforcement agencies, or the CMHL. There are no restrictions based on insurance (insured/non-insured)	Referral Form is completed at hospital for those with a behavioral/physical health ER visit and then faxed to Pathways; when possible Pathways outreach team will meet with the client at the ER. Local law enforcement agencies will call and the referral form will be completed and faxed to Pathways; Pathways staff will attempt to meet with the new referrals within 48 hours. Eligibility is confirmed at this point, and if eligible, the IHNA will be completed by Pathways professionals.	Once a person is entered in the program, it is considered one episode for the duration of the ERE program. Once the person has been closed from the ERE Program, readmissions are then considered a new admission.	The hospitals will provide the information on the insured/uninsured. Medicaid clients will be collected from Medicaid records such as CYBERACCESS, Emomed, and PROACT and CIMOR.	Their intention is to have a QMHP meet with the patient by person or phone. The QMHP will confirm eligibility and assign to a Community Engagement Specialist.	There is some ability for the Community Engagement Specialist to physically transport the patient for services. There are other local resources that can be arranged for those needing transportation.	Pathways Community Engagement Specialists will make arrangements with the CMHC's and treatment providers.
2. ReDiscover Kansas City	The hospitals determine high utilizers and contacts a designated ERE referral line, which is managed full time by a ERE outreach worker who triages referrals and provides support to hospital staff and other community partners to determine eligibility for the program. For those not easily engaged, there is a quarterly collaborative community wide meeting to discuss the efforts of the ERE program. There are also monthly meetings with each hospital to provide education and	The outreach worker will meet with the patient at the hospital, designated facility or in the community to complete the initial screen. They will ask as few questions as possible initially to build rapport in hopes of engagement with the program. Assessments are completed at this stage and assignment to an outreach worker for case management is determined by approval by the individual agreeing to services.	The individual is considered in the program for the duration of the ERE program. We will attempt to outreach if they have not had services for a while or are re-referred. During the first three months, the outreach worker provides intensive crisis stabilization services to reduce the risk of readmission and re-use of emergency	Data is obtained using a combination of patient reporting, Cyber Access and hospital data.	Outreach workers anticipate transitioning individuals to long-term programs within three to six months by ensuring co-case management support or at minimum providing support to the newly assigned workers/programs to ensure success.	Outreach workers and Artists Helping the Homeless provide transportation to services if other transport cannot be arranged until the person is stable and able to maintain independently.	Outreach workers will contact designated staff at each of the CMHC's and treatment providers to schedule appointments and provide transportation to the providers if needed. They will provide transportation until the individual is stabilized and connected to services.

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	support about the ERE program, eligibility criteria, discuss highly vulnerable individuals and to determine those most in need of services, which allows our team to prioritize need for intensive outreach services.		services. The outreach worker will provide case management to the individual on average two to five times a week as necessary to reduce re-admission and reuse. By three months, our team anticipates stability for the individual and that rapport and readmission have been significantly been reduced or eliminated.				
3. Burrell Springfield	Any existing SMI, 18 years and older. Uninsured and underinsured, individuals not engaged in services. Hospitals determine high utilizers.	ERE Clinicians and Staff from the Burrell Access Center administer the initial screen for those that call in to their hotline & to those referred for their services. ERE have the ability to go mobile to meet people where needed. ERE clinicians are positioned in 2 major ER's.	Upon agreement to engage, participant is considered a program participant until goals are met.	Dr. Schaible said MHA should report this based on HIDIS uploads. Also some hospitals provide recidivism data.	Clinicians are placed in major ER's, and a free clinic to provide a warm handoff. 24 hour assistance is provided by backup from the Crisis Team.	Transportation is provided from ER's to treatment centers and respite centers for stabilization. Buss passes and outreach workers can provide transportation as needed.	There is centralized scheduling in the Burrell Access Center. Referrals are coordinated from providers to ERE.
4. BHN Eastern Region	10 Hospitals & CMHLs refer patients with significant BH needs, high utilizers of hospital and/or police services (minimum of 3	ERE Coordinator (or Outreach Team Member) meets patient in the ER or community to complete the initial screen. She gathers basic information including primary concerns, then works to build	Once a client engages with ERE, it is considered one episode. If a client disengages for 30 days	The participating hospitals provide baseline data on number of hospital encounters at their (or their system's) facilities for the previous 3 & 6	The ERE Outreach Team performs intensive outreach services for ERE clients engaged in the project. Outreach staff facilitate warm	Transportation costs are one of the areas where ERE Flex funds are expended, plus ERE Outreach Team members drive clients to services	The ERE Outreach Team coordinates referrals and expedites (prioritized) appointments to the 7 CMHCs, 3 SU Treatment

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	encounters in 3 months or 6 encounters in a year), un/under-insured, 18 years of age and older, residents or presenting as homeless in the region, not active with a CMHC (nor on a DM cohort list).	rapport and engagement in the program. Hospitals also provide basic information. Baseline data collection is completed by the ERE Outreach Team member to whom the client is assigned.	and staff have made extensive outreach efforts, we will close that episode of care. A client can be re-engaged by the ERE Outreach staff or re-referred to ERE.	months. After enrollment in ERE, staff collect utilization data from client self-report and Medicaid records from CYBER ACCESS and emomed. Occasionally, staff will contact hospitals to get utilization data at 3/6 month follow-up if client is unable to report hospital utilization.	handoffs during critical transitions of care such as, linking to substance use treatment and connection to a CPR/ACT teams. Should the client disengage after being transferred to CMHC services, the Outreach Team works to re-engage the client (in collaboration with their Community Support Specialist at the agency).	appointments when necessary, especially at key transitions of care (i.e. admission to SU services).	providers, and various other needed community services.
5. Burrell Columbia	Any existing SMI, 18 years and older, with case management needs.	Staff from the Burrell Assessment Center will administer the initial screen to those that call in to their hotline and to those referred for their services. They have the ability to go mobile to meet people at the hospital/home/street.	Burrell intends to include everyone that comes through the Assessment Center as an ERE participant.	Dr. Schaible stated MHA should report this based on HIDIS uploads.	Yes, Burrell Assessment Center staff can meet patients at the hospital and at their home/street to meet with providers.	Transportation is provided when necessary to ensure appropriate services are received.	There is centralized scheduling in the Burrell Assessment Center.
6. Family Counseling Center Poplar Bluff	To be eligible for ERE services, the person will meet at least one of the following criteria: (1) Multiple ER visits; (2) Co-Occurring Disorder; (3) Not engaged in Community Behavioral Health services and unlikely to engage in traditional services; (4) Persons w/ chronic medical	The ERE Crisis Therapist (also member of ACI team) will meet with the participant and complete the initial screening.	ERE is set up as a unique program, with treatment episodes. Once the participant is stabilized and intensive supports are no longer required, the episode is closed. Any readmits are considered new	Baseline data on ER utilization and lengths of stay are obtained via CIMOR and Medicaid data. For those without funding, data is obtained via medical records (if available), hospital staff, and self-report.	ACI team member will respond in person, with a face-to-face introduction to either the Outreach Coordinator/Intensive Care Coordinator/Crisis Therapist.	Our ERE team is a mobile response team that provides transportation. Furthermore, we use flexible funding to assist with fuel for those persons who have access to a vehicle as well as cab expenses, when applicable. The ERE team also uses other existing resources to assist	The ERE Team (Crisis Therapists/Outreach Coordinators/Intensive Case Managers) schedule and meet with persons-served. The frequency/duration of visits is based on the level of care need.

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	conditions; (5) Uninsured/under-insured; (6) Homeless or unstable housing situations.		episodes.			with transportation needs.	
7. Mark Twain BH Hannibal	ERE care coordinators determine eligibility based upon initial referral and contact. Eligibility criteria includes: Clients who are 18+; unstable housing; mental illness and/or substance use; uninsured/under insured (high deductibles). System of care meetings held once per month to prioritize those in need of various forms of engagement.	MTBH staff will meet with the individual to collect the screening form information. Focus on meeting basic needs to promote engagement. Initial referral may come from any source including self, another agency, LE, ER's.	Their policy is to close a file after discharge. All readmits are handled as new episodes of care.	MTBH staff attempt to gather data from participating hospitals may provide baseline data on ER utilization and lengths of stay for the previous 3 months. CIMOR data will provide this information on DMH clients. The intent is to enroll those not currently in the CIMOR system. For uninsured /transient, staff relies on self- report.	MTBH staff will be called by any referral staff, and will provide warm handoff to wrap-around /treatment services as much as possible. For after hours, ACI will be contacted for evaluation/contact. MTBH staff has cellphones, so can receive calls if needed. CMHL & ERE staff will work together on warm handoffs.	They are currently working with area law enforcement to provide secure transportation to services for patients that receive involuntary commitment. They provide vouchers for cabs/alternative transportation options for transportation to treatment and CMHC services.	At the first contact with individual, they receive a scheduled appointment. MTBH staff send text and phone reminders as well as uses of caring letters if the individual misses an appointment. Attempts are made for face to face outreach as well if person misses an appointment.