Network Development Strategies & Three Year Objectives

Through the CMBHC, Barton Health seeks to collaborate with multiple community, county, social, health and human service providers (the Network) to plan and deliver improved mental and behavioral health outcomes through a comprehensive and coordinated approach to health services. Four essential strategies are described below and outlined with corresponding objectives and metrics in the next section.

1. ***Collaboration and Data Sharing System***
The CMBHC will establish a comprehensive hub and spoke data network (the "system of care") with participation by multiple service providers. Barton Health will serve as the operational "hub" and offers the EPIC platform of health records management as the central framework. EPIC modules that will be customized and adapted to meet network needs and objectives include "CareEverywhere" which enables medical service providers to share data and patient records and "CareLink" which will facilitate participation by non-medical model providers (the spokes) with-or-without existing electronic health record systems. This strategy incorporates the five approved HRSA RHND objectives (a thru e) as enumerated in the grant Work Plan (see Attachment I).

2. ***Continuing Care Coordination***
The central focus of the CMBHC Network is to provide proactive care coordination to individuals ages 0-24 presenting with mild-to-moderate behavioral health needs including those with co-morbidities. The network intends to deliver better health outcomes at a lower cost while reducing cycles of acute episodes which may exacerbate care needs.

3. ***Acute Care Coordination***
While the primary focus of the CMBHC is serving patients with mild-to-moderate care requirements the Network also seeks to reduce the frequency and severity of acute episodes by moving patients promptly into care pathways that lead to better and more sustainable long term health outcomes. Reducing community-wide dependence on the hospital emergency department and public safety officers is central to this strategy.

4. ***Education: Engage The Community***
The Network recognizes that stigma reduction is critical to building a culture of health through "acceptance" in South Lake Tahoe. Accordingly the Network will focus on systematic and decentralized education programs designed to improve awareness of behavioral health needs, challenges, and services available. This is also where the Communication Plan will operate to increase community participation in the collaborative care coordination systems outlined above.

CMBHC Strategies and Objectives 2018-2020

1. Collaboration & Data Sharing System	Calendar Year Objective Achieved		
	2018	2019	2020
a. Develop, implement and refine **uniform referral and data sharing protocols** to improve coordination of primary, mental health, and behavioral health services	X		
b. Design and develop a **technology-assisted infrastructure** for communicating with patients and across participating network providers and services		X	
c. Facilitate and support **targeted training and navigation resources** to bolster the skills and capacity of care coordinators currently employed by network organizations	X		
d. Provide expertise and framework to guide **data capture and data analysis** for quality improvement focused on mental health and behavioral health services and network coordination	X		
e. Strengthen the rural health care system as a whole by implementing evidence-based approaches to **integrate primary and behavioral health services** and mitigate provider shortages in greater South Tahoe.			X
f. Establish a market brand position for the CMBHC network services that honors a "no wrong door" and "stigma free" approach to comprehensive health care.	X		
g. Strengthen the CMBHC Governance structure in support of planned services and outcomes to include tiered membership, memoranda of agreement (MOA), and defined commitments with Barton Health and network partners.	X		
h. Produce a business plan that provides for network, fiscal and service model sustainability (per HRSA Work Plan).		X	
i. Integrate Primary Care Service providers in the network to reinforce consistent behavioral health needs assessment, detection, & referral.		X	

2. Continuing Care Coordination	Calendar Year Objective Achieved		
	2018	2019	2020
a. Establish and Deliver Targeted & Intensive Care Coordination System		X	
b. Install and Mobilize Care Navigator(s) in South Lake Tahoe		X	
c. Full Deployment, Utilization, & Distribution of a Comprehensive Care Coordination System			X
d. Maintain Path in Terms of Staying Timely and Growing Target Populations	X		
e. Implement One Release Of Information with Provision for Bi-State Access Subject to State and Federal Laws		X	
f. Establish a transitional Living Program for Homeless Youth ages 16-24 (Homeless)		X	
g. Access to section 8 housing via landlords (Homeless)	X		
h. Seamless -Smooth Collaborative Approach (Homeless)		X	
i. Comprehensive communication between PCP, family, county mental health, and jail for continuation/ coordination of care (Justice Services)		X	
j. Co-occurring Support Groups, Life Skills Group; Services information (Justice Services)	X		
k. While incarcerated - for Recovery based meetings ensure peer-counselors trained in brain-science (Justice Services)	X		
l. Follow up services "After Release"; Injections Post Release as Appropriate (Justice Services)			X
m. ACES screening used by all PCP's; funding in place to bridge the gap between primary care and behavioral health (Integrated Behavioral Health Services in Primary Care)		X	

2. Continuing Care Coordination	Calendar Year Objective Achieved		
	2018	2019	2020
n. Trauma Informed Agencies, Increased Foster Care homes (Integrated Behavioral Health Services in Primary Care)		X	
o. Every medical exam with PCP must include a preventive mental health schedule/ depression screening (Integrated Behavioral Health Services in Primary Care)		X	
p. Aggressive plan of early diagnosis of severe mental illness and addiction intervention since all are progressive and can be treated best through early intervention (e.g. FEP).		X	
q. Replicate RA-1-SE treatment locally (can't just screen then send people 100 miles away for "daily" treatment. (Integrated Behavioral Health Services in Primary Care)		X	
r. Ensure psychiatrists and other mental health and substance treatment providers use electronic health care records (the same record system primary care physicians use) (Integrated BH Services in Primary Care)			X
s. No wait list better follow-up\ aftercare - bilingual services community wide (Increased Access for Services)			X
t. Clear entry point in system to access needed level of care (Multi-Disciplinary Approach for Patients)		X	
u. Develop Comprehensive Dual - Diagnosis process - screening drives focus on co-occurrence); Wrap Services; (Multi-disciplinary Approach for Patients)	X		
v. Screening by all medical professionals including ER visits and school personnel trained in suicide prevention/ intervention/ postvention (Suicide Prevention)	X		

3. Acute Care Coordination	Calendar Year Objective Achieved		
	2018	2019	2020
a. Develop recommendations and resources to deliver acute care treatment services within 24 hours of episode onset including secure access to acute care beds as close to SLT as possible	x		
b. Develop action plan for more responsive Mental and Behavioral Health acute care procedures to minimize reliance on the Barton Hospital Emergency Department and include bed/placement referral agreements with regional facilities (CA and NV)		x	
c. Strengthen care coordination between EDC Mental Health and primary care service providers in SLT; Barton & EDC as Hub & Hub Foundation for the Hub & Spoke Network	x		
d. Implement a Community Wide Suicide Prevention/Intervention/ Postvention Program (E1.1, 2.1, 3.1)	x		
e. Acute facility to serve mental illness - 23 hr. crisis center for mentally ill (hospital/ ER centric approach with qualified psychiatrists performing assessments & providing care.) (Increased Psychiatric Services)	x		x
f. Zero wait time for access to an adult or teen psychiatrist - for those in crisis or decompensating or in need of early intervention (Increased Psychiatric Services)			x
g. Implement an immediate referral to an identified qualified treatment professional in response to suicide based "trigger events" AND including a 24 hour, 30, and 60 day direct contact follow-ups (subject to verify insurance eligibility, release/ consent and privacy parameters) (Suicide Prevention)			x

4. Education: Engage The Community	Calendar Year Objective Achieved		
	2018	2019	2020
a. Develop and Deliver Community Knowledge and Education Programs and Services (Build on Current Programs & Kiosks)			X
b. Deliver education programs that increase utilization of services and support stigma reduction	X	X	X
c. Optimize the 211 line with people aware of resources and contacts (Resource Directory)		X	
d. Improve Transparency - Reduce/ eliminates underground systems (Resource Directory)		X	
e. Address Latino community service & support needs: education, jobs, Spanish NAMI; NAMI peer support (Reduce Stigma)	X	X	X
f. Public screening: educate community, Ted Talks, Movies (R/ Stigma)	X		
g. Peer education for mental health to create culture of understanding & decrease stigma (School Based Interventions)	X	X	X
h. Involve various community agencies volunteering for workshops at the schools (School Based Interventions)		X	
i. Community based, Parent/Caregiver support classes (Prevention and Early Intervention)	X		
j. Community based Parent/Caregiver & child interactions (play groups, early literacy, etc.) (Prevention and Early Intervention)		X	
k. Medical policies for substance use that are brain-science fact-based – isolate what triggers or exacerbates brain changes that can lead to psychosis, other mental health, or dependency (Prevent/Early Int)		X	
l. Provide training for all agencies and schools (Increased Access)			X
m. Implement an education campaign targeted by population segments focusing on stress, service navigation (e.g. directory)	X	X	X
n. Provide regular suicide education/ awareness services building on the foundation provided by the Suicide Prevention Network curriculum	X	X	X