Policy Academy Webinar: Oklahoma Department of Mental Health and Substance Abuse Services and the National Council for Mental Wellbeing

June 29, 2022

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

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Agenda

- Welcome and Background
- MH Crisis Services and CCBHCs
- Oklahoma's Approach to Building a Crisis Continuum of Care
- Question and Answer

Building out Rural Crisis Services

Themes among states

Maximizing community resources

Building telehealth capacity

Treating the whole person

Recruiting and retaining workforce

Achieving sustainable financing

Today's Speakers

Brett Beckerson, MSW; Director, Policy and Advocacy, National Council for Mental Wellbeing

Brett Beckerson has more than 12 years of experience working at the intersection of public health and public safety policies at local, state and federal levels. At the National Council for Mental Wellbeing, Beckerson leads the state-based efforts on Certified Community Behavioral Health Clinics (CCBHCs) to ensure high-quality, integrated services for people with behavioral health needs. Prior to joining the National Council, Beckerson worked at The Pew Charitable Trusts where he provided strategic guidance on Pew's work on medications for opioid use disorder, suicide prevention and correctional health care. He provided policy recommendations to governors and legislative leaders and lobbied at the federal level for policy changes on topics such as provider workforce, health care financing and population health.

Before joining Pew, he led Medicaid policy reforms in states with a primary focus on justice-involved populations at the Council for a Strong America. There, he helped launch the organization's Police Training Institute to work directly with law enforcement agencies on issues of behavioral health, implicit bias and adolescent development.

Brett began his career providing state- and local-level technical assistance on school bullying policies. This position grew into an advisory role with the Michigan Department of Community Health and Surgeon General of Michigan on access to school-based mental health services for children, youth and families and integrated care with community-based settings. An alumnus of The University of Michigan, Beckerson earned a graduate degree in social work with a focus on child welfare policy, as well as a Bachelor of Arts in political science.

Today's Speakers

Joe Parks, MD, Medical Director; National Council for Mental Wellbeing

Joe Parks, MD is the Medical Director for the National Council for Mental Wellbeing. Dr. Parks also holds the position of Distinguished Research Professor of Science at the University of Missouri – St. Louis and is a Clinical Assistant Professor of Psychiatry at the University of Missouri, Department of Psychiatry in Columbia. He practices psychiatry on an outpatient basis at Family Health Center, a federally funded community health center established to expand services to uninsured and underinsured patients in central Missouri.

Previously, he served for many years as Medical Director of the Missouri Department of Mental Health and as Director of the Missouri Medicaid. Dr. Parks has also served as Director of the Missouri Institute of Mental Health at University of Missouri St Louis and as Division Director for the Division of Comprehensive Psychiatric Services of Missouri Department of Mental Health.

Today's Speakers

Carrie Slatton-Hodges, Commissioner; Oklahoma Department of Mental Health and Substance Abuse Services

Carrie Slatton-Hodges is currently serving as the Commissioner for the Oklahoma Department of Mental Health and Substance Abuse Services. Prior to her current role, Carrie served 12 years as the Deputy Commissioner for ODMHSAS, overseeing treatment and recovery services through state operated and contracted treatment providers statewide. In this role, Carrie managed budgets, oversaw contracts, streamlined policy, developed cutting-edge programs, cultivated the workforce, expanded partnerships and integrated evidence based practices across the State.

Carrie has a Bachelor's degree from Southern Nazarene University and a Master's in Applied Psychology from Southwestern Oklahoma State University. As a Licensed Professional Counselor for 29 years, Carrie has hands-on experience in the field of mental health, holding a variety of clinical and administrative positions, in both the public and private sectors, delivering and managing all aspects of behavioral health services in rural and urban settings including the role of Chief Operating Officer at Oklahoma's largest Community Mental Health Center.

Carrie has transformed the delivery of treatment services through innovative programming and strategically leveraging resources to improve Oklahoma's behavioral health, including the launch of Urgent Behavioral Health Care Centers, integrating Comprehensive Community Addiction Recovery Centers, developing a system of ambulatory detoxification services, and transitioning to an outcome based payment system for Community Behavioral Health Centers. Carrie has a strong commitment to mental health and addiction recovery for Oklahomans and believes we all deserve to live a valuable, productive life in the community.

The Certified Community Behavioral Health Clinic (CCBHC) Model

A Conversation with the National Academy for State Health Policy (NASHP)

June 29, 2022

The CCBHC Model

- Staffing
- Availability & Accessibility of Services
- Care Coordination
- Scope of Services
- Quality & Other Reporting
- Organizational Authority, Accreditation & Governance

A CCBHC is a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community to ensure health equity and high-quality care for underserved populations.

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Establishing the CCBHC Medicaid

Establishing CCBHC at the State Level

- CCBHC Medicaid Demonstration
- 1115 waiver or State Plan Amendment

Establishing CCBHC at the Clinic or Community Level

- $4 SAMHSA grant for 4-year person
- Certification by your state through Medicaid

Medicaid Waiver (e.g., 1115)	State Plan Amendment	CCBHC Demonstration
Enables states to experiment with delivery system reforms	Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.	Enables states to experiment with delivery system reforms
Requires budget neutrality	Does not require budget neutrality	Does not require budget neutrality and provides an enhanced FMAP for states
Must be renewed every 5 years	With CMS approval, can continue PPS	For only 10 states till Sept. 30, 2023
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)	Cannot waive "state-wideness," may have to certify additional CCBHCs (future CCBHCs may be phased in)	State may limit the number of clinics selected to receive the PPS rate
With CMS approval, offers opportunity to continue or establish PPS		State must be sure to follow all CCBHC criteria with ability to build onto them

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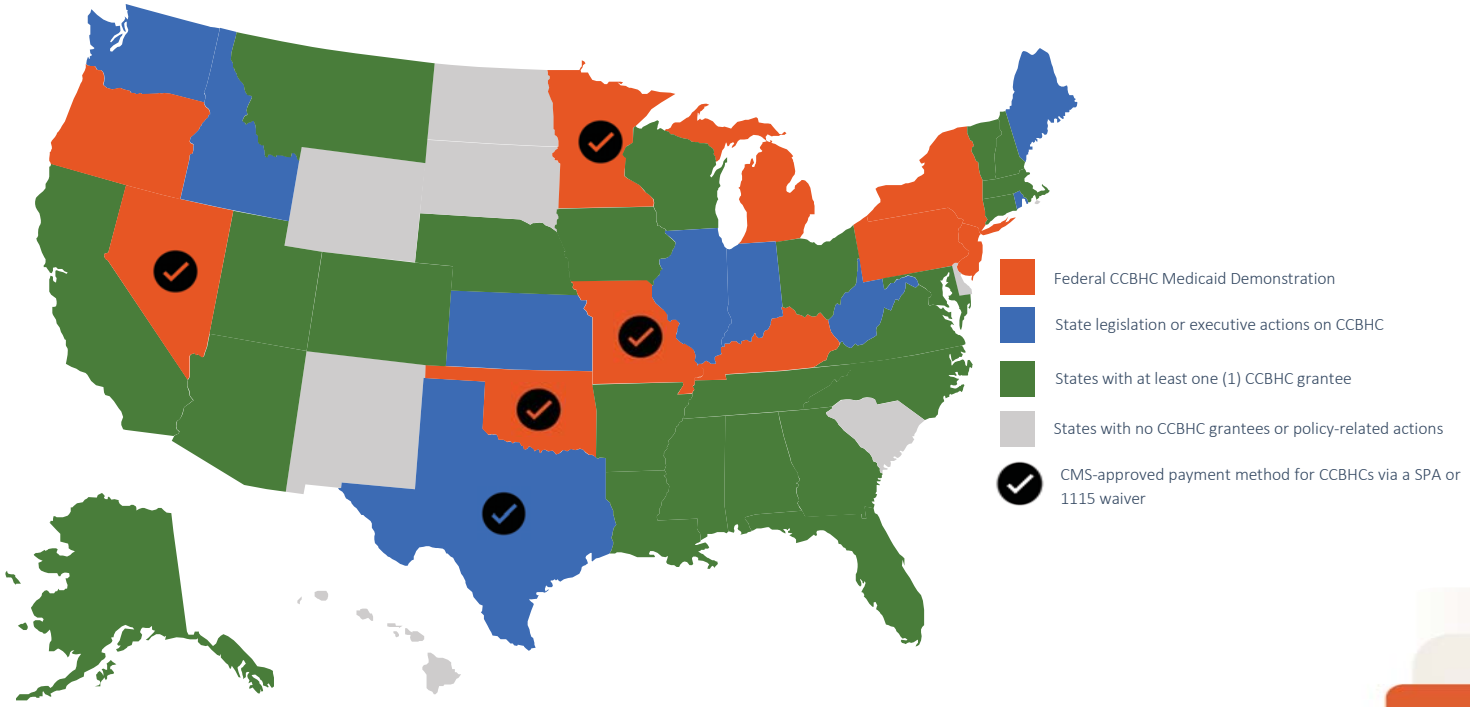
CCBHCs Across the Country

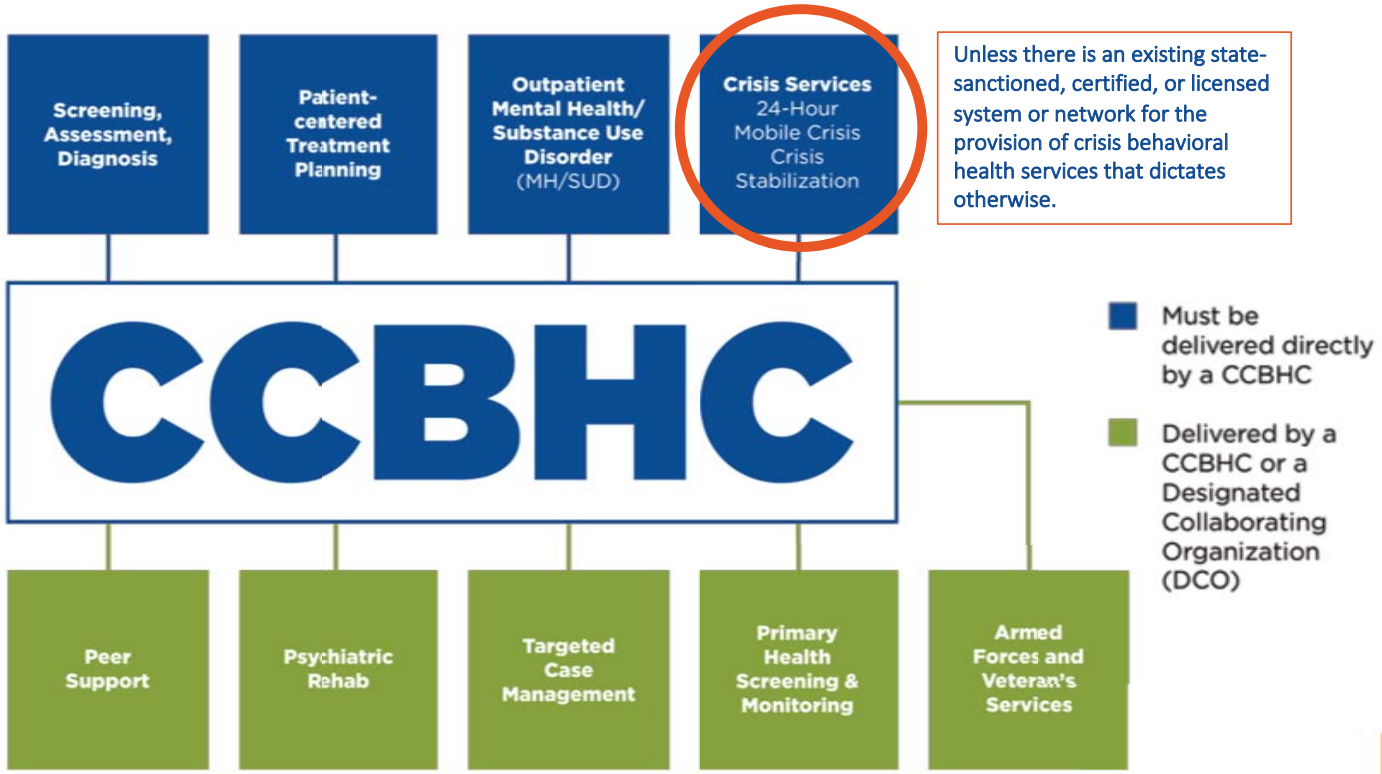


Note: Delaware, Hawaii, South Carolina, North Dakota, and Wyoming are part of a national CCBHC learning Collaborative and have confirmed that more than one clinic within their states have applied for the CCBHC grant

Key Features of the CCBHC Model

- CCBHCs are **required to serve everyone** regardless of insurance status or diagnosis
- CCBHCs must meet **timeliness of access standards**, including **immediate response for crisis needs** and access within 10 days or less for routine needs
- CCBHCs must **directly provide** or **ensure access to an array of crisis response services and supports,** including 24/7 mobile crisis response and crisis stabilization
- CCBHCs must **partner and coordinate with other entities involved in crisis response** (e.g., law enforcement, emergency departments, and more)

CCBHC Scope of Services Criteria



Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise.

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CCBHCs' Role in the Crisis Continuum

CCBHCs are not intended to supplant their communities' existing crisis response networks. Crisis response may be delivered directly by the CCBHC or by a Designated Collaborating Organization (DCO) partnering with the CCBHC.

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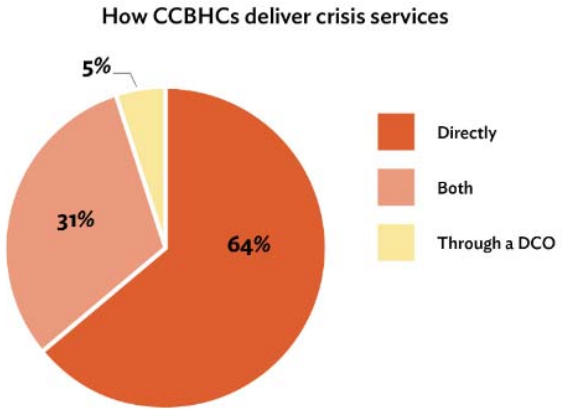
Two options for delivering crisis services: directly or via DCO

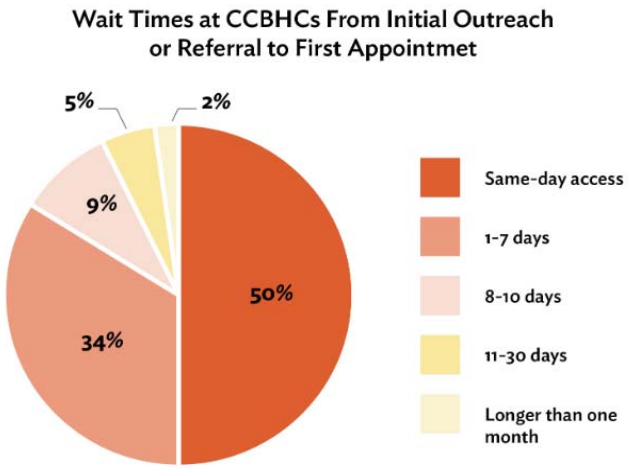
- CCBHCs can partner with “state-sanctioned crisis networks” as Designated Collaborating Organizations (DCOs) to deliver crisis services
- In a 2021 National Council survey of CCBHCs (incl. demonstration sites and grantees):
  - 95% of CCBHCs delivered all or some crisis services directly
  - 36% partnered with a DCO for all or some services
  - CCBHCs can deliver some services directly and partner with a DCO for others – about a third reported doing this.



Timely access to care

CCBHC timeliness of access requirements:

- Emergency needs: must be met immediately
- Urgent needs: within 1 business day
- Routine needs: within 10 business days



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Additional Crisis Response Activities

- **91%** are engaging in one or more identified **high-impact activities** in crisis response, including:
  - Coordinating with hospitals/emergency departments to support diversion from EDs and inpatient (79%)
  - Operating a crisis drop-in center or similar non-hospital facility for crisis stabilization (e.g. 23-hour observation) (33%)
  - Deploying a behavioral health provider to co-respond with police/EMS (e.g. clinician or peer embedded with first responders) (38%)
  - Deploying a mobile behavioral health team to relevant 911 calls instead of police/EMS (e.g. CAHOOTS or similar model) (19%)
  - Partnering with 911 to have relevant calls routed to CCBHC (17%)
  - Providing telehealth support to law enforcement officers responding to mental health/SUD calls (20%)

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CCBHCs as a Building Block for 988 Implementation

The Certified Community Behavioral Health Clinic (CCBHC) model holds the potential to:

- Fill gaps in communities' crisis response continuum
- Alleviate the workforce shortage
- Provide sustainable reimbursement for certain crisis activities built into CCBHCs' scope
  - Potentially leverage 85% Medicaid match for mobile crisis services to partially finance CCBHC model (has yet to be implemented in a state)
- Establish standardized delivery structure, quality reporting & accountability

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Anticipated Impact of 988

- **Surge in demand** expected
  - More accessible number = used by more people for a broader array of needs
- **Increased workforce** will be needed to address demand
- Many callers will need **additional MH/SUD resources & support**, post-crisis ongoing services
- Communities will need to **fill gaps** across the crisis response continuum
  - Coordination across crisis response entities will be critical
- **Add'l coordination** will be required with EMS, hospitals, law enforcement
  - Some callers will need emergency medical support or law enforcement involvement
  - Some callers will continue to use 911 to report MH/SUD emergencies

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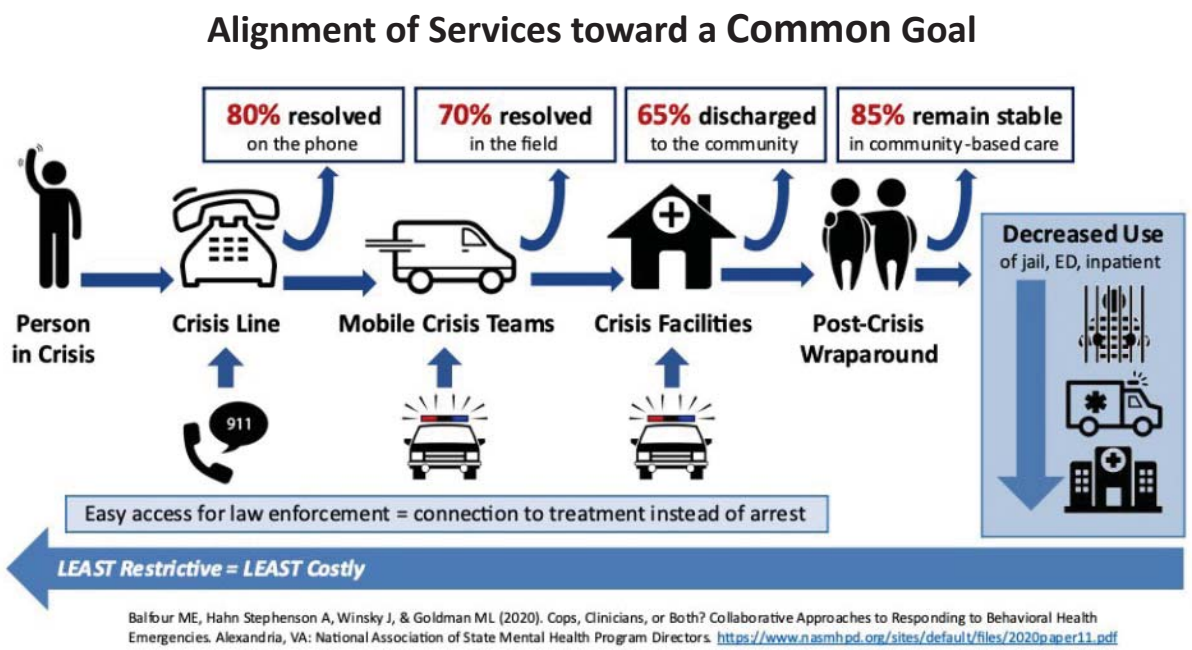
Crisis Response Continuum



Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

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How can states build CCBHCs into 988 implementation?

Three broad opportunities:

1. CCBHCs as 988 call centers
2. CCBHCs as providers of crisis support services not provided by 988 call centers
3. CCBHCs as referral partners for post-crisis or non-urgent needs

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CCBHCs as 988 Call Centers

- CCBHCs receive and respond to 988 calls; they are part of the National Suicide Prevention Lifeline network
- CCBHCs triage callers, address needs that can be met on the phone, and ensure access to higher-intensity services when needed
  - Higher-intensity services may be provided directly by the CCBHC or by DCO partners
  - CCBHC is responsible for coordinating with partners and ensuring callers are connected to care
- CCBHCs ensure access to post-crisis follow-up care with the CCBHC or coordinate with callers' other care provider(s) for any necessary post-crisis services/supports

Examples: CCBHCs participating in the Suicide Prevention Lifeline Network

1. Guam Behavioral Health and Wellness Center, Tamuing, GU
2. COMCARE of Sedwick County, Wichita, KS
3. Mountain Comprehensive Care Center, Prestonburg, KY
4. Seven Counties Louisville, KY
5. Macomb County Community Mental Health, Clinton Township, MI
6. Network 180, Grand Rapids, MI
7. Compass Health, Clinton MO
8. Western Montana Mental Health, Missoula, MT
9. Rutgers University Behavioral Health Care, Piscataway Township, NJ
10. The Nord Center, Lorain, OH
11. Family and Children's Services, Inc., Tulsa, OK
12. Centerstone of Tennessee, Nashville, TN
13. Integral Care, Austin, TX
14. Emergence Health Network, El Paso, TX
15. MHMR of Tarrant County, Fort Worth, TX
16. Harris Center, Houston, TX

CCBHCs as Crisis Care Partners

- CCBHCs do not directly receive 988 calls, but fill other gaps in the crisis response continuum
- 988 call centers have partnerships with CCBHCs, with the CCBHC delivering crisis response services to 988 callers as necessary
  - May happen if the 988 call center does not directly offer higher-intensity services (e.g., mobile crisis response, crisis stabilization)
  - 988 call center and CCBHC are responsible for coordinating with one another and ensuring callers are connected to care
- CCBHCs ensure access to post-crisis follow-up care with the CCBHC or coordinate with callers' other care provider(s) for any necessary post-crisis services/supports

CCBHCs as Post-crisis Referrals

- CCBHCs might not directly provide crisis services (crisis response can be provided by local organization serving as a DCO to the CCBHC)
- 988 call centers and other crisis providers have referral relationships with the CCBHC and assume responsibility for connecting callers to the CCBHC for any necessary post-crisis services/supports

Enhanced Medicaid Match for Mobile Crisis

- 85% Medicaid match available for qualifying mobile crisis services and activities
  - Available for first 12 fiscal quarters the program is in effect during the period April 1, 2022 through March 31, 2027
- "Mobile crisis intervention services should be integrated with the national suicide prevention and mental health crisis hotline, state funding of core crisis care elements, **and community-level efforts to implement CCBHC crisis management services.**"
- States should be aware of requirements around qualifying activities and claiming the enhanced match

https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

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Closing reflections

- Like 911, 988 will not be fully built out overnight
- States will have many opportunities to strengthen their crisis response networks after 988 goes "live" in July
- The CCBHC model offers a helpful strategy – not just for filling gaps in the crisis response continuum, but for improving access to care and preventing individuals from (re)experiencing a crisis
- How states integrate CCBHCs into their 988 efforts may differ based on state-specific considerations
- The CCBHC requirements and financing represent a major opportunity for strengthening crisis response

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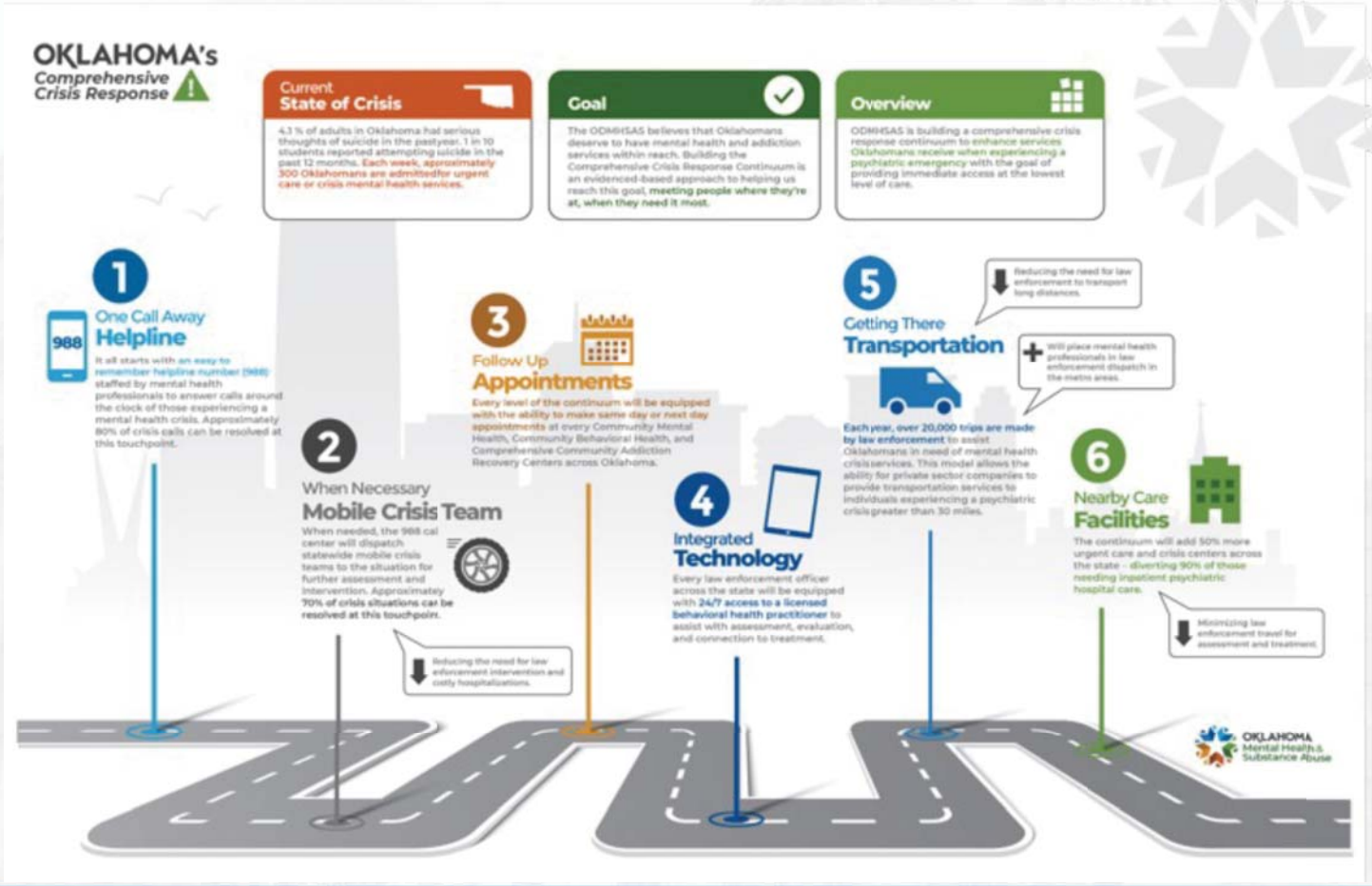
Questions?

Goal Progress and Status Updates

988 call center status and campaign launch

Comprehensive Crisis Response



Goal Progress and Status Updates

Alternative Transportation Services (RideCARE) provided over 5,000 safe, secure, and trauma responsive transportation services to date.

Integrated Technology - Over 22,000 enabled devices across the state currently.

- 2,600 staff devices
- 6,300 community partners (law enforcement, hospitals, etc.)
- 13,000 consumer devices
- 2,500 crisis calls answered each month
- Approximately 600,000 minutes of services provided each month

This map displays URC & Crisis Centers that are existing or scheduled to open soon.

FY22 (Existing or Opening)

FY23 (Opening)

Goal Progress and Status Updates

Adding 22 more Urgent Recovery and Crisis Centers across state.

Questions and Answers

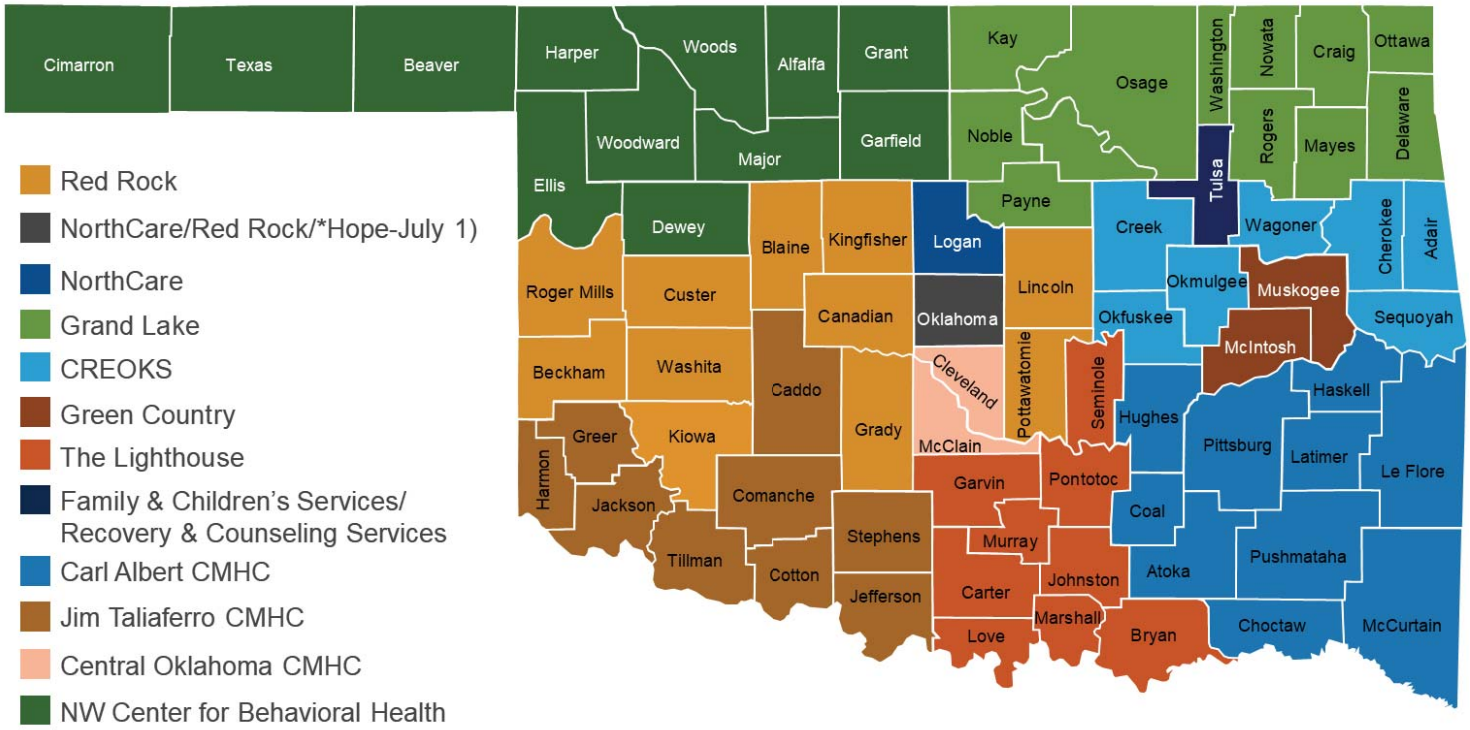
OKLAHOMA
Mental Health & Substance Abuse
SERVICES WITHIN REACH

Certified Community Behavioral Health Clinics:

Incubator for Innovation

Commissioner
Carrie Slatton-Hodges

Statewide CCBHCs
(Certified Community Behavioral Health Centers)



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Oklahoma Innovations

Consumer Report Card

Individualized, one-page consumer “report card” included lab results, medication compliance, services received and screenings for each consumer. The cards assigned a grade to the agency on how well services to each consumer were coordinated and provided, with results also available to staff involved in the individual’s care.

Most in Need

Prioritized treatment recipients accounting for the most crisis center and inpatient stays, distributed information in real time to each provider identifying consumers to prioritize stabilization of these individuals.

Telehealth and Law Enforcement

Approximately 22,000 tablets with built-in cellular connection are being used across the state, providing immediate access to care and treatment services.

Devices are within homes, health and emergency departments, sheriffs and police departments helping Oklahomans overcome transportation barriers to accessing care in rural communities.

CCBHC Enhancements

Expanded services to increase availability and access, while adding recovery supports to enhance scope of services.

- **Added** Care Coordination, Vocational, Housing, Nutrition, and Occupational Therapy
- Numbered served grown **102%**
- Increased number of **Urgent Recovery Centers**
- Established infrastructure for **Mobile Crisis Teams**

Service Type	Pre CCBHC	Year 4	Percent Increase
Care Management	19	887	4568%
Case Management	5797	10265	77%
Crisis	1290	1467	14%
Peer and Family Supports	5237	9239	76%
Primary Care	7046	8290	18%
Therapy	8354	12392	48%
Vocational and Housing	34	138	306%
Wellness	819	2425	196%

Crisis Continuum

- Established and expanded Mobile Crisis Teams to include adult and children response
- Increased Urgent Recovery Centers from 3 to 22

Technology use Increase

900%

Over 600,000 minutes of services are provided through mobile technology established through CCBHC

Oklahoma Outcomes

Added **981** new jobs to the healthcare workforce sector -an estimated economic impact of **$34,953,525.41** annually.

CCBHC also realize

- **21% reduction** in the use of psychiatric inpatient beds
- **14% reduction** in ER visits
- **69% reduction** in the use of crisis stabilization and rehabilitation.

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Oklahoma Outcomes

Reduced the average time for initial assessment to **3.2 days**

78.4% change in adults receiving a body mass index and follow-up counseling

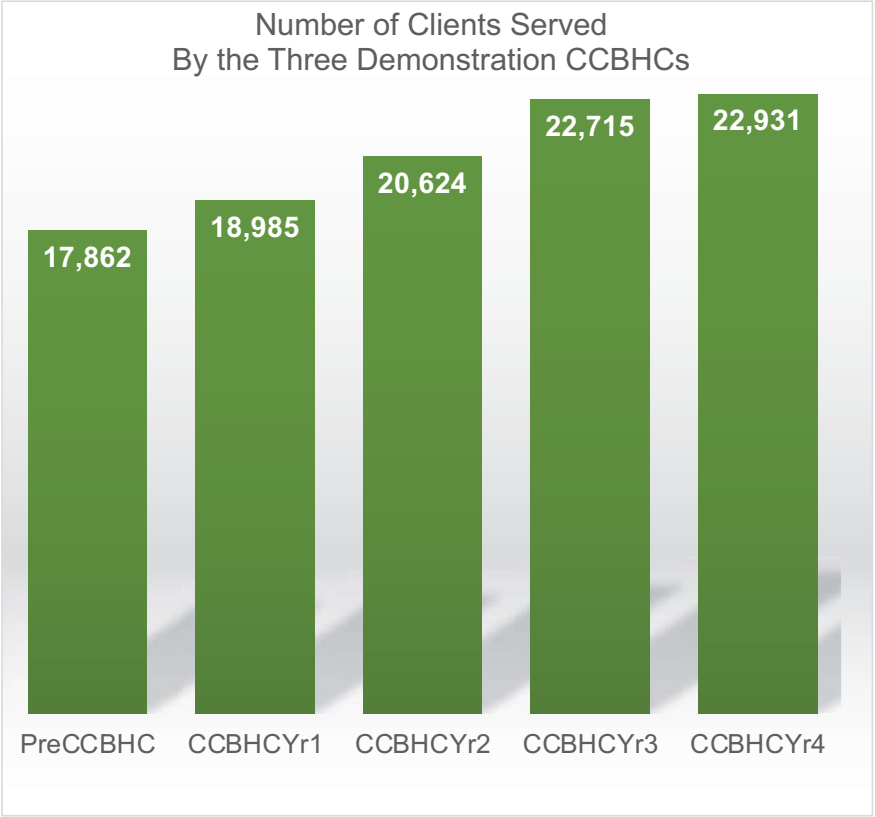
82.4% increase in children's weight assessments

70% change in suicide risk assessment

76.4% change in adult suicide risk assessment

75% percent of adults are seen within seven days following a hospitalization and **93%** are seen within 30 days.

70.1% of children are seen within seven days and **92.3%** are seen within 30 days.



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For More Information go to:

odmhsas.org

@odmhsas

@csh_ok
@odmhsasinfo

Prescription for Change
OKImReady.org
@rxforchangeok

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Thank you!

Questions?

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