Mid-America (HHS Region 7)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Understanding the National Landscape, the Model, and the Opportunities

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SAMHSA Substance Abuse and Mental Health Services Administration

DISCLOSURES

This presentation was prepared for the MHTTC Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA). This presentation will be recorded and posted on our website.

At the time of this publication, Miriam Delphin-Rittmon served as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA. The opinions expressed herein are the views of the speakers and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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Mid-America Mental Health Technology Transfer Center (MHTTC)

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- Awarded to UNMC's Behavioral Health Education Center of Nebraska (BHECN).
- Serves to align mental health services across Missouri, Iowa, Nebraska, and Kansas with evidence-based practice.


The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:
STRENGTHS-BASED AND HOPEFUL
INCLUSIVE AND ACCEPTING OF DIVERSE CULTURES, GENDERS, PERSPECTIVES, AND EXPERIENCES
HEALING-CENTERED/ TRAUMA-RESPONSIVE
INVITING TO INDIVIDUALS PARTICIPATING IN THEIR OWN JOURNEYS
PERSON-FIRST AND FREE OF LABELS
NON-JUDGMENTAL AND AVOIDING ASSUMPTIONS
RESPECTFUL, CLEAR AND UNDERSTANDABLE
CONSISTENT WITH OUR ACTIONS, POLICIES, AND PRODUCTS
Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Announcements

- This webinar is being recorded.

https://mhttcnetwork.org/centers/mid-america-mhttc/moving-towards-certified-community-behavioral-health-clinics-ccbhc

CCBHC: National Landscape, Model, and Impact

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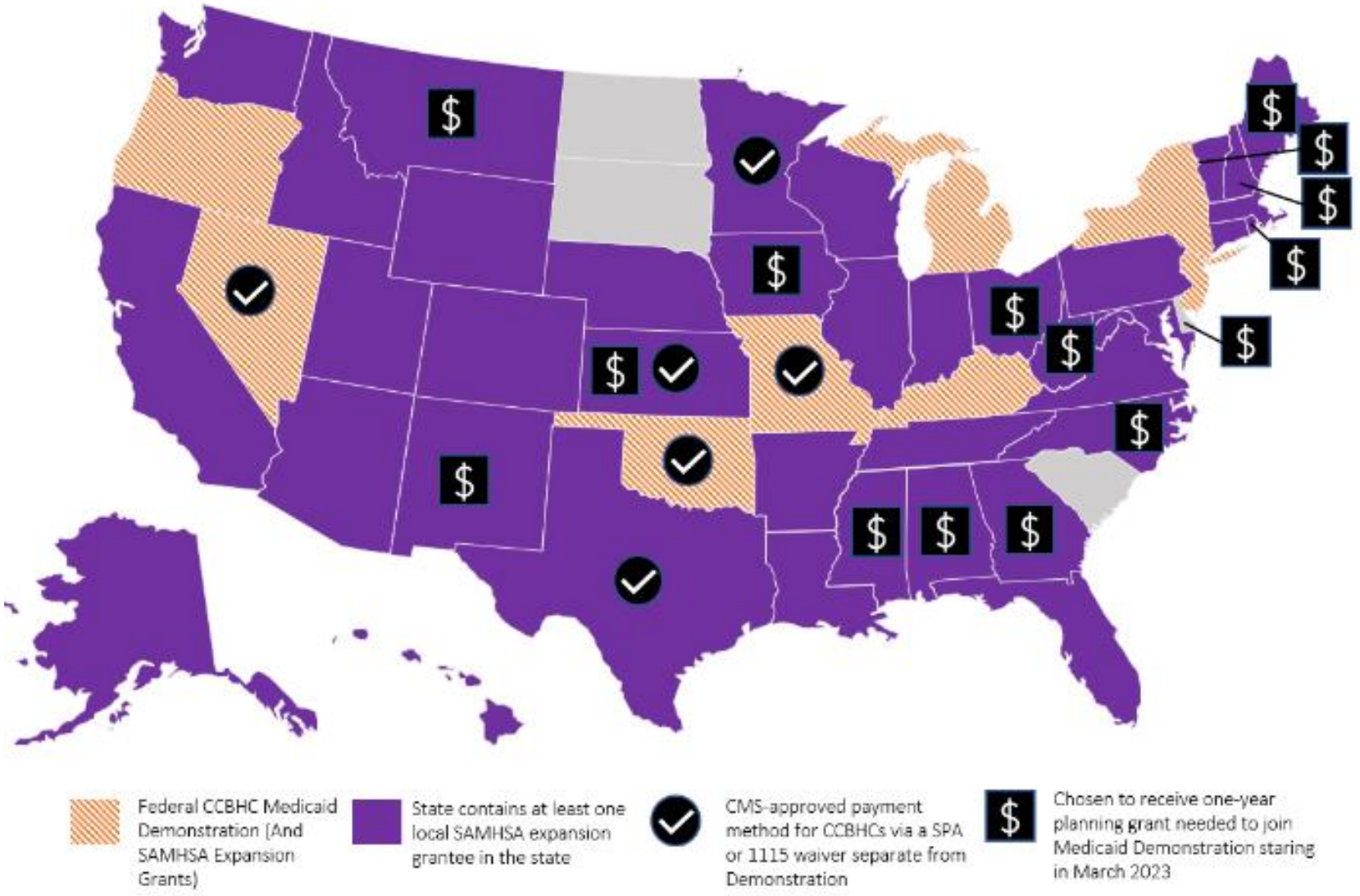
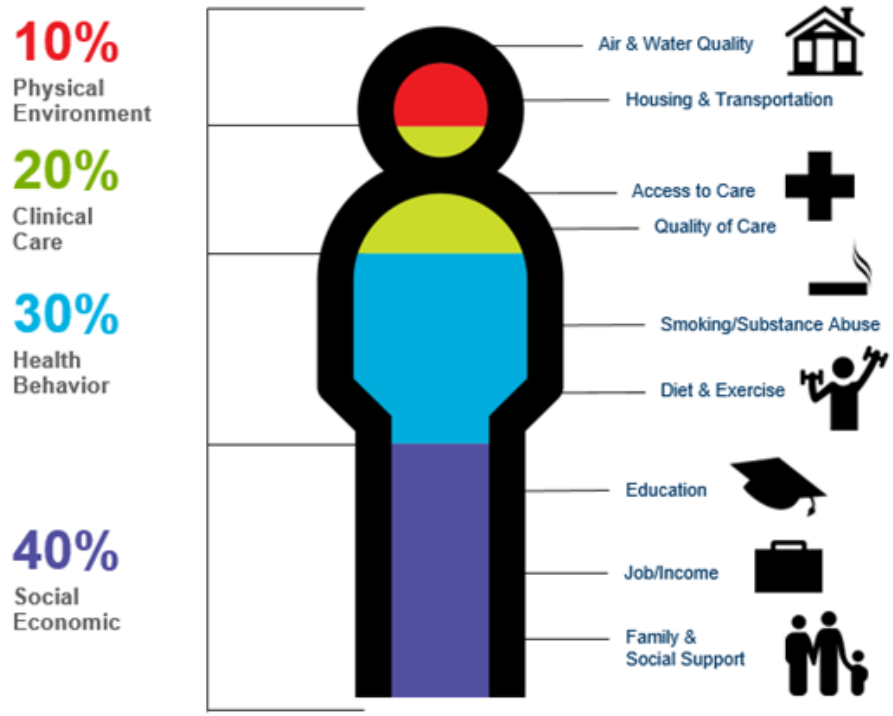
Learning Objectives

- Describe the national model for Certified Community Behavioral Health Clinic (CCBHC) including the types of mental health and substance use services.
- Discuss CCBHC requirements involving staffing, accessibility and scope of services, care coordination, and organization authority.
- Identify ways the health care team can engage and develop valuable partnerships and innovative activities to help improve community mental health centers.

More than 540 CCBHCs Across the United States!!!



Why CCBHC?



- As many as **40 percent** of all patients seen in primary care settings have a mental illness.
- **68 percent** of adults with mental disorders have comorbid chronic health disorders
- **80 percent** of patients with behavioral health concerns present in ED or primary care clinics.

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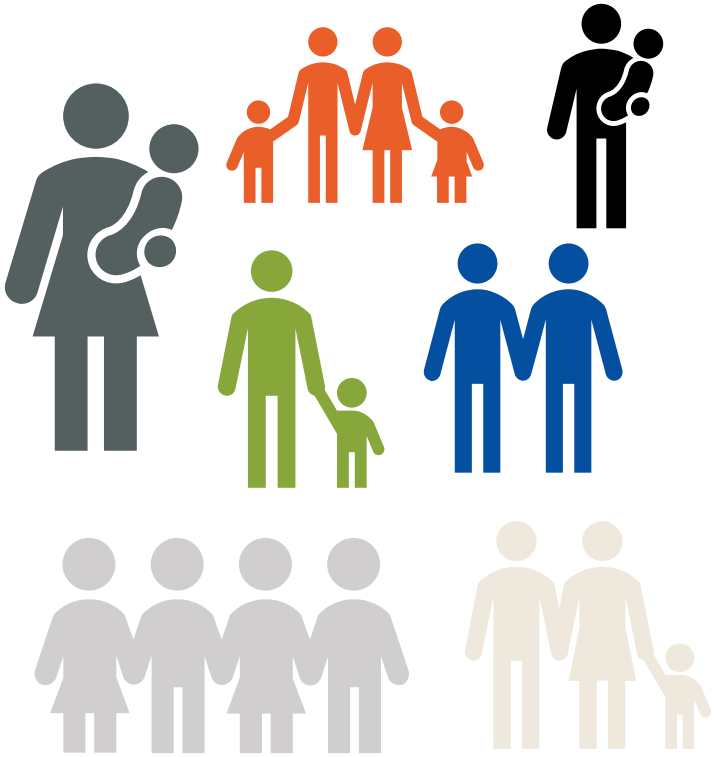
What is a CCBHC?

CCBHC is an integrated community behavioral health model of care that aims to improve service quality and accessibility. CCBHCs do the following:

- Provide integrated, evidence-based, trauma-informed, recovery-oriented and person-and-family-centered care
- Offer the full array of CCBHC-required mental health, substance use disorder (SUD) and primary care screening services
- Have established collaborative relationships with other providers and health care systems to ensure coordination of care

Person-centered and Family-centered Care:
A Cornerstone of the CCBHC Model



- All CCBHC services, including those supplied by its DCOs, are provided in a manner reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received.
- Services for children and youth are family-centered, youth-guided, and developmentally appropriate.

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Populations Served by CCBHC

CCBHCs are available to any individual in need of care, including (but not limited to):

- people with serious mental illness
- serious emotional disturbance
- long-term chronic addiction
- mild or moderate mental illness and substance use disorders and complex health profiles.

CCBHCs will provide care regardless of ability to pay, caring for those who are underserved, have low incomes, are insured, uninsured, or on Medicaid, and those who are active-duty military or veterans.

CCBHC Criteria

- ❑ Staffing
- ❑ Access & Availability of Services
- ❑ Care Coordination
- ❑ Scope of Services
- ❑ Reporting
- ❑ Organizational Authority

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Staffing

- The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment (CHA), in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.
- CCBHC staff must include a medically trained behavioral health care provider who can prescribe and manage medications, including buprenorphine and other FDA approved medications used to treat opioid, alcohol, and tobacco use disorders.
- The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families AND the CCBHC regularly assesses the skills and competence of each individual furnishing services.

Access & Availability of Services

- Services are provided during times that facilitate accessibility and meet the needs of the population, including some evening and weekend hours.
- Services are provided in locations that ensure accessibility and meet the needs of the population to be served (ex: in the community or in home)
- Transportation or transportation vouchers are provided, as needed, for people receiving services.
- The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible,
- Outreach, engagement, and retention activities are conducted to support inclusion and access for underserved individuals and populations.
- Timely access to services for routine and emergent/urgent needs for both new and current clients.
- Crisis management services are available 24 hours per day/7 days per week.
- No refusal of services due to inability to pay or place of residence.

Care Coordination

Partnerships or agreements required with:

- FQHCs/rural health clinics
- Inpatient psychiatry and withdrawal management
- Post-withdrawal management step-down services
- Residential programs
- Other social services providers, including: schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, child placing agencies for therapeutic foster care service
- Department of Veterans Affairs facilities
- Inpatient acute care hospitals and hospital outpatient clinics

Considerations

- ❑ Leverage technology to ensure quality data
- ❑ Coordinate care across the spectrum of health services, including physical and behavioral health and other social services
- ❑ Establish or maintain electronic health records (EHR)
- ❑ Health IT systems are being used to conduct population health management, quality improvement, reducing disparities, and for research and outreach

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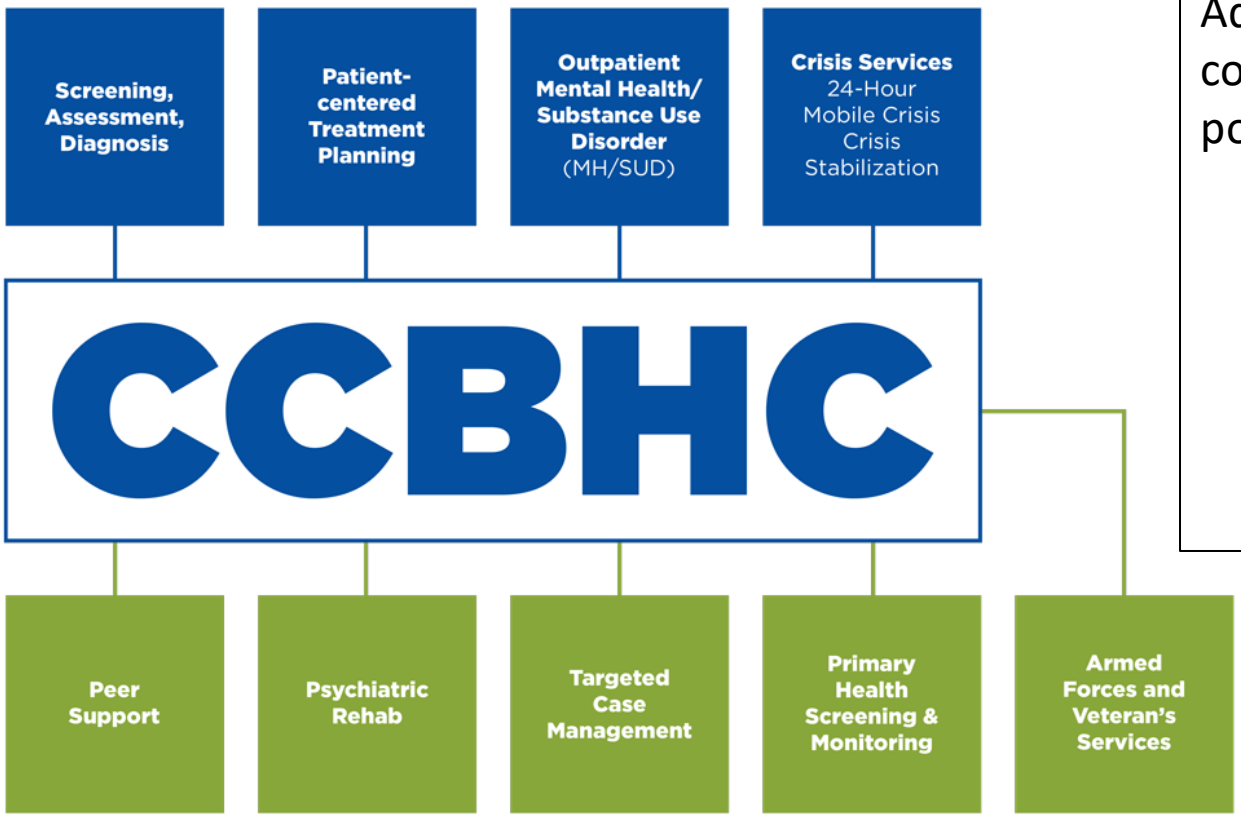
CCBHC Scope of Services



Additional service considerations based on population needs:

- MAT
- Cultural and linguistic outreach
- Integration with primary care

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CCBHC Reporting Requirements

SAMHSA CCBHC Grants	State Certified CCBHCs (demo)
• National Outcome Measures (NOMs) • Health information, such as vitals an • Infrastructure Development, Prevention and Mental Health Promotion (IPP) • Annual/Programmatic Report • Disparities Impact Statement • Quality measures	• Quality measures • State specific reporting requirements

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Organizational Authority and Governance

The Board must have meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers through the options listed below:

- 51 percent of the board are families, consumers or people with lived experience of mental health and/or substance use disorders
- Establish an Advisory Work Group comprising of individuals with mental and substance use disorders, and family members, to provide input and guidance to the CCBHC on implementation, services, and policies.

Early Outcomes and Innovative Partnerships in the CCBHC Model

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Early Outcomes of the CCBHC Model

CCBHCs are:

- Hiring **dedicated population health** analysts, clinicians, other staff.
- Using **data analysis** to understand utilization and risk among client population.
- Developing **care pathways** to ensure comprehensive, assertive service delivery to high-risk populations.
- Strengthening **integration with primary care** to help clients manage chronic physical health conditions that are cost drivers.
- Partnering with hospitals to **streamline care transitions** and prevent readmission.
- Assessing for **non-health needs** that are determinants of health (e.g. housing, food, etc.).

Addressing Health Disparities

100% of CCBHCs said their CCBHC status has helped them serve people of color, improve access to care, and reduce health disparities in their communities.

- **75%** increased screening for unmet social needs (e.g., housing, income, insurance status, transportation)
- **67%** developed organizational policies and protocols to improve diversity, equity, and inclusion
- **60%** hired staff who are demographically similar to the populations their clinics serve
- **53%** initiated or expanded translation services

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States reported reductions in emergency department and hospital visits among CCBHC clients, leading to cost offsets.

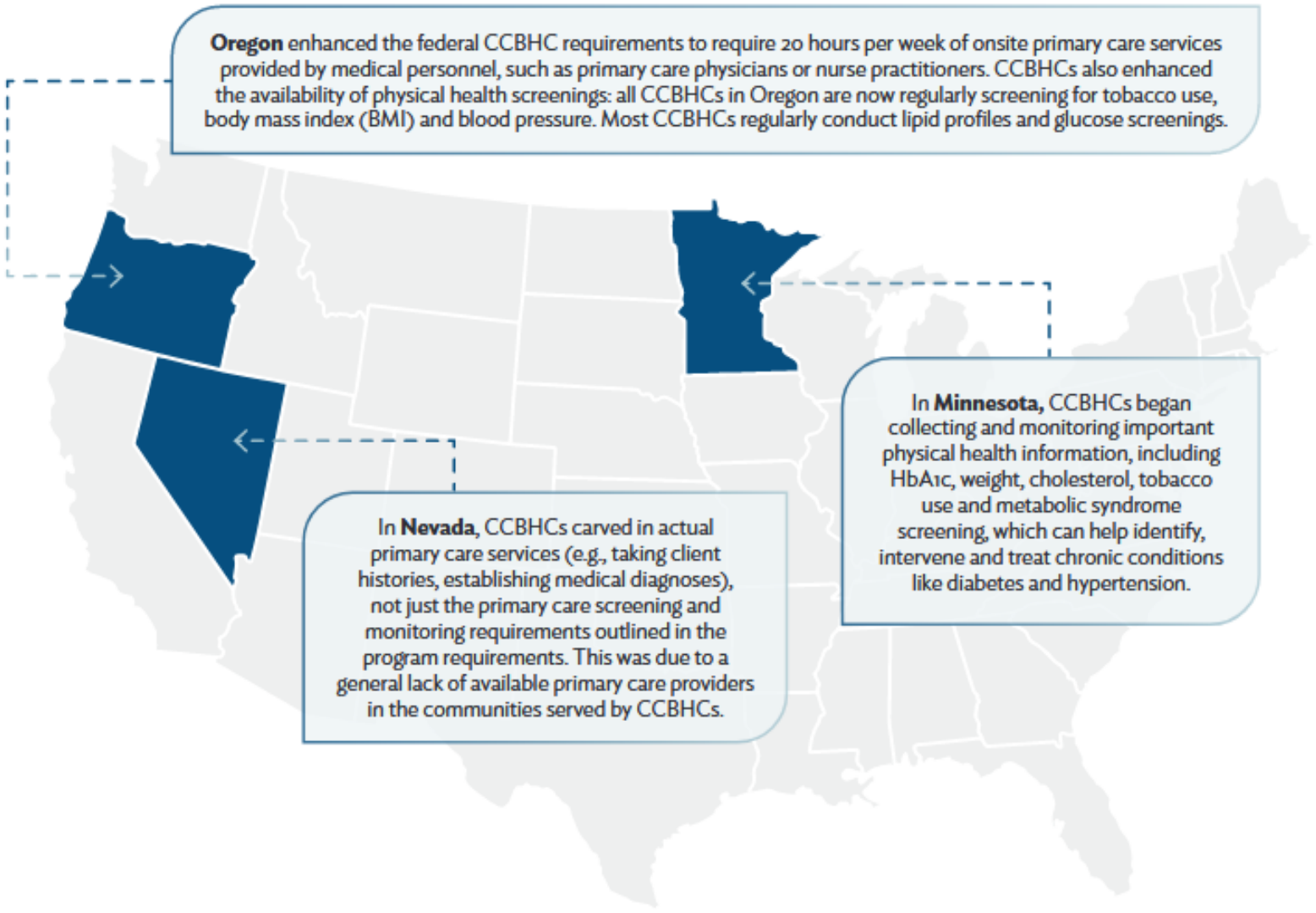
Oklahoma's three CCBHCs reduced the proportion of their clients seen in emergency departments by 18–47% (rates varied by clinic) and those admitted to inpatient care by 20–69% over the first four years of the program, compared to baseline.

In its first year, **New York** reported a 54% decrease in the number of CCBHC clients using behavioral health inpatient care, which translated to a 27% decrease in associated monthly costs. Similarly, the state reported a 46% decrease in the number of clients using the emergency department, leading to a 26% reduction in monthly costs. New York also saw a 61% decrease in the number of clients using general hospital inpatient services and a 54% decrease in all-cause readmissions.

New Jersey reported a decline in all-cause readmission rates from the first to second demonstration year.

Missouri reported that among clients with a prior emergency department visit engaged in outpatient care at a CCBHC, 76% experienced reduced emergency department visits and hospitalizations. Of those engaged in care who had some type of prior law enforcement involvement, nearly 70% had no further law enforcement involvement at six months.

The CCBHC demonstration resulted in improved integration of physical care with mental health and substance use care, with CCBHC sites in some states exceeding program requirements to offer onsite primary care services.



Making Crisis Services & Supports Available to All

- **100%** of CCBHCs offer crisis response services.
  - **51%** newly added crisis services as a result of certification.
- Required crisis activities: 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- **91%** are engaging in one or more research-based practices in crisis response, incl.:
  - **Coordinates with hospitals/emergency departments** to support diversion from EDs and inpatient (79%)
  - Behavioral health provider **co-responds with police/EMS** (e.g. clinician or peer embedded with first responders) (38%)
  - Operates a **crisis drop-in center** or similar non-hospital facility for crisis stabilization (e.g. 23-hour observation) (33%)
  - **Mobile behavioral health team** responds to relevant 911 calls instead of police/EMS (e.g. CAHOOTS or similar model) (19%)
  - **Partners with 911** to have relevant calls routed to CCBHC (17%)

Partnering with Law Enforcement & Criminal Justice Agencies

95% of CCBHCs are engaged in one or more researched-based practices in collaboration with law enforcement/criminal justice agencies:

Research-based Practices in LE & CJ Collaboration	Percent of CCBHCs
Participate in mental health court, drug court, or veterans' court	76%
Train law enforcement or corrections officers in Mental Health First Aid, CIT, or other mental health/SUD awareness training	72%
Provide pre-release screening, referrals, or other activities to ensure continuity of care upon re-entry to community from jail	70%
Increased outreach and/or access to individuals with or at risk of criminal legal system involvement	63%
Initiated data or information sharing with law enforcement or local jails to support improved collaboration	34%
Embed a clinician or peer specialist with law enforcement officers responding to mental health/SUD calls	32%
Provide telehealth support to law enforcement officers responding to mental health/SUD calls	20%

Questions?

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