UIC Academy for Policymakers
Certified Community Behavioral Health Clinics (CCBHC) Podcast Series
Transcript of Interview with CenterPointe CCBHC

Announcer: Thank you for visiting the University of Illinois at Chicago's Health & Recovery Academy for Policymakers. The following recording comes to you from the UIC Center on Integrated Health Care and Self-Directed Recovery. Visit our online Academy to obtain free information and resources about policies that promote health, self-direction, and employment for the behavioral health field.

Sam Shore: Thank you for joining us for our CCBHC podcast series. My name is Sam Shore and I'm the co-director of the Policy Academy within the Center for Integrated Health Care and Self-Directed Recovery at the University of Illinois at Chicago. Today we'll be hearing from our guests at CenterPointe, a CCBHC in Nebraska. I'm joined by Topher Hansen, the president and CEO of CenterPointe, Ryan Caruthers, Chief Clinical Officer, and Isaac French, the director of Quality Improvement and Data Management, who is also the CCBHC project director for CenterPointe. We'll also hear from Tonya Aultman-Bettridge, the lead evaluator for CenterPoint's CCBHC expansion project. Thanks to each of you for joining us today.

Let me jump right in and start with you, Topher. You have a long history, as I understand it, in community mental health, and you were involved in the early discussions around the creation of what we now think of and call a CCBHC or a Certified Community Behavioral Health Clinic. Could you talk to us some about those early days in terms of how CCBHCs came to be?

Topher Hansen: Certainly, thanks for having us on today Sam, I appreciate it. So, the origins really tie back to policy meetings at what was then called the National Council for Community Behavioral Health care. But now is called National Council for Mental Wellbeing. The policy committee discussions revolved around integration and whole health, and also how to move the mental health and substance use arena into more stable systems. The financial systems and all the other systems that go with that that would help communities really address the mental health and substance need, as well as primary care needs that were going on for them. And so, from those discussions came an idea proposed about doing something similar to what the federally qualified health centers had done, which is provide holistic care. For people low to moderate income in the community that either had, back then, had Medicaid or that the FQHC got rates from their Medicaid payments that allowed them to do other things like serve people who weren't insured, and then provide that stable base for primary care, and then they would weave in the mental health substance use and dental and ancillary other services. So that model was one that we were looking at as a way to provide the same sort of thing on the mental health and substance side.

In the theories in the conversations about this, it's called bilateral integration. So, on the one end of the continuum is the primary care that brings in mental health and substance care. And on the other end is mental health and substance care that brings in primary care. So, no matter where a person shows up that they could get the whole health care that they needed, and the community could be better served that way.

So that conversation started evolving and out of one particular discussion – I can't even remember how many years ago, this was, but 10 or 12 – out of that came some ideas about legislation and to propose to bring forward a CCBHC model, and it happened to be the week of a Hill day for National Council. And indeed, we got a couple of senators who were interested in helping with this and sponsoring legislation to move forward. And we had not thoroughly expected that to happen that day as we all left to go to the hill but came back and we had two senators that were interested in. So, that was a great success in the beginning of the journey, and much has happened since then to then flesh that out in terms of payment system, implementing and providing a model for prospective payment systems and other kind of standards to meet the model.

From CenterPointe standpoint, we have long had interest in whole health and integrated care. In fact, we started providing integrated mental health and substance use care back in the late 80s, when it almost wasn't even written about and certainly nobody I knew of was even doing it at that point. And we started deeply integrating mental health and substance use. So, the person that came in the door, we did whole health assessments and also then as they were identified as having mental health and substance issues could be served by the same person rather than bouncing from one provider to another provider to get those services.

So, we started that a long time ago and had that interest and have the interest of bringing primary care in as well, but it was difficult to find the funding to do that under what state systems, we have, and in any federal system. And so CCBHC provided a model that would give that opportunity, assuming that Nebraska could utilize that, become a CCBHC state, if you will.

And then of course Medicaid expanded in Nebraska, voters elected to bring that in, and we then were able to start billing for primary care, whereas we could not do it before. To bring all this together in an integrated way through CCBHC which then not only gives you the opportunity to provide the primary care in the mental health and substance in a whole health fashion, but do other things that then support the person in the ways they need it and also really identify programs in your community that are needed that don't exist where a gap exists, and those programs will help meet that gap and round out the kinds of offerings available in the Community, according to need. So, it was my dream come true, because I had long been focused on this, on providing full continuum of services that were fully integrated and provided whole health to people from the point of homeless outreach to crisis response, all the way up to full recovery and in permanent housing. And so we have long thought about this and dreamed of it and the

CCBHC model has really helped us spring forward in what we've been able to do in the Community and meeting that vision of whole health integrated care.

Sam Shore: Well, thank you, I appreciate some of that history and have been surprised, I think, with a lot of others that how much traction this program in this model has received nationally. Today I know we're up to over 400 sites that have been certified to cross the country and are operating in the majority of states. And in some states, there are multiple sites. And, of course, we have the demonstration states which it's my understanding, potentially will be expanding from the current ten, and the states will be offered the opportunity to become a demonstration state and work with the Center for Medicaid and Medicare Services to work out those kinds of prospective payment arrangements that are helpful and also used by FQHCs as you pointed out earlier. So very exciting time.

I would like to hear some about the catchment area, the geography, the population bases that you serve there at CenterPointe give us a bit of the flavor of the area where you're providing CCBHC services.

Topher Hansen: So our catchment area really is the borders of the state, we serve people across the state. Because we are known for providing whole health integrated care and have a full continuum of services that other organizations in more rural and frontier areas are not able to provide, and so we end up contracting for people with different governmental bodies out in the rural and frontier areas specifically on our grant for CCBHC because we were not one of the 10 states, so we received a grant but specifically that is in the Lincoln area.

And so, to give you an idea of who CenterPointe serves, we serve this last fiscal year our fiscal year ended June 30th – we serve 4,418 people across our system and over 60% somewhere in the 62% of those people made less than $1,000 a year, meaning basically they made nothing. And probably 75 to 80% of those people have co-occurring illness, of the other twentyish percent then it's either mental health only or substance use only so the people we tend to serve are very ill. Often living day to day, and in crisis have no money, many are homeless or living with friends or family. So it's a pretty devastated population, and so our job is to provide that and so no better fit for a CCBHC then that description because we can come in with a whole range of services, able to serve all the complex needs that those people come to the front door with.

Our area really is the Lincoln area – that's where the outpatient program is that we receive this – and thus far has been good for us to then be able to get focused in this way and take what we're already doing and enhance it but also, for the people in the Community that we're able to offer the kinds of things they need when they stepped to the front door.

As I said, this, this is not usual everywhere, in fact, I know of someone out on the west coast, who is looking for services like we offer, but they had to go to one place to get the mental health and another place to get the substance and another place to figure out their housing and then primary care was a whole other issue so bringing it together like this makes a lot of sense for the people served and for the Community as a whole.

Sam Shore: The integration of services and creating such a comprehensive array and, as you point out you're serving a population of people who have a lot of complex situations and conditions that they have to deal with. Poverty sounds like key one which, of course results in all kinds of complications when it comes to having good health. I know that you all have worked very hard at bringing in primary care and working out that bidirectional aspect of integrated care. I would really like to hear more about that journey and kind of where you started and where you had ended up so that you're able to deal with both the mental health substance abuse and primary care needs of the people you serve.

Topher Hansen: You know the secret to any program whether it's a large residential program or a one-person program or, in this case, a primary care practice – so we basically, CenterPointe started a primary care practice, we didn't bring in an FQHC, we started her own – and the secret of course to all of that is the person that comes in, to do it. And if you get the right person that has the right motivations and skill sets to really advance a program, then you're good, and we have that person. In fact, she came to us from the federally qualified health center and just felt the fit with what we were doing fit her personally in a way that made sense to her and we really have had some good success with that, and are growing that. In fact we're now developing a new facility that will take the providers and the therapist from about 3,000 square feet of operational space to about 12,000 square feet of operational space, so the leader of this primary care program. We'll be able to then inspire others and to grow it and so we're excited about that.

The difficulty in bringing primary care in and in closely integrating it is the speed at which mental health and substance care move and the speed at which primary care moves. And I think about it in terms of RPMs and, and so the wheel on the primary care side is moving rapidly, and the wheel on the mental health and substance side is moving more slowly. And so, how to then bring those practices together from the building standpoint, from the practice management standpoint, from the cultural standpoints, they operate as one team. We're not interested in having many silos under one roof, we're interested in having an integrated team, and so we have undertaken the integration effort to provide a not only programming but design a physical space so we're able to integrate. And what I mean by that is the primary care prescriber and the psychiatric prescribers are in close proximity to each other, and so they see each other all the time, so they know each other and can do one of the primary mechanisms of good integration, which is warm handoffs. And if you tell somebody to go down the hall and go into the next office and sign up to get some counseling, they probably won't do it. But if what you do is bring a provider in and you introduce them to that person and say "Hey John or Jane, I'd like you to meet this person and do

some work with them" and so on, that warm handoff results in a much higher success rate of people being involved in whole health care.

So spatial proximity is important in integration. Team meetings, where you get people focused on the same culture and the same team effort is important in lacing all that together, so we have undertaken that and, frankly, are still in process it's not a, "give an instruction to everybody, and then they all do it," it's really a process of describing what needs to happen and how it needs to happen and then living that day in and day out, to the point where it becomes culture for all the people doing that. And so we have done that with our primary care, psychiatric service, therapy, and then of course we have, what we call "care management," it's also kind of community support or case management in general concept. And then peer support services, and nursing, and so on, and pharmacy, and all that comes together in a team meeting. So everybody who's participating is there in a team meeting to coordinate care for individuals that team serves and, and so thereby the team becomes expert in that person's care and recovery plan. So all those elements are important, I think, to weaving that in because primary care and mental health and substance are different worlds, and so learning how to bring those things together is important and challenging sometimes too.

Sam Shore: So, it sounds like an incredible amount of culture change has occurred, it's been intentional by bringing people together so that they actually see each other, begin to understand each other's work, and what they need to do to be good partners. I'd really like to hear more about that and Ryan, I know you're the chief clinical officer and it'd be interesting to hear your perspective of how that culture has emerged and what some of the elements are that that you found to be critical.

Ryan Carruthers: Yeah, appreciate the opportunity to jump on and talk a little bit about that, our culture and our scope of services and all that. I think when we start thinking about culture, you have to kind of boil it down to the real basic things, and then try to build out from there. And, and so at CenterPointe our mission is quite simply to help the people we serve get better, sooner, for longer.

And it's really from that mission that that we have, as you said, very intentionally tried to build our culture centered around that mission statement. When we kind of fed out, we had identified, we are generally aware, but then very intensely tried to identify that the areas that we want to improve and strengthen, and we knew that moving to a fully integrated care model would really be transformative for our staff, and so the cultural elements that we, that we worked on, we really want to identify kind of a model of care. Who are we, and how do we do what we do? And what we what we ended up with was kind of a five-pillar model for our care. And so we utilize the bio-psycho-social model and again that's really hand in hand with integrated care, that you're addressing the biological through primary care, through psychiatric medications. The psychological through ongoing therapy or rehabilitative services and support. And the social – really trying to involve the family and the natural supports that the person has.

The second pillar of our model is that we utilize the approach of housing first and harm reduction. And so we're really meeting people where we're where they're at we're not leaving them there, but we're starting where the person is that. And so we know the absolute necessity for long term recovery for someone to have a permanent supportive housing environment, and so we utilize that approach.

And we really focus in on, the third pillar if you would, using strength-based trauma informed and person-centered approaches to working with people. One of the key things that we focused in on at the beginning of the CCBHC grant was changing the way and being very intentional about how we speak about the people that we work with. And so we are quite adamant about the way that we talk about people we serve and we use that terminology of people and individuals to really try to emphasize their humanity, emphasize their lived experience, and the struggles that they are having, and speaking about it in those terms, rather than speaking about it in terms of problems and deficits and the symptomology and the diagnoses avoiding judgmental language, avoiding words that focus on their diagnostics. So we don't say "we're working with alcoholics and addicts," we would say "we're working with people with substance use disorders, or people who are struggling with mental health issues."

The fourth pillar is that we have really tried to emphasize the use of evidence-based practices and so we've taken on a lot of initiatives to make sure our staff is appropriately trained and utilizing fidelity-based dialectical behavioral therapy in several of our programs where that's. appropriate given the people that were serving in those programs. Cognitive behavioral therapy, of course, and motivational interviewing are some of the other evidence-based practices that we've really focused on.

And the last pillar of our model of care is making data-informed decisions. And what we really want to do was just make sure that our staff from the entry level behavioral health technicians, to our peer supports, all the way up through our administrative leadership, our program directors, are really familiar with the data elements that the CCBHC number one requires but also the data elements surrounding "how do we know when someone is making improvements, and how do we track that, and how do we speak about that using the same language?" One of the things that's been kind of interesting in that as Topher talked about earlier was bringing in primary care where primary care has a completely different language that they speak about how they're working with people. And so we are all now speaking one language, we have one model of care that we provide and really, it's just focused on that mission of helping the people we serve get better, sooner, for longer.

And then in terms of the scope of services that that we provide that CenterPointe in line with that mission, as you can imagine it's a – it's a pretty comprehensive continuum of care. We provide rehabilitative services, so that's like a psychiatric day rehabilitative program. We have psychiatric residential rehabilitation. We have housing. We provide over 200 units of housing in the Lincoln Community every

day. And then our outpatient services, and this is where most of the coming and going where we serve by far the highest number of people, is in our outpatient services. And there, as we said already, we have substance use, mental health, primary care. We have peer support services and care management services, outpatient therapy, psychiatric providers, it's really a kind of a one stop shop. And we're really excited about the new facility that we're going to be moving in for that outpatient Program.

Then we have our residential programs, and there we provide short-term and long-term, what we call co-occurring treatment. And we actually have those in the Lincoln community, and we have another set in Omaha about an hour down the road. And so we have for traditional, what people think of as traditional, substance use treatment. But we really try to focus more on treating the whole person – making sure that the mental health is addressed, the substance use is addressed, and the primary care issues are addressed.

And then we have our crisis team. And so our crisis team is primarily housed out of our outpatient offices, but we have a 24-7 crisis line that we've operated for many years. And we have a street outreach team as well that works with people that are experiencing ongoing homelessness.

And so our continuum, one of the things that I think is always really exciting, is that we're always trying to kind of fill in the gaps. As we got the CCBHC grant almost two and a half years ago now, what we had identified was three areas that we really wanted to expand. One was our crisis response; we had a small team of about three that did our crisis response in the community and for people coming into our outpatient location that were in crisis and we've now been able to expand that through the CCBHC and some other programs to where we now have nine members of that team. We're actually looking at a further expansion in the coming months of our crisis response team. We also decided to focus on, as we talked about quite extensively, getting into primary care. And this was a whole different world for us and met new issues in the electronic health record, we had to expand, we had to bring on new positions, and then the third area we expanded into was traditionally we've focused on serving adults with mental health substance abuse issues, and now we expanded into the area of youth and family services. And so that was the third area that we really kind of tried to fill a gap and a need in the community through the CCBHC grant.

So, again we're always trying to look for ways to expand even further and have more programs that we're planning on expanding into. I think the exciting thing is that the new funding that, well hopefully Nebraska will opt into, that we'll be able to get prospective payment, rather than trying to kind of piecemeal from one CCBHC grant into another because the full-blown model for a CCBHC really does require us to get into that kind of prospective payment area.

Sam Shore: Well both you Ryan, and you Topher talked about the use of data to make the kind of changes and to monitor the kind of changes. I'd be interested in your perspective, Isaac, in terms of some

of the key areas where you've been able to bring data to bear to help make these kinds of cultural changes and improvements in what CenterPointe is doing.

Isaac French: Oh yeah that's a, that's a big question. I mean for many years CenterPointe has been a just a data driven organization focusing on outcomes, on satisfaction, on you know financial efficiency. I think, you know the CCBHC grant brought in some new measures in terms of tracking things related to say, primary care. You know, are we making sure that people with diabetes have follow up things on time and are getting their A1c checked?

Of course, there's those types of things that the CCBHC brought in, but in terms of the measures that we have and utilize to drive you know, new needs, new initiatives those types of things. We just operated under utilizing the same set of metrics for a long time and it's those things that come out of, you know, perceptions of care surveys, which of course provides us with a lot of feedback just directed towards what people are looking, for what people are missing, what people are liking a lot about certain programs, which has led into you know us, for example, emphasizing DBT skills in nearly all of our programs, as opposed to having necessarily super dedicated DBT-specific programs. Because we found that folks are finding that super beneficial.

So by training, you know our care managers are BHTs and those types of things, we're able to just see more improvements in our other outcomes measures, above and beyond, you know say before then. So, but of course we've always just generally tracked things, you know, related to functional improvements through we utilize primarily the daily living activities functional assessment or the DLA-20 but we of course use other assessment tools to track, you know what's working well for what populations. PHQ-9, GAD-7, and what we really end up doing, and the strength of what we end up doing is being able to parse through that functional improvements from one time to another, and then dig through and see, what populations are we missing? What diagnoses aren't improving as much? And then we get to design our personal initiatives within the programs and resources that we have to A- try to address those; B- understand what are those service lines or service types or evidence-based practices that we could be utilizing better, or more? Or we could create say with CCBHC grants or other funding streams to address those.

And so we've you know that type of being a data driven culture has also taken its sometime to really create and foster but especially in the last several years to feel like the leadership across the agency within programs, as well as on the executive team, administrative leadership, has really embraced that and really encouraged and are starting to want to get on the forefront of that they want to know what populations, we could be serving better. And I think that that. Just helps us be smarter, better and overall, just more effective in the care that we provide.

Sam Shore: Thanks for that Isaac. Let me turn to you, Tonya and you've been evaluating the work being done as by CenterPointe as an independent evaluator and been monitoring the data that they've been inputting. And I'd be really interested in hearing your perspective about things that have stood out with the work they're doing, and I know you have a perspective of working with several CCBHCs – so what kinds of things have stood out with CenterPointe as they've progressed with being a CCBHC.

Tonya Aultman-Bettridge: Sure, thank you. The evaluation for the CenterPointe CCBHC has really been both a qualitative and quantitative, where the focus has been on learning as much as possible during the implementation process and then also focusing on those required data elements, and the data collection around NOMs to look at outcomes for people being served. And I think you know holistically, looking back over the entire two and a half years now, that that I've been working with this group I think what has stood out to me the most is on the qualitative side. And thinking about implementing CCBHCs that I really think that the level of commitment on behalf of the leadership team and then really the staff as a whole to this orientation of fully patient-centered comprehensive, integrated care was a very important piece of them being successful in implementing a CCBHC.

As you know and as I'm sure many know, the model itself is has a lot of components and a lot of requirements, and can be a real struggle for a Community Mental Health Center to implement when it when it thinks about just looking at all those different pieces that you have to put in place. And I think as we've heard here just talking to this team, that having that initial orientation already to that model and the general principles of the CCBHC model I think really positioned them well to do this implementation, and to do it well.

I think the outcomes that really stand out, for me it was how much they were able to, just in the two years, drastically increase the range of services that are available now in their community, including significant expand expansion of their crisis response services. Seeing almost a 50% increase just in their first year of the crisis services. Really, increasing their relationship with the Lincoln police department. And then to see those crisis response services grow between year one and year two from referrals and information sharing, to really in person in the community crisis contacts, immediate crisis responses, and getting people into treatment.

Again, I think that the interdisciplinary care point teams also really kind of stand out in terms of them being able to sort of develop and to continue to develop that holistic person-centered approach to treatment that's truly integrated.

And then in terms of outcomes that really stick out for me: in a two-year period of the CCBHC expansion grants is not very much time to observe long term client outcomes. But the perceptions of care observed were just outstanding as measured by the NOMs, with more than 95% of people responding positively

and pretty much every single category in terms of their perceptions of care and satisfaction with services. And so, I think that is much higher than the state average on typical questions. So I think that was one of the big patient outcomes that stood out for me, and then we did see even in the short measurement time that we had available, and the small numbers, we were able to work with, with the NOMs, we are seeing improvements beginning to show in terms of reductions of troubled nights, in terms of improvements and functioning, in terms of decreases and symptoms.

So overall I think it's been a really positive journey for CenterPointe and I think their evaluation results are kind of bearing out that they've really kind of had that strong, consistent commitment to this model through the whole day.

Sam Shore: I want to ask about things we've not talked about that would be useful. If a center were thinking about becoming a CCBHC, the kinds of considerations or pointers you would give – are there things you all have in mind that you'd like to say around things we haven't talked about or things you think folks should consider if they're becoming a CCBHC?

Topher Hansen: I'm going to jump in there with a couple of thoughts. One being what we didn't talk about, and Ryan's comments made me think more about it and to add to that which is our change in focus on health care, you know that we're focused on health and well-being. I just wanted to underline that, you know, that that is really our philosophy now. We've turned our attention to a strength-based approach to health care that is focused on people being healthy and having emotional well-being. And again, we've sort of humanized our approach to it by referring to the people that we serve as people, or individuals, or persons. And we believe that all of us are on this journey. This is not an us and them thing. This isn't a bunch of providers being experts and helping these poor people. This is CenterPointe helping its neighbors, helping its citizens, fellow citizens move through some really difficult illness to getting better and our approach to that.

So not everyone would be familiar with the fact that Gallup organization, which is really the chief promoter of strength-based positive psychology and that whole orientation came from Don Clifton who own Gallup and was a professor at the University of Nebraska Lincoln. And so it emanates out of this community. And so in the land of Don Clifton I think only appropriate that we really adopt a positive psychology strength-based, asset-focused approach to people's health care. And so, what we try and focus on, then, is not a treatment plan, implying a deficit, but a recovery plan, implying the goal attainment of health and well-being.

And, and so it has become our philosophy and I think is a better healthcare philosophy, for all of us we don't need our nose rubbed in our problems, we need the tools and the optimistic focus to getting better. And don't we all think about "where am I going to work out today?" or "what am I eating, is that

healthy?" or "am I happy?" those kinds of things, all the time. And so we are trying to provide expertise in that to help people of any walk of life attain those things. So that number one I think is important.

Two, as to what do you need to do what are prerequisites for becoming a CCBHC: electronic health records – using those for data, having infrastructure so that you're able to move to a data culture and operate somewhat nimbly. In terms of what Isaac talked about – planning something, doing it, studying it, and then acting upon that. What we want to do is look at the data of the operations that we're doing, make the tweaks that are necessary and then implement those. And so having that continuous quality improvement cycle in operation to tweak everything that we're doing – organizations need to really think about that and be part of that. The beauty of a CCBHC, though, is if you're a small organization and there are many, many out there, then, to the extent a larger organization gets a CCBHC, then you might be able to partner with them to provide some care that the larger organization cannot or be involved with it in in some fashion. It can be, especially in a rural community, it can be a hub and spoke type model for the community to collaborate and provide quality care to everybody. But you know Ryan and Isaac were involved in the day-to-day ground level operations of not only starting this up, but then operating it so they may have some perspective on that as well.

Ryan Carruthers: Yeah, thanks I would just say that the importance of being aware of the culture of a CCBHC is vital, and when we were initially applying for the grant, I think we had a lot of kind of pie in the sky very high ideals about what we thought we were going to be able to do and, ultimately, I think we accomplished most of those things in spades. But it was it was an adjustment for a lot of our staff. The cultural elements that we talked about earlier, and just the expansion of services. One of the things that that happened right, as we got the grant was the initial COVID lockdown. And so as a lot of our community partners were furloughing staff and we're shutting down programs and restricting access, we were going on a hiring spree. We hired 22 new employees. And the way that the grant rolled out, partially because of COVID was, we found out on April 28 that on May 1 we were going to be implementing this grant. And so we basically had three days' notice that we had received a grant and we needed to begin our preparations and start hiring. And of course there was a three-month period that we had to hire all those staff but expanding three programs, two of which were brand new to us and bringing on and onboarding 22 staff in a building that was short on space prior to this grant, we really had some cultural elements that we needed to be very careful with and just be very intentional about.

Sam Shore: Other thoughts from any of you – things that you know were spurred as you listen to this or with through this discussion that. You think would be useful for listeners to hear about. terms of your experience and becoming a CCBHC.

Ryan Carruthers: Topher I don't know if you want to talk at all about some of the behind the scenes, just advocating and conversations with lawmakers and all that kind of stuff. I know you kind of touched on it from a historical perspective but, but even now some of that that's still going on.

Topher Hansen: Yeah. Because of course, the marketing department did not think of the name of this program. A CCBHC, or a Certified Community Behavioral Health Clinic is a mouthful. And most people look at you with open eyes with the either the implied question or the actual question of "what?" Because it just all kind of jumbles together for somebody who's not in the field and not familiar with it. So the first goal is for people who are interested, or are starting one out is to get the data get the information that comes from data and talk to policymakers about what this is so they become more familiar with it. And so we've been doing that at many levels. The National Council is excellent at doing education and lobbying at the national level. We've tried to educate at the local level, and the good news is, last time I went to the Hill to talk to our delegation, every person I talked to (these are the subject matter experts within each office) knew exactly what a CCBHC was. And the first time I went there no one had any idea what it was. And so, we really are we're at square one. But now everyone does and, as you pointed out earlier, Sam, there are 420 or so of these across the country, and so they've come up in major appropriation bills and the concept has been introduced from many angles. And so they have become familiar with them. That is a victory.

And so, what that enables us to do, then, is then go to the local level and begin to have these conversations about sustaining this and we have done that in Nebraska by being in touch, not only with our state senators and have had them in meetings where we present data, they've made contact at the national level in workshops around CCBHCs, we've had them in touch with experts on this at the National Council, we've introduced legislation, we've brought in people from other states. Like Missouri, for instance, that was one of the initial 10 to talk about what CCBHCs our with our legislative health and human service committee.

And then I've had many conversations with the Medicaid director in Nebraska who's from a provider background and understands all this and is willing to then look at it and be educated on it and has gone to meetings about it. So that familiarity then starts to submit the concept and it's not a radical concept, it's a very intuitive and logical concept of how to provide care. Once people begin to understand it, it is brought in readily, I think.

And so in Nebraska, then, what we're doing is now, especially now, that the funds are available through the recent bills that passed in Congress having to do with mental health, around the gun legislation and so on, that provided the funding for all 50 states and territories to become CCBHC states or territories. And so we're then working with our local policymakers and directors to then get to the point of making that decision. There's a lot of work on that end to help bring it in so they understand it, they see what the

benefits are they see what the expenses are. Fortunately, SAMHSA has required us to provide a lot of data. And so there are reports that have generated from the 10 pilot states on what the outcomes have been. The National Council has been very focused on trying to bring that data into information that could be shared so States understand what this looks like and what the implications are, and it helps us move forward.

So, we're hopeful in Nebraska that we will become a CCBHC state and be able to really expand our ongoing – it's hard with a grant – but with that ongoing support you're really able to put the foundation in place and make this sustained operation that really impacts the community and provides the quality that we want. So when you're not involved and you think, well let's have an organization and yeah, we want them to be good, but when it's your loved one…

In fact, I have a meeting later this afternoon with someone who is a parent who's contacting me because they know what I do in the world and saying I need your help my kid who's an adult is crashing to the ground, and I'm scared that they're going to die on the streets, because of what they're involved in. And I need your help. At that point, do you want a flimsy, weak, hanging by its claws system, or do you want a robust competent, well organized well-funded operation that can step in and start to intervene in high quality ways to help your child get better, sooner for longer. And, of course, the answer is the latter and so that's what CCBHCs do for communities.

Sam Shore: That's really good Topher, and I think it kind of brings it home kind of back home, it's not about the organization it's about what you're able to do to help real people in your communities.

We've got just a little bit of time left, but the two things that I thought about were person-centered recovery planning. The other one is around same day access or your no wait outpatient. So, Topher let me get your sense of on either of those or something else you feel like would be important for us to capture in this discussion of CCBHCs.

Topher Hansen: You know Ryan might be your man on that. You hit it on the head Sam. It is not a snap your fingers, tell everybody what to do, and get it done kind of. There are cultural issues in it, people are trained in certain ways, their expectations of how they will be a professional are pretty locked in, and what we do is kind of tip all that and turn it around. And I gotta say this is one of the ugly facts in the world, right now is the staffing issue. And you can only do same day access, if you have sufficient staff to do it. And, frankly, we are now in a spot in the world where our staffing issues are dramatic and we have had to start waitlists because of this, and so on. But we are fully geared for and dedicated to same day access. But you don't get it done if you don't have sufficient people to do it. And so that's one of our big challenges. But, frankly, our other challenge, probably the equally large has been the cultural one. Culture

means how we do things here. People walk in the door as new employees, and they are oriented and trained to how to do things. And we have to retrain and reorient and help them change their systems.

So let me toss to Ryan first and then Isaac you may have some reflection on this as well.

Ryan Carruthers: Yeah, thank you. The topic of you know, creating an open access or same-day services model has been a kind of an ongoing journey, for us. And right now it's one that we're not able to meet our own standard for that, because of the staffing issues that I think not just us in our local community partners are facing but is really hitting the nation. And especially with licensed mental health therapists, we're just really struggling. You know some of the things that we have done is prior to COVID happening, which again happened kind of side by side with our CCBHC implementation, we had never really dove into the area of providing telehealth services, at least not at any substantial level. And so we're now providing a lot of our services via telehealth and what that's allowing us to do is be a lot more flexible and a lot more creative in how we utilize the time of our staff. Especially because we do have staff in two different cities. It allows us, you know if a therapists has availability, even if they're working in Omaha that day, they can still do sessions.

One of the one of the decisions we had to make with our clinical staff, especially the administrative staff that have licenses, including all the way up to myself, is that if you have a clinical license, it's our expectation that you provide services. And so you know, Tuesday mornings for three or four hours, I do assessments for people that are trying to get into services. Even as the chief clinical officer, our senior directors and our program directors are providing direct service to individuals seeking care every week in a way that before the staffing crunch, we never really had to.

One of the other things that's happened, I think coinciding with COVID is that there's also been a pretty substantial increase in demand that we will probably would have had a hard time maintaining enough supply of therapists to meet the increased demand if we were fully staffed. And so when you combine the two, where we have this, you know, unprecedented amount of people seeking help for mental health services, along with a reduction in the workforce, that we're really having a hard time maintaining that same day access. We have all the systems, and we had same day access up and working. And that was a process, and something that was kind of always tweaking always trying to improve and make sure we utilize the therapist time as much as possible. Because one of the great things about open access when it's working and when we're fully staffed to it, is that we don't have the no shows. We don't have therapists sitting around doing nothing, certainly not at the level that you would in a in a traditional “let's schedule you three, four weeks out and then give you a reminder call kind” of situation.

Like we said, though, unfortunate, we have had to implement waitlists currently and we think that there might be some light at the end of the tunnel with staffing and some of our positions. But mental health therapists in particular are still difficult for us to find and hire.

Isaac French: And I just wanted to add a couple of things to what Ryan and Topher have said. So in terms of traditional or I guess our traditional sense of same day access, of course, that means someone walks in, whether we've seen him before or not, and you know we get their paperwork done, we get them to see either you know, a site provider or therapist or primary care same day, all within the same day. You know you walked in and then you get you walk out after having seen somebody. And the challenge with that system is sort of what Ryan was speaking to.

But, of course, what also Ryan mentioned was that we've been able to and have been agile enough to shift. You know, who is available to see somebody, or who is available to help someone address the needs that they that they need to dress when they walk in. What we continue to hold true is if somebody walks in legitimately needing to see somebody, or problem solve something that is happening, regardless of not having the full formal same day access structure, we are fortunate of having our crisis team still available within that building. And we have peer supports, we have therapists on that team. You know, we don't turn somebody away if they need to see somebody today. You can meet with somebody if you needed if you need help figuring out how you're going to get fed, if you need to figure out how to deal with whatever specific symptoms, you might be experiencing those types of things we still always will have somebody available to chat with people about that.

Sam Shore: We're pretty close to time. Anything else before we wrap up, and this has been super helpful, rich full of information, so not pressing for anything in particular just, but I do want to leave it open if there are things we haven't touched on that you want to.

Topher Hansen: I think the only thing I would add, is if you're considering doing a CCBHC, reach out to sort of get an assessment, and National Council can be very supportive in that. They operate The Center of Excellence for CCBHCS under a SAMHSA contract. So the National Council for mental well-being is a resource you can contact to really get an assessment of what you need to, how you can prepare, and so on.

Sam Shore: Let me just give you a heartfelt thanks for taking this time out and sharing what you have. This has been great, Really rich.

Topher Hansen: Glad to do it thanks for asking us, we've enjoyed being connected to you all and try West and doing all this, so it's been part of our good experience.

Announcer: Thank you for listening. You can obtain additional recordings, or download a transcript, by visiting the Academy for Policymakers on the Center's web site.