MS CCBHC Steering Committee Monthly Meeting-20230912_152929-Meeting Recording

Attendees

Amy Swanson
ANDREW DAY
Beth Fenech
Bill Rosamond
Bobby Barton
Crockett, Kathy L (Ctr for Counseling &
Family Studies)
Don Brown
Heather Brister
Jackie Sue Griffin, MBA, MS
Jason Ramey
Karin Lewis
Kate J. McMillin
Kay Daneault
Keenyn Wald
Keith Heartsill
Kelly Burrow
Kim Hoover
Kimberly A. Sartin-Holloway
Lay, Toniya
Lisa Hillhouse
Mark Scott
Mona M. Gauthier
Nikki Tapp
Peter Gamache, Ph.D. (Guest)
Phaedre Cole
Rayfield Evins, Jr.
Rayfield Evins, Jr.
Rebecca Small (Guest)
Richard J. Manning
Sally Hoogewerf EdD (Guest)
Stephanie Foster
Stephanie Stout
Tiffany Baker
Will Ruff (Lifecore) (Guest)

Discussion Notes

Amy Swanson called the meeting to order at 2:32 p.m.

I am really pleased to be here with all of you today. Please remember we are recording today's call to ensure that we capture minutes from these meetings. The meeting minutes and presentation are posted on the CCBHC page of DMH's website.
I do want to extend wishes from director Wendy Bailey. She is unable to participate today due to some outside meeting.

Review of Agenda for the Meeting, see below:

- CCBHC Planning Grant Activities Update
- Open Discussion: MS's CCBHC Certification Criteria
- CCBHC Resources: Web Page, Upcoming Meetings and Trainings

Amy Swanson had issues projecting the presentation and emailed everyone on the call. She apologized for the problems with technology.

Amy Swanson reviewed the Department of Mental Health's mission statement. She reminded everyone that the work of the CCBHC and our vision for this work aligns to those principles.
Our goals around the CBHC work in Mississippi are to:

- Improve access to and delivery of community-based services, address barriers and gaps to that care established a sustainable funding and additional comments in quality offer more competitive wages because of a cost reimbursement model.
  Alleviate some of our workforce shortages, holding our CMCs accountable to those quality outcomes.
- This is not doing business as usual and it is an amazing opportunity to engage stakeholders and consumers to develop what is a customized approach for the state of Mississippi.
  So while we are using federal guidelines and criteria, this is really, truly about what's best for Mississippi.

Amy Swanson provided an update on our planning grant activities and timeline. Overall, everything is on track for us to develop and submit for the Demonstration Grant in 2024. Today, we are sharing the preliminary results of the Needs Assessment.

The goals of the Community Needs Assessment were to:

- Select CCBHC scope of services.
- Gather information from all community stakeholders and consumers currently using those resources.
- Catalog important Community partnerships and securing insights on training resources and capacity.
  increased awareness of the CC BH's and gaining understanding of barriers to accessing treatment services.
  Use the results from the Community needs assessment, both the statewide assessment results across the entire state to inform the elements of the state's behavioral health system.

We had nearly 2000 people complete the surveys. All CMHC regions participate in delivering that survey out to their stakeholders in the Community.

We obtained input from people who lived experience, people engaged currently with CCBHC's, and the community mental health centers. CMHCs are distributed to local health departments, inpatient facilities, local schools, crisis responders. The survey was distributed through social media, telephonic, and paper copies from clients served by CMHCs.

To date, survey responses were received by:

- 35% have mental health or substance abuse issues.
- 16% of those surveyed had caring relationships with adults and 22% of children under the age of 21%.
- 26% work with kids, 25% provide services to people with substance abuse and 13 1/2 provide Primary Health care services.

Respondents shared 69% don't believe we are doing that at the local level and 73% did not believe we were sufficient with state resources. And as you can see, 10 to 11% remain unsure, but overwhelmingly we are not meeting the needs, according to Mississippians.

On the next slide, you'll see what the top barriers were to accessing care, overwhelmingly lack of money to support treatment services. A high number of people who just don't understand what mental health is and what that would mean to access those services. Limited transportation. Always a persistent pain point. Again, lack of awareness is of services limited access to telehealth option, including the equipment to support that and then access to services 24/7.

They also identify these priorities for transforming our system. First and foremost is funding to support the workforce and expanding services in our transportation. Again, another top priority person and family centered care. This was a reoccurring theme as well in the open what I call verbatim comments, and we'll have a more detail on that in the in the more complete report coordination between Primary Health and behavioral health, the availability of walk-in appointments needs to be a priority and transforming our system adequate and highly trained workforce services and support excuse me, services and service providers that reflect an understanding of people's values and traditions and translation resources.

What were the top ten resources and services that Mississippians expressed wanting to see from their mental health system?

- Number one family supports crisis stabilization units in the community, 24-hour crisis.
- Mental health services targeted case management services, screening, assessment, and diagnosis from professionals who can help figure out what's going on.

- So appropriate screening assessment and diagnosis, outpatient clinic, primary care coordination, psychiatric rehab services, counseling, treatment teams that include the person in the treatment and planning.
- And then finally, intensive community based mental health for members of the veterans and armed forces.

What were the care coordination resources they believed were important?

- Secure, safe, and affordable housing
- Job training
- Transportation
- Employment support
- Support and enrolling in Medicaid, including supporting renewal of that coverage, educational support supports for families and caregivers working in collaboration with other Community resources, collaboration with law enforcement, the ever persistent need to reduce stigma.

We asked respondents to share what training is needed to support the workforce needs in Mississippi?

- Mental health first aid awareness training.
- Suicide prevention and intervention strategies.
- Crisis intervention support, substance abuse prevention and training and education, helping families of kids who have mental health challenges with issues at school, domestic violence prevention care for Co-occurring mental health and substance abuse disorders.
- Opioid overdose prevention and reversal.
- And then veterans' specific services and trainings.

We asked individuals to really share with us how did they want to participate in our work as a state, transforming our system and 54% identified that they wanted to help in recruit staff. So that was great news to see because that means that we've got some folks who will engage in our workforce development efforts and planning 44%, we're willing to refer individuals for services.

Again, good news for our CMHC's there is an appetite to identify, refer and get to know more what our CMHC's do and then 41% will provide support for those care coordination activities.
Those care coordination activities. So, this is in in many ways, good news folks.

Amy Swanson shared that the results will be available for the October 11th Steering Committee meeting. we will finalize all these results in September and use these with our planning teams to identify opportunities to fine tune and tweak our implementation plans.

She invited attendees to share any questions or comments before we review the certification criteria questions. No responses from attendees. She invited attendees to drop anything in the chat if they have any additional questions on the Community Needs Assessment.

Amy shared that next we are going to walk through a series of strategic questions that DMH needs your input on.

In the CBHC criteria, there are several areas where the feds allow us flexibility in our state to, you know, do things maybe a little differently or do things that go above and beyond the minimum requirements. What we would like to get your feedback on as an agency is what direction do you think Mississippi should go as it relates to some of these options.

DMH has decided on these options:

- CCBHCs will be required to complete an annual Community Needs Assessment. DMH will supply them with a standardized Community Needs Assessment survey and CCBHCs will be required to collect and report data at the County level.
- DMH will include language on decertifying CCBHCs if they are not meeting their requirements.
- DMH will require these additional staffing requirements as part of the CCBHC certification criteria:
    - CCBHC staff are trained in the minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.
- DMH will allow:
    - A CCBHC that is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director.
    - In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.
- DMH will request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria. For example: This could be very beneficial for less formal providers and organizations that might be willing to engage in a DCO relationship allowing the CCBHCs to execute more DCOs with community-based providers rather than building it all on their own.

- DMH has elected to require additional criteria above minimum CCBHC screening and assessment requirements to include adding “Needs” in addition to strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services.
- DMH will not require CCBHC’s to include any additional person and family-centered treatment planning requirements beyond the federal CCBHC criteria.
- DMH will not require any additional screening and monitoring beyond the minimum CCBHC certification criteria.

DMH wanted the CCBHC Steering Committee input on the following:

Partnerships: So, the first area that we need your help on is what would you like us to do as it relates to partnerships? Currently, CCBHC criteria requires there are minimum requirements around which organizations we need to partner with, but then they ask us to look at optional partnerships that will need to be needed on the minimum requirements. What DMH is really looking for is what organizations do we want our CCBHC to have required partnerships with?

Amy Swanson shared an example: Housing agencies are optional organizations, however, given our State’s Community Needs Assessment, should we require our CCBHC’s to have formal partnerships with housing entities?

The same could be said for: job training, number 2; transportation was number 3; and employment was number 4, so even if you thought about it from that perspective and we use the data in our needs assessment on this list and there's a bulleted list there, starting with service providers who prescribe medication, homeless shelters, housing agencies, employment service system, aging and disability resource centers, legal aid, criminal justice.

Don Brown stated it would make sense to require partnerships in housing and employment. Involved law enforcement.

You know, it was interesting that that came up as a priority organization for outreach, working with law enforcement that came up as one of the care coordination resources.

Rebecca Small shared transportation is a huge issue and I know I don't see it on this list, but you know, we do have transportation companies that you know we contract with and things of that nature.

Stephanie Stout then shared that there was a need for more peer support. Even though it’s not on the minimum required partner list, it would be good to include that as a requirement. She shared that with the work of the Association of Mississippi peer support specialist, but we are trying to hire

peers through the agency that can then be contracted to work at different places. And we are, UM, developing a veteran's module for peer support training as well.

Melody Madaris said we need to make sure that we keep a keen eye to not impose requirements where we don't have local organizations or capacity to work with them.

Stephanie Stout raised that for housing, it is important to include recovery transitional housing as well.

Staffing Requirements: Are there any staff disciplines that DMH you want to require in our certification that are just a base requirement that there's no options for flexibility around them?

The group reviewed but did not recommend any additional from the federal minimum requirements.

Care Coordination. Do you want DMH to require incentivizing providers to partner with CBHC's? Amy Swanson shared an example: If you wanted to provide an incentive for hospitals to provide care coordination from a hospital stay to a local community-based provider.

Keith Heartsill shared that when it comes to connection with an inpatient hospital, both acute general hospitals and behavioral health hospital, I don't know how many people own the call, are totally aware of this before our hospitals in Mississippi, both the general acute care hospitals and behavioral health hospitals we have what's called the Mississippi Hospital Access program impact for short. We have two quality components related to MSFT. One is called PHR. Potentially preventable hospital returns program. The other is called PPC, potentially preventable complications. Hospitals are measured through the PHR program owned their readmission rate 1 area that we see very high in readmissions, and this will not come as a surprise to the professionals on this call. And for those who work in this area, behavioral and mental health is we see a very high readmission rate as it relates to mental health diagnosis. Those make up about 40% of our top ten DRG, so we see a very high readmission rate as we meet with hospitals and we see their corrective action plans because if they are above a certain rate, they must send us a corrective action plan as to how they're going to reduce their readmission rates.

Keith Heartsill identified one of the things that I see is a collaboration between our CBHC's with hospitals. To say, here's how we can work with you to help you reduce your readmission rate. When you have that patient, that beneficiary being discharged with a mental health condition and you know health diagnosis, let us help you follow up post discharge with the care. So, I see a real opportunity here in the readmission reduction program.

Keith also shared that they do have an incentive with our program, with our three Co whereby we have several HEDIS measures. Measures we have a measure related to C-section rate and we have a measure related to the readmission reduction rate for them as well as the hospitals for our current HEDIS measures relative to state fiscal year 24. Two of those measures are related to mental health diagnosis. One is antidepressant management, effective acute phase treatment and the other one is followed up after hospitalization for mental illness. So, we have a direct correlation in our incentive withhold program already where monies are deducted from them, and they must earn it back by achieving scores in their incentive withhold quality measures.

Amy Swanson asked the group if they would want to pursue these incentives. The group did not recommend any incentives, but follow-up with the Division of Medicaid on how to ensure CCBHCs worked with these providers to build off the existing work, right, rather than imposing an incentive program.

Quality Measures. Of the optional measures, what does the Steering Committee recommend we collect. Here are the optional measures:

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- Major Depressive Disorder (MDD)
- Suicide Risk Assessment (SRT)
- Preventative Care & Screening Tobacco Use: Screening & Cessation Intervention
- Child and Adolescent Major Depressive Disorder and Suicide Risk Assessment
- Adult Major Depression and Suicide Risk Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents
- Use of First-Line Psychosocial Care for Children and Adolescents in Antipsychotics.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics

Phaedre Cole asked what Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) was. Amy Swanson pulled up the NCQA details for that measure: Although antipsychotic medications may serve as effective treatment for a narrowly defined set of psychiatric disorders in children and adolescents, they are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first-line treatment.[1] Safer, first-line psychosocial interventions may be underutilized, and children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.

Kerry McMillin asked when you're when you say these are the, these are requirements. So these are the quality measures that you are going to be reporting on? Amy Swanson responded yes.

Kerry McMillan responded. I'm just trying to wrap my head around. Obviously, you wouldn't do these with everybody, so you would have an indicator of when you would do that major depressive disorder. That would be part of the quality measure of when you would do that and did get done. Amy Swanson stated, that is correct.

Kerry McMillin then suggested adding the suicide risk assessment.

Amy Swanson asked if anybody opposed adding MD in SRT?

Phaedre Cole and others responded. No, not at all. What would be the additional optional measure for MDD? You have the screening for clinical depression, medication management for depression. What would be additional measurements?

Amy Swanson shared that the new guidelines for these Quality Measure specifications will be distributed shortly. She will make those available to the Steering Committee.

Since the meeting was a few minutes from ending, Amy Swanson asked that we cover the remaining optional areas for our next meeting. She asked that everyone review these remaining questions:

What are the minimum set of evidence-based practices that DMH will require of CCBHCs? Examples could include:

- Motivational Interviewing
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Seeking Safety
- Assertive Community Treatment (ACT)
- Forensic Assertive Community Treatment (FACT)
- Long-acting injectable medications to treat both mental and substance use disorders.
- Multi-Systemic Therapy
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Cognitive Behavioral Therapy for psychosis (CBTp)
- High-Fidelity Wraparound
- Parent Management Training
- Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation.

What is the scope of other CCBHC targeted case management services that DMH will require, and the specific populations for which they are intended?

Current CCBHC Certification Required Targeted Case Management Services:

- The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and

gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports.

- CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC.
- CCBHC targeted case management should include support for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization.
- CCBHC targeted case management should also be used accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons.
- CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services.

In addition to the minimum requirements, what specific evidence-based and other psychiatric rehabilitation services will DMH require?

Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers.

What scope of peer and family services will DMH require?

Potential family/caregiver support services that might be considered include community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support.

Peer services may include:

- peer-run wellness and recovery centers
- youth/young adult peer support
- recovery coaching
- peer-run crisis respites
- Warmlines
- peer-led crisis planning
- peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care.
- mutual support and self-help groups
- peer support for older adults

- peer education and leadership development
- peer recovery services

Meeting Ended.

Amy Swanson closed out the meeting. She invited attendees to submit feedback in the chat, etc. Amy Swanson thanked everyone for the support they've provided to DMH in in our CCBHC work.