**March 12, 2024, CCBHC Steering Committee Monthly Meeting Notes**

**Attendees**

- Allyson McDonnieal
- Amy Swanson
- Beth Fenech
- Bill Rosamond
- Bobby Barton
- Brownell, Shira
- Cindie Martiny
- Deborah Brockaway
- Don Brown
- Hambleton, Scott
- Hope Tomfohrde
- Jackie Sue Griffin, MBA, MS
- Jake Hutchins
- Jamie X. Caugills
- Jason Ferguson
- Jason Ramey
- Jones, Richard
- Joy Hogge (she/her)
- Kate J. McMillin
- Kay Daneault
- Kelly Breland
- Kim Hoover
- Kimberly  A. Sartin-Holloway
- Kiri L. Parson
- Leslie Cain
- Mark Scott
- McGillivray, Lesa

- Melody Madaris
- meridethselby
- Mohr, Edward
- Nikki Tapp
- Olivia Blount (Guest)
- Palmer, James R
- Peter Gamache, Ph.D. (Guest)
- phaedrecole@region6-lifehelp.org
- Ray Evins
- Rebecca Small (Guest)
- Richard J.  Manning
- Rita Porter
- Sally Hoogewerf, EdD
- Stephanie Foster
- Stephanie Stout
- Steven Allen
- Teri Brister
- Tiffany Baker
- Vaassen, Lea
- Wendy Bailey
- Will Ruff

Director Wendy Bailey kicked off the meeting at 2:37 p.m.  She reviewed our agenda, see below:

Agenda

- Welcome and CCBHC Activity Highlights
- CCBHC Planning Grant Updates
    - February In-Person Meeting
    - Demonstration Application Update
    - Discussions with Regions 6 and 14
    - CCBHC Planning Grant Work
- Workforce Development Committee

Director Wendy Bailey shared gratitude and updates from the in-person February events.


**Same Day Access Call to Action Meeting**

**February 22nd 10:30 a.m. to 4:45 p.m. Location: Hinds Behavioral Health Center, 3450 US-80, Jackson, MS 39209**

**Learning Objectives**

1. Gain a better understanding of the importance of same day access to services.
2. CMHCs learn about experiences from the Mississippi SAMHSA's CCBHC grantees.
3. Understand written practices and protocols needed to achieve same day access to services.

**AGENDA**

| | |
|---|---|
| 10:00-10:30 a.m. | **Registration** |
| 10:30 a.m.- Noon | **Overview of the Same Day Summit Agenda and Goals** |
| | *Scott Lloyd, President of MTM Services, Senior SPQM Data Consultant and Senior National Council for Mental Wellbeing Consultant* |

**Roundtable Discussion: Lessons learned from Mississippi's CCBHC SAMHSA grantees** *Facilitated by: Peter E. Gamache, Ph.D. and Jackie Sue Griffin, MBA, MS of Turnaround Achievement Network, LLC and Turnaround Life, Inc.*

**Participants:**

- Tiffany Baker, Ph.D., Singing River Services
- Melody Madaris, Ph.D., LCPC, CRC, CMHT, CSAT, AI, Communicare
- Karen Atkinson, MS, LPC-S, Hinds Behavioral Health Services
- Will Ruff, M.Ed., CMHT, LIFECORE HEALTH GROUP
- Wm. Scott Sumrall, ScD, MHSA, Region 8 Mental Health Services
- Danna Hopper, EdD., LPC-S, Region 4 Mental Health Services
- Rita Porter, Ph.D., Pine Belt Mental Healthcare Resources

Noon **Lunch/Networking Break**

12:30-1:15 p.m. **Environmental Scan Results on CCBHC Criteria vs DMH Standards**

1:15 p.m. **Prioritization Exercise**

**Facilitator:** *Scott Lloyd, President of MTM Services, Senior SPQM Data Consultant and Senior National Council for Mental Wellbeing Consultant*

2:30 p.m. **Break-Out Groups: Developing Implementation Work Plans**

- Identify 3 SMART Goals for Prioritization Areas
- Identify activities that support 3 SMART Goals for Prioritization Areas
- Identify accountable owner(s)
- Schedule work group meetings

3:30 p.m. **Report Out for Breakout Groups**

4:30 p.m. **Meeting Debrief and Evaluation**

4:45 p.m. **Meeting Ends**

# The Systems Needed to be a CCBHC

## Where to Start/Change Suggestions for Success -

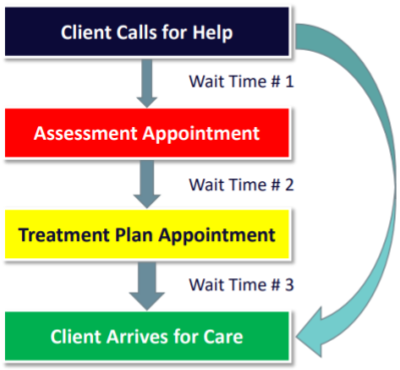
1. Access Systems fully implemented to fidelity –
   - ***Same Day Access***
   - ***Just in Time Prescriber Scheduling***
2. Forms and IT Systems that work
   - *Collaborative Documentation*
   - ***Statewide form sets***
   - ***Data Mapping/GAP Analysis to offer Data Driven Feedback to your state/SAMSHA***
   - *Agile Focused IT Changes*
   - *DCO Data Sharing*
3. Individual Organization/Statewide Cost Finding
4. **Appropriate No Show and Engagement Policies/Episode of Care Guidelines**
5. Back Office Readiness - Proper Billing and Collection Protocols *(If you go to CCBHC, then a way to monitor PPS performance)*
6. Team Wellness Planning to help your staff overcome the stressors of today's challenging environment





# What Does Access Actually Mean?!

## Defining Access...Based upon over 30,000 Access Flows...

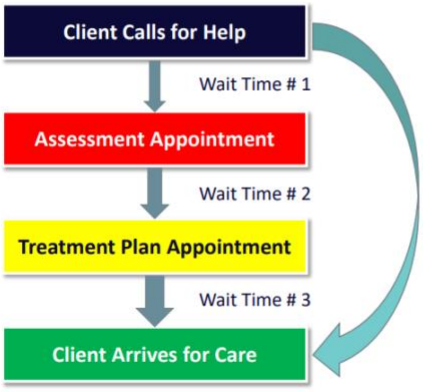



**Organizational View -**

**Client's View -**

# What Does Access Actually Mean?!

## Defining Access…Based upon over 30,000 Access Flows…




### Access System Realities -

1. Client vs Agency View.
2. The False Reality of Full.
3. The Impact of Silos.
4. Mission versus Reality.
5. Huge Engagement Opportunity.
6. Clients Voting with their Feet.
7. CCBHC – Time to 3rd Appointment





## Access to Treatment Is a Value-Based Leadership Requirement…

1. **Primary Access** – Time to provide client face to face initial intake/assessment after call for help – **Same Day/Open Access Model implemented at over 900 CBHCs nationally**
2. **Secondary Access** – Time to provide client face to face service with his/her treating clinician following intake/assessment date – **3 to 5 days but not later than 8 days after same day assessment provided**
3. **Tertiary Access** – Time to first face to face service with Psychiatrist/APRN following the intake/assessment date **- 3 days or fewer after the same day assessment provided.**

**NOTE: The Just in Time Medical Services Scheduling Models has been implemented by hundreds of organizations in more than 20 states**

## Same Day Access Scheduling Defined -

Same Day Access is the process of establishing the appropriate staffing and systems needed to offer a full Diagnostic Assessment with a Therapist on the same day it is requested to all consumers, without a scheduling delay or waitlist. This assessment will be the determinate for what services are clinically appropriate going forward and greatly improves consumer satisfaction and engagement, while also eradicating no shows in the assessment process! MTM has moved more than 800 teams through this process and knows how to tailor it to the specific needs of each organization!





## Just in Time Prescriber Scheduling Defined -

This process allows teams to move a consumer from their diagnostic assessment to a psychiatric evaluation within 3 calendar days or fewer (3 to 5 as a worst case around holidays, etc.), greatly increasing engagement and reducing no shows and cancellations. As well, this schedule system builds in a much higher level of scheduling flexibility for follow up appointments to allow teams to better respond to their consumer's needs.

This move improves that consumer's experience and the staff member's quality of life by removing obstacles like non-billable med call-ins that generate high levels of frustration.

# Making Same Day Access a Reality?!

## The Set Up Steps for Success!

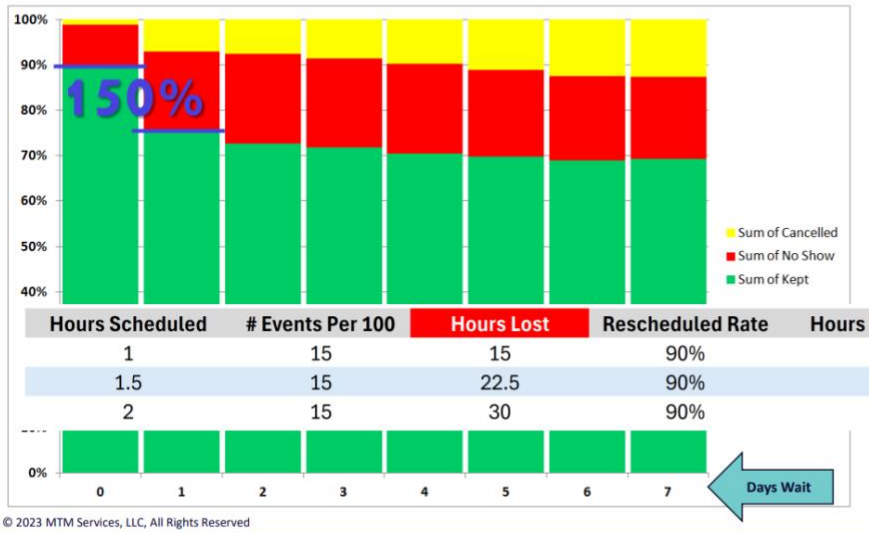
1. Determine your Organization's Demand and Optimal Hours of Operation
2. Select Your Staffing / Team Model / Back-Up Contingency Staff
3. Set a Plan to handle your Existing Appointments
4. Choreograph your Wait time
5. Communicate and Go!

6. **All of this is after setting up your systems to be ready to do SDA!**
7. **Are your caseloads full?!**





## The SDA Difference vs. Scheduling




***Initial Primary Questions*** –

- Is there really a difference?
- But what if they need to set up transportation?
- Will we need more staff?

| Hours Scheduled | # Events Per 100 | Hours Lost | Rescheduled Rate | Hours Rescheduled | Total Hours Lost |
|---|---|---|---|---|---|
| 1 | 15 | 15 | 90% | 13.5 | **28.5** |
| 1.5 | 15 | 22.5 | 90% | 20.25 | **42.75** |
| 2 | 15 | 30 | 90% | 27 | **57** |

# The Results Tell The Story…

## We are going to be a CCBHC and the standard is having a consumer to an Assessment within 7-10 days…..

## So why would we do SDA!?

### Same Day Access Consultation –

Return on Investment includes:

1. An instant and significant increase in client show rates to 100%,
2. An increase in engagement that leads to an increase in outcomes,
3. The ability to see the same number or more consumers with fewer staff,
4. A wholistic system change that boasts a 97% client approval rating according to client surveys,
5. Addresses important system issues with Episode of Care planning, Collaborative Documentation Training, & No Show and Engagement policies,
6. Exceeds the Access Requirements for all known programs,
7. Helps alleviate crisis calls, and
8. Financially, teams see an average of an 8 to 1 return on investment in the first year based upon the efficiencies generated with those savings continuing into the future, and normally additional billings of 5-10% that are generated by the higher show rates and engagement levels.





# Same Day Access Scheduling

**Access Comparison Worksheet**

| | Total Staff Time (Hrs) | Total Client Time without Wait-time (Hrs) | Cost for Process | Total Wait-time (Days) |
|---|---|---|---|---|
| Old Process Averages: | 4.94 | 3.35 | ($347.20) | 45.72 |
| New Process Averages: | 3.74 | 2.85 | ($265.95) | 25.81 |
| Savings: | 1.20 | 0.50 | $81.25 | 19.92 |
| Change %: | 24% | 15% | 23% | 44% |

MTMSERVICES www.mtmservices.org



| | |
|---|---|
| Avg. Number of Intakes Per Month | 24,349.20 |
| Intake Volume Change %: | 10% |
| Monthly Savings: | $1,676,428.44 |
| Annual Savings: | $20,117,141.29 |
| Average Savings Per Center: | $135,926.63 |

The sample size of this change information is taken from 169 organizations in 25 states.

Average Savings Per Center is based upon Fewer Organizations as some teams did not need to change their staff time, only their wait time

## JIT Prescriber Scheduling

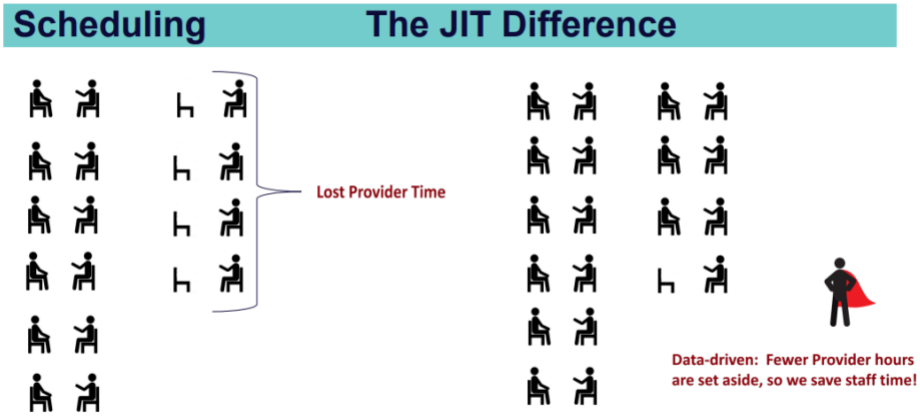
### Benefits -

1. No show/late cancellation rate of 10% or below!
2. Better consumer engagement.
3. The ability to see consumers more quickly/to be flexible.
4. Exceeds the access requirements for all known programs.
5. Helps alleviate crisis calls.
6. No more med call-ins/e-scribing.





## The Results Tell The Story…






As part of the meeting on the 22nd, 7 of the SAMHSA CCBHC grantees participated in a panel discussion, results are provided below.

# Same Day Access: Call to Action Meeting

February 22, 2024, 10:00 a.m. to 4:45 p.m.
Location: Hinds Behavioral Health Center, 3450 US-80, Jackson, MS 39209

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## Learning Objectives

1. Gain a better understanding of the importance of same day access to services.
2. CMHCs learn about experiences from the Mississippi SAMHSA's CCBHC grantees.
3. Understand written practices and protocols needed to achieve same day access to services.

Seven of Mississippi's CMHCs are already recipients of CCBHC Expansion grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that leads public health efforts regarding behavioral health in the nation. Those recipients are:

1. **Region 2** Communicare
2. **Region 3** LIFECORE Health Group
3. **Region 4** Mental Health Services
4. **Region 8** Region 8 Mental Health Services
5. **Region 9** Hinds Behavioral Health Services
6. **Region 12** Pine Belt Mental Healthcare Resources
7. **Region 14** Singing River Services


**Roundtable Discussion:** Lessons Learned from Mississippi's CCBHC SAMHSA grantees, Facilitated by: Dr. Peter Gamache and Jackie Sue Griffin MBA, MS, Turnaround Achievement Network, LLC

**Panelists:** Tiffany Baker, Ph.D., Singing River Services; Melody Madaris, Ph.D., LCPC, CRC, CMHT, CSAT, PAI, Communicare, Rachel Alcorn, LCSW, EMDR II, ART, CMAT, CSAT, PAI, Clinical Director; Karen Atkinson, MS, LPC-S, Hinds Behavioral Health Services; Will Ruff, M.Ed., CMHT, LIFECORE HEALTH GROUP; Wm. Scott Sumrall, ScD, MHSA, MBA, Region 8 Mental Health Services; Danna Hopper, EdD., LPC-S, Region 4 Mental Health Services; and Rita Porter, Ph.D., Pine Belt Mental Healthcare Resources.

**Tiffany Baker, Ph.D., Singing River Services (Region 14)**

- As of September 29, 2023, the CCBHC enrolled **226** (of 100) individuals, achieving **226%** of the Year 1 service goal.
- Create a **designated team** for startup and a process to implement the model.
- Include **employees** from all departments.
- **Educate** all staff on the model before **implementation** begins.
- Create a supportive **Continuous Quality Improvement (CQI)** environment that involves training for all staff and action plans detailing opportunities for improvement.
- Develop **systems** to improve **communication** internally and externally being sure to involve consumers.
- Be **adaptable** and **open** to **continual evolution**. Focus on the **ultimate goals** and written quality improvement **action plans** to drive improved quality care and practice.
- Develop **data tracking systems** (and **data collection tools**) in the beginning to inform decisions.
- Share **data** with staff so that they can rejoice in achievements and understand shortcomings and opportunities for improvement.
- Remain **innovative**. Think outside of the box pertaining to expanding staff, addressing workforce shortages.
- Be **creative** about **workforce recruitment** and **diversification**.

## Melody Madaris, Ph.D., LCPC, CRC, CMHT, CSAT, PAI, Communicare (Region 2)
## Rachel Alcorn, LCSW, EMDR II, ART, CMAT, CSAT, PAI, Clinical Director

Our three years of experience as a CCBHC grantee have resulted in the following lessons learned as we work toward further improving, advancing and expanding **access** to trauma-informed, culturally relevant and evidence-based comprehensive whole person centered behavioral healthcare services.

- The first CCBHC Expansion grant enrolled **314** individuals during the two-year project period.
- The CCBHC-IA grant will enroll **600** individuals during the four-year project period.

Using **data to inform planning and development** prior to **implementation** of whole person centered care **across the lifespan.**

The importance of **planning** (financially, programmatically for training, retraining of EBP with adherence to fidelity)

Results of your **primary care screenings** and physical health measurements can inform your future need to develop **diverse** community collaborations (i.e. HIV/Hep. Screenings, diabetes, sleep disorders, etc.).

**MTM gap analysis experience**

- Examining treatment silos, workflow, duplication of services and areas that need to be improved, modified to implement same day access.
- Regulatory requirements from DMH, DOH, and/or accredited bodies, etc.

**Vision** and **Buy-In** to the **CCBHC model of care** and **shift** in service delivery.

Make sure your **medical providers** understand the goals of the program and are willing to **engage**, remain **flexible**, and **innovative** (work outside the box).

Importance of **Engaging all Workforce**

- Make sure all your staff feel heard and have an understanding of why we are doing what we do by explaining the benefits to the CCBHC model of care by using **data** to demonstrate impact.

**Importance of Engaging Community Stakeholders**

- Establish talking points and/or a PowerPoint to visually show and explain why the shift in service delivery is needed.

Establish **a culture of diversity, inclusion, adaptability** and **customer service**

- Diverse and culturally responsive workforce
- Use your **disparities data** to inform community engagement, outreach, workforce staffing and/or modifications needed to strengthen retention and outcomes

**Measurement Based Care self-rating screening instruments**

- Make your EHR flexible where clients can complete the data collection part of the intake.

**Incorporate telemedicine** to ensure individuals in need receive all the help they need, i.e. therapy session w/ a telemedicine appointment with a prescriber in another office to help divert from a commitment.

**Collaborative Documentation** - in the middle of being trained and getting all our staff trained, but this is imperative to make it work. **Collaborative Documentation** is imperative because of documentation requirements. Using collaborative documentation allows you to work with the clients and complete your documentation before they leave the session.

**Expand access to MAT**

Strong **collaborations** and formal agreements with diversion partners (courts, criminal justice, jails)

Expanded **Family Engagement and Family Centered Care**

**Karen Atkinson, MS, LPC-S, Hinds Behavioral Health Services (Region 9)**

- As of September 29, 2023, the CCBHC enrolled **963 individuals** (of 100), achieving **963%** of its Year 1 annual service goal.

**Providing Whole Person/Integrated Care Takes A Village**

- On-site collaboration with Central Mississippi Health Services (FQHC) and its benefits to consumers.

**Identifying/Incorporating Screening Tools**

- Responsiveness of an EHR vendor is critical for timely adoption/implementation of HIT criteria and CCBHC requirements.
- Measurement-Based Care and clinical use of screening tools. If you collect the data use it to inform practice, treatment planning and quality care.

**Agencywide Phased Adoption of the CCBHC Model**

- Discuss why we chose this approach
- Ensure agencywide integration of service delivery to ensure that all CCBHC required services are included in our population and that we random sample for the purpose of the grant AND the transition to statewide certification as a CCBHC will be a lighter lift down the road.

**Challenges Staff Buy-In**

- Many staff look at CCBHC as adding burden to an already difficult workload. Look for ways to highlight the benefits of the model.

**Agencywide Staff Turnover and Workforce Shortages**

- Constant turnover makes it difficult just to maintain the status quo much less incorporating a completely new way of approaching our work.

**Transient Nature of our CMHC Population** makes care coordination and continued follow-up for NOMS reassessment data collection at 6-months post-baseline and clinical discharge more difficult. Solutions involve frequent updates to Locator forms, contact information.

**Balance** between existing requirements with new CCBHC requirements

- How all of the new data points, screening tools, etc. has created what can be viewed as an administrative burden for our clinicians.

Looking toward **streamline processes** (*MTM Same-Day Access Consultation*) to explain benefits of the new tools and work with staff on strategies to incorporate these items into normal **workflows** so it doesn't negatively impact productivity and quality care.

**Will Ruff, M.Ed., CMHT, LIFECORE HEALTH GROUP (Region 3)**

- As of September 29, 2023, the CCBHC enrolled **353** (of 75) individuals, achieving **471%** of the program service goal in Year 1.
  - Getting staff to buy into **integrated care**.
    - We still have staff on the behavioral health side that don't see the utility and value in integrated care. Create a PR campaign early on to get staff on board and help them understand why services and workflows are being modified; i.e. collecting vitals for individuals coming into the clinic for counseling sessions.
    - We have our own RHC. Getting medical staff to buy into referring internally and understanding the scope of the RHC and Preventative Care.
  - Tie NOMS collection to in clinic care as much as possible without overloading therapists. LIFECORE uses administrators in the clinic to complete NOMS at baseline and then we get them however we need to (in person/phone) for reassessment and discharge utilizing the staff we have at that time. Works great when you only use NOMS for sample population and not total population.
  - **EHR building capabilities**.
    - Make sure that everyone involved in building capabilities has time. We do this in house and our systems analysts were not used to the load of reporting and building that needed to be done even with months of lead time.
    - This helps keep data clean and helps our data analyst and clinicians keep things clean and reliable.
  - **Internal Communication**
    - Make sure that there are ways for people within the agency to communicate internally between program and staff. Taking on something as large as CCBHC requires buy in and understanding from multiple staff in multiple departments. Educate them so communication is better. Use technology to help drive this.
  - **Measurement-Based Care** is a large systemic issue within MHC. Training and educating staff on how to use measurement tools and their value and utility is key.

**Scott Sumrall, ScD, MHSA, MBA, Region 8 Mental Health Services (Region 8)**

- As of September 29, 2023, **127** (of 75) individuals were enrolled in CCBHC services, achieving **169.3%** of the program service goal in Year 1.
- Start the **reassessment** process earlier than later.
- **Discharge** all individuals as clinically appropriate. Collect a NOMS full reassessment interview at Discharge from clinical services whenever possible.
- Make certain the **data** that is collected for IPP performance measures agrees with the data collected in the Electronic Health Record and can describe care coordination for all new individuals enrolled during the quarter. Use the IPP data collection tracker to monitor monthly prior to the quarter ending to ensure **data is accurate and reliable**.
- Keep in **contact with individuals** you have referred out for **care coordination** and remain aware of the **resources** that have been provided.
- Use of **outcome measures** to **inform practice and person-centered treatment** planning.

**Danna Hopper, EdD., LPC-S, Region 4 Mental Health Services (Region 4)**

- The CCBHC will begin enrolling individuals into services by **March 31, 2024**.
- The understanding that providing the degree of services in the CCBHC involves more than just one agency. That the **involvement of community partnerships** are also important referral sources in the community.
- It is important to **communicate** with other CCBHCs to gain a better understanding of how they have managed the process.
- **Communication** with staff and community members to ensure that individuals understand the **shift** in services, the changes in the **access to care** and the **reason why** the shift is occurring.


- We are learning that **leadership** will be working closely with staff and individuals being served to help them understand the vision of the CCBHC and we will be eliciting their **involvement and feedback** as the changes take place.
- The importance of the ability to **engage in evidenced based practices**. Staff members will be required to complete **additional trainings** to support them in providing an expansion of services to all individuals.
- We are learning that we will have to make some changes as the **process** and **vision** of the agency shifts to **modify** existing policies and creating some new ones to align with the CCBHC.
- We are looking into the involvement in **health information exchange**, to gain a better understanding of compatibility with our current electronic medical record system. We have learned that this will allow staff to have **increased collaboration** to contract with **other facilities across specialties** for improved **data tracking**.
- In our **electronic mental record** system, we have learned that we will need to establish a method to be able to identify an individual that is enrolled specifically in CCBHC services.
- We are learning that we will be transitioning into a more **data driven process** through the collection of NOMS which can help our agency and staff to recognize the value of collecting data.
- We have learned that we are able to make **timely adjustments** in the budget for the upcoming years that could serve to benefit us to be able to include some of the funding for Netscape.

**Rita Porter, Ph.D., Pine Belt Mental Healthcare Resources (Region 12)**

- The CCBHC will begin enrolling individuals into services by **March 31, 2024**.

**Adaptability and Flexibility**

- Be prepared to **change your plans**
  - Your Project Officer and the SAMHSA grant reviewers may read your application differently than you intended (**Random Sampling Methodology Plan**, SPARS service goals).
  - The **scope** and **size** of the project may change.
  - Every GPO and PO have different ideas. Even if you have SAMHSA experience, it is hard to factor in individuals' unique approach to projects and project outputs.
- Be **prepared** to wait to start **implementation** services
  - The planning Zoom calls are plentiful, almost too many.
  - Some of the planning calls about important topics are later than I would have scheduled them for the project timeline.
- **Budget**
  - You may want to revise your budget to decrease the salary of positions that can't begin to work on the project until the planning period is over. Have ideas as to where this money could be spent to **add value** to your project.
    - Unexpected, required grantee meeting.
    - PSR or other beneficial service.
- **Planning**
  - Become familiar with the **CCBHC criteria**
  - Compare your agency policies and procedures against the criteria
  - Choose your **focus**
  - Develop/continue developing **relationships** with outside care providers, especially **primary care**
- **Problem Solving**
  - Use good communication skills with your GPO, PO, and partners. Develop **relationships**. This is a long-term project.
  - Everyone wants a successful project. Have **patience**.

On February 23rd, we hosted a statewide convening with 140 Mississippians to identify, engage and develop a workplan.

During this meeting, we had a panel discussion with representatives from many of the required partnership organizations. It included the following representatives:

**Yolonda Boone**, Senior Advisor, **Accelerate Mississippi**
**Tammy Burris Smith, Educator**
**Cassandra Dove Brown**, Director of Prevention Health and Felisa Simpson, Director, Office of Community Health Worker Clinical Consultant Office of Preventive Health & Health Equity Mississippi **State Department of Health**
**Robert DeYoung**, Director Office of Grant Management, **Mississippi Department of Employment Security**
**Henry Moore**, Director of Family Driven Practice, **Families as Allies**
**Jason McCarty**, Executive Director, **Mississippi Harm Reduction Initiative**
**Derrick Moore**, HUD-VASH Supervisor. **Veterans Administration**
**Dr. Joe Parks**, Medical Director for the **National Council**
**Brenda Patterson**, Executive Director, **CONTACT the Crisis Line (988 Crisis Line)**
**Dustin E. Sarver**, Associate Professor, Director, MAGNOLIA Clinical Scholars Program in Integrated Behavioral Health, Director, Neurodevelopmental and Behavioral Disorders Research and Services Lab PCIT Within Agency Trainer, Department of Psychiatry & Human Behavior, Department of Pediatrics | Center for Advancement of Youth, **University of Mississippi Medical Center**
**Stephanie Stout**, Executive Director, **Association of Peer Support Specialists (AMPSS)**
**Kimberly Wheaton**, **Deputy Commissioner of Child Welfare**
**Dena Wittman**, Executive Director, **Open Doors Homeless Coalition**

The session brought representatives, and people with lived experiences, from the external stakeholders required for CCBHC certification. We discussed and shared impact for Mississippi of the CCBHC efforts, gathered feedback from representatives, and people with lived experiences, from the minimum mandatory partnerships required for CCBHC certification. Attendees networked and identified concrete population specific outreach and engagement strategies, including:

- **Developing and implementing a comprehensive state or territory-wide 988 and CCBHC communication strategy.** *The 988 and CCBHC Planning Grant teams will work together to draft the Communications Plan with data on the populations at risk of crisis/suicide and identify the best communication distribution channels, including: billboards; retail outlets; gas stations; churches; sports advertising; value-based marketing partnerships.*

- **Formalizing crisis protocols with 988, CMHCs, and CCBHCs.** The 988 call centers are critical in supporting individuals and families in crisis and helping process and resolve their crises. In the event the crisis cannot be resolved via the telephone, text, or chat, the 988 call centers can connect the individual/family with other crisis providers and/or other supports to help resolve the crisis. Additionally, the 988 call centers are responsible for connecting these members post-crisis with timely behavioral health services, health services, and other social services.

- **Enhancing statewide data collection to improve 988 and CCBHC service and communication, with specific focus on high-risk populations and populations with high numbers of suicide deaths and attempts, by enhancing the collection of demographic data and resource referral and utilization, while safeguarding individual information consistent with applicable Federal and State privacy laws.** DMH has identified and is working towards securing a new Population Health Management (Care Coordination platform) that the CCBHCs, 988, and Crisis centers could use to document care coordination and activities. A population health platform is a technology resource that facilitates the identification, referral, and care coordination between multiple organizations to improve access to behavioral and mental health services. This single care coordination portal allows staff from multiple agencies, providers and even community stakeholders to log into a single system to input and share information in a safe and secure way. This will allow us to expand our systems' capabilities to accurately collect and report data without additional or manual work for providers.

Director Wendy Bailey invited **Dr. Tiffany Baker, Singing River Services and Merideth Selby, Life Help to share their feedback on their experience as two pilot regions with us. See below:**

- Share your experience in implementing the CCBHC model, what has been rewarding and challenging?
- What are the top three things your organization has been doing to prepare for becoming a certified CCBHC in MS?
- Highlights?
- What do you recommend others consider in becoming certified as a CCBHC?
- Are there things you'd like to know from the Steering Committee members on recommendations they have as you implement your work?

**Dr. Tiffany Baker:** Well, there have been many rewarding experiences while we've been implementing the CHC model. Some highlights include improving primary and behavioral health care treatment outcomes through physical health measurement, inappropriate lab testing. That's something I'm excited to be a part of. We've also increased access for ongoing management of Primary Health care needs with 74% of individuals referred for laboratory testing. And this would not have been available to these individuals without us implementing the model. And we've also increased measurement-based care with 100% of our grantees. We're screening for depression, anxiety, PTSD, and other things. We've also increased partnerships by 300% of our annual goals, so

that's another rewarding experience. We've increased the use of evidence-based practices and trainings throughout our agency, and you know throughout all these different highlights, you know we've had different impacts on individual served and that's been the most rewarding experience. Being able to walk with our consumers through all these processes and see their improved outcomes. Now as far as some challenges you know with any kind of rewards comes challenges. So, for example, when challenge that we had was, you know with the increase of measurement-based care that resulted in a need to track additional data requirements. But with the limited capabilities of our EHR, we had to look at other options for being able to track this data.
Also, you know and I think Mark has touched on this at every steering committee, you know another challenge is workforce shortages and so you know we've had to look eternally or internally for some of these positions within the agency and then revisit the way that we were marketing to recruit staff and we also participate in the Workforce Committee and we've got a lot of great ideas from that.

**Director Wendy Bailey:** Meredith, I know Life Help is not an operating CCBHC, but what are the top three things that your organization has been doing to prepare for becoming a certified CBC in Mississippi?

**Merideth Selby:** The primary thing is when we first, well, we knew even looking at the beginning where our biggest gaps were going to be and that was going to be veteran services and really making them much more robust. And surprisingly, learning from our community needs assessment that not as many people in our area knew about our services as we all think and assume that they do. And so, we've really listened to those results and have since made huge efforts to increase our outreach in the Community and the first and foremost thing was our creating Instagram and Facebook accounts. We've hired a social media consultant and so we expect the reach from social media to help a lot and to really get out more in the community. So increasing awareness there and then and today the reason I'm late exactly the great CBHC work that we're doing. We had our quarterly Advisory Council meeting today and it ran over because there was so much good stuff to talk about. Our veteran's representative had a whole host of things to share with us and information that he had gathered after a round table meeting that they had held last summer about services for veterans. And I think by the time we left there, we have plans in place to start with some new veterans' groups. We're looking at some training that Phaedrus already OK to get some of our uh therapist to increase their, enhance their training and their and what services they they're going to be able to provide and his and he is going to actually our veteran is going to take it back to the American Legion and see if we can even hold some of those veterans groups at the Community Center and hopes to facilitate attendance because, you know, not everybody with there's still a stigma out there.

**Director Wendy Bailey:** A lot of your comments and points that again the needs assessment brought to light, a lot of things that we may have known, but we weren't certain about. And then things that we weren't aware of, and we didn't know. And I'm glad you touched on a lot of times it is not knowing what resources are available or how to access those resources. Going back to Dr. Baker, what do you recommend others consider and becoming certified as a CCBHC?

**Dr. Tiffany Baker:** Well, I would really recommend you know taking a good look at the agency and where you're at and where you're heading. And I would recommend using the CCHC checklist. It's available online and it's a simplified version of the criteria and it just lays out everything that you have to do and I would really start there if I was, you know, making the decision whether I wanted to go down this CCHC journey or not because they it lays it all out for you and you can gauge, you know, where are you at currently, where can you see your agency heading to meet these requirements. And so, I really think just diving into that checklist could give you a lot of information. So, you know

what you must do because they'll be a lot of change. It will impact all the staff and all the people that we serve, but it'll be positive change.

**Director Wendy Bailey:** That's where all of this is helpful as well. Sharing your own personal experience. What you're going through, either in the process or starting the process or part of the planning grant it is changed, but it helps to know that's what the head on the road. So, this is really a question for both of you, but are there things that you would like to know from the steering committee? Are recommendations that they have as you implement your work. How can the steering Committee help support you as well?

**Dr. Tiffany Baker:** I don't know anything specifically where the steering committee could help, but I would say that, you know, I'm open to any kind of feedback if anyone has any to give is, you know, people that are implementing the model. Anything that maybe we're not thinking about or something that's important for us to keep in mind.

**Merideth Selby:** What Tiffany is saying. The main challenges I think are things that the steering committee can't control. I mean, they can't help us get our HR upgraded the quicker or. Give me more hours in a day. You know, there's just or and they can't create warm bodies for the workforce. So, I mean we I think we all share the same bigger problems, but anytime they sometimes we're so in the weeds with the hands-on work that we're doing getting it implemented we don't see. We welcome any feedback or thinking outside the box to help us improve implementation.

**Director Wendy Bailey**: Now kind of turning it to the steering committee members. Do any of you have any questions for Doctor Baker or Meredith from their perspective of where they are in the process or anything that you want to share with them as they're continuing in the planning grant journey?

**Shira Brownell** asked a question: What help do you need with data?

**Dr. Tiffany Baker.** I think in the beginning when piece of advice that I could give would be to look at all data points that you're going to need to be able to collect. And then I would use that to drive different workflows and processes to collect those pieces of data. And one thing that we've had to do because we've had limited capabilities of our EHR is to create a lot of spreadsheets. We're tracking things like umm, you know, you wouldn't see levels, BMI, perception of care. I would say and so we've got a lot of master spreadsheets, but you know, I've got a great team and so we got a work process in place where you know someone comes in and we collect that data and then it just starts going through the CMHC team and we get it entered. We also have to report that data out to SAMHSA, so we make sure that you know that's in our workflow process, but also we work with evaluators to look at the data and see different impacts that we're having or you know is there something that we're picking up on umm, maybe some kind of disparity in health outcomes that is happening in our population. So being able to look at different things like that is important. And so really, I would just start with everything that you must collect and then anything that you may want to collect and then let that drive everything that you do from there into look to incorporate that into existing workflows before you create an entirely new workflow. So, for example, one thing we found with some of the DMH reports that we do, those are also different numbers that we need for SAMHSA. And so instead of having staff report that two times is it possible for us to, you know, use that DMH form to pull out what we need. So, we're not causing a lot of extra burden on staff.

**Kerry Parson with Magnolia:** So, when reporting and collecting all this data, are you able to report that through your electronic medical record or you having to what format are you currently reporting those quality measures in

**Dr. Tiffany Baker:** We use Excel to pull out all our numbers and do all the tracking and so right now we're not reporting the exact quality measure per se. We're getting all of those in place, but we have all the basic numbers in Excel that we're going to need to be able to compute the numerator and denominator to get that final quality measure number that we must end up with.

**Director Wendy Bailey:** Doctor Baker, I have another one that I just want to piggyback off the last two around data and quality measures. Since you are further along in this process, I'm how do you feel like the data that you are required to collect through CCBHC and the quality measures that are the focus of the model are helping improve the quality of services you are providing.

**Dr. Tiffany Baker:** Well, I think now I'm a very data driven person and so I think it naturally this would be my answer, but I'm not sure how you know other people may feel but you know it gives us a measure of where someone is when they first come into our agency and where they are throughout that journey. And so, when I can give, umm, you know, a person that we're serving the PHQ 9 and they have a high schooler and then we relook at that in six months and we see there, you know they're doing pretty good, the depression is getting better. You know, I think that gives them a tangible thing to hold on to, that there is improvement in care, or you know, maybe we have the opposite situation, and we need to relook at the maybe the evidence-based practice that we're using or something is not working, and we must revisit that situation. And so, it's just real quality points that give us a tangible gauge of how that person is doing, whether they're improving or they're not. And that tells us the information that we need to deliver the best possible care.

**Director Wendy Bailey:** That's an excellent answer in response and goes back to show why we're why we want to do this in the state. OK, then I'm going to pass it back to Nikki.

**Nikki Tapp:** Thank you, Wendy. So last, we just kind of wanted to touch base and share with you guys what remaining work we have left here in 2024.

We have been steadily hard at work, a working on the demonstration grant application that should be submitted around the 18th of this month. In addition to that, see below:

- Finalize cost reporting and rate setting
- Configure claims systems
- Workforce Development Plan implementation
- IT Roadmap for Data and Reporting
- Communications Planning and Outreach

So, if I would assume that if nobody has any other questions or comments, then we can close out and consider this another wonderful meeting in the books.

Meeting ended at 3:27 p.m.