UIC Academy for Policymakers
Certified Community Behavioral Health Clinics (CCBHC) Podcast Series
Transcript of Interview with Texas Panhandle Centers 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: Thanks 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 I'm joined by Libby Moore, the chief clinical officer at the Texas Panhandle Centers, and Karla Carrizales, the program manager of the CCBHC Wellness Clinic.

In this podcast, we'll be discussing Texas Panhandle Centers transition to becoming a CCBHC. Thanks for joining us today.

Libby Moore: Okay, well, thank you, Sam, for inviting us to talk about TPC and our travels to becoming as CCBHC.

Sam Shore: So, tell us about the Texas Panhandle Centers, the communities you serve, and something about the region, so that we can understand the environment that you're providing services.

Libby Moore: TPC.is a nonprofit organization. We're also considered a unit of local government, and we're part of the Texas community center system. So, we've been in existence since about 1966, primarily serve people in the upper twenty-one counties in the Texas Panhandle. So, to kind of give you an idea of what that looks like, it's about twenty three thousand square miles, which is a little bit smaller than the size of West Virginia. So, we're rural and spread out. We have lots of counties. Um. Some people call us frontier. Our biggest city is Amarillo - it's got about 200,000 residents, and it's split between two counties. But we've only got six towns that have a population of 10,000 people or more. So, we have clinics in in those communities - that'd be Amarillo, Borger, Clarendon, which is under 1,800 people, Dumas, Hartford, Tampa, and Perryton which is about 8,600 people. So, we serve people throughout their lifespan with substance use, serious mental health conditions, intellectual and developmental disabilities. Our services are psychosocial rehabilitation, CBT, DBT, Counseling pharmacological management,

integrated care with primary care, skills training, peer support, crisis respite, telehealth, asserted community treatment teams, interdisciplinary response teams primarily with law enforcement, coordinated specialty care and substance use screening assessment and counseling.

Each area has a collage of those services, but primarily people have to come to our Amarillo area to get any kind of services. And so that's why becoming a CCBHC was s so important to us – because we wanted to expand that complement of services out to our more frontier and rural areas.

Sam Shore: Well, thank you, Libby. That's really helpful to get a sense of what you've been doing, and where you started your journey from being a Community Mental Health center which you've done for decades Moving to a CCBHC. Sounds like things are pretty comprehensive already, and yet, as a CCBHC, they're becoming more comprehensive. Can you talk some about some of the key services that you've developed because of your transition to being a certified clinic for behavioral health services?

Libby Moore: Yeah so, we just – we're just newly certified. We got certified in in March of 2022, and when we were going through that certification, we were also applying for two grants through SAMHSA. One for a CCBHC expansion grant, and one for the Community Mental Health Center grant. And so, each of those grants are two year grants. As a result of looking at our needs and rural and frontier areas. We knew that how we get out to those areas was going to be crucial. We have a workforce shortage like the rest of the country, but we're also seeing those rural communities shrink so the professionals within those communities are leaving or just non-existent. So, what we did as a CCBHC is said, "we've got to get to the people instead of people always having to come to us."

So, the expansion Grant allowed us to have a wellness, mobile clinic. We decided to put people in it that really could reach treatment means instead of just always assessment. So, we have an advanced nurse practitioner, we have four qualified mental health professionals that are traditionally bachelor's to master's level. We have two peer support providers. We have a transportation specialist which is really crucial to these programs. And we've got some licensed folks that can really address those, those counseling needs. And Karla is going to talk more about that as we go through. And then we've got another grant, our CMHC grant. We call that the better living program. And that's really looking at people that need on demand psychiatric care. Trying to get to folks so they don't end up in a jail setting, or they don't end up in a hospital setting unless they absolutely need

to. So that grant looks at how do we get the prescriber to the person as opposed to always the person having to come to the prescriber?

The people who are in that grant - traditionally our partners are law enforcement, mobile crisis outreach teams. We're partnering with university police departments because we're seeing people that are starting college, and they're starting to really have that need and hard to engage folks. So, what we're looking at in our rural centers is, how do we create those interdisciplinary response teams with the resources that we have in in those communities? The people that really want to engage in services for folks that have mental health and substance use, but also the people that have the skills. Every community is different.

So, you know I'll, I'll say this to folks that serving 21 counties is almost like serving twenty one countries, just because the dynamics and the resources are so varied and really the culture. What people in that community find is their biggest need.

We're working, out details now. And one of our rural areas is an example. We're partnering with EMS and hospital social work person that had been going out and doing wellness checks on people that had recently been hospitalized. We would like to add a peer support provider to their team, and also to have an iPad that can connect to that prescriber. So that what they were telling us is that they're seeing about 80% percent of the people that they go out to do a wellness check on – they're seeing heightened rates of anxiety and depression. And so, we felt like that's a place that we really could impact.

We're also working with the University of Colorado to look at first responder wellness. They're teaching us about the eight dimensions of wellness. We think that's going to help our workforce and to keep our responders connected to their own well-being when they're doing this work.

The second benefit to that will be that when we learn to manage our own mental health, we'll be able to apply to the people that we're seeing that are needing that same kind of extra support. And so, we'll be able to take the skills that we use for ourselves to stay healthy and transfer that to other folks we're seeing in the community that need that extra help too.

Sam Shore: Thank you for that information. It sounds like you've got a lot of stuff going on right now, as you develop services, and particularly at this stage of where people are beginning to come out of the pandemic, and some of the isolation that they've experienced. And

what I'm taking away from what you're saying is that you're really doing things to engage people where they are, rather than asking them to travel great distances to come to some of your clinics your facilities where they can get services. You're going out to them in various forms, including in-person, by mobile wellness clinic that you take out to communities, as well as telehealth telemedicine, using electronic devices to bring mental health and behavioral health expertise out to them in a virtual format as well as the in person.

Libby Moore: That's right, I mean that's where we were losing people. That was our gap – that's what we heard from our community. And that's what we heard from our providers is that if people have to come to us all the time they're making, and they're needing to make other choices with their life. I mean their jobs are affected with scheduling their family life's affected, and they have to prioritize mental health above maybe other physical health needs. So, coming to them, we see where they live, we're working ourselves into their schedule, and I think we're, we're seeing some good results with that.

Sam Shore: Are there aspects to this transition from a regular community mental health clinic to a CCBHC that you'd like to talk about, what that's been like for the center, the staff to do that?

Libby Moore: At a state level, the public mental health system has really been the safety net. For people in our community that need mental health and substance use treatment. We primarily focused on people who were indigent or considered indigent, and we largely ignored physical health. We weren't, looking at the whole person for years and years, so transitioning into the holistic care, and really looking at the physical aspects mental illness can create or contribute to, and substance use has been a shift in in how we approach the person. You know just even the words. We came from an illness kind of framework of treatment, and we moved into a health framework. So, we talked about mental illness and then we started talking about mental health, and now we're talking about behavioral health, and we're having to educate the whole community on what does that mean? And it's three prongs, at least – mental health, substance use and primary health care conditions.

So, it's been a shift in the language in our communities, and the focus on how we're working with people. Because we're asking our judges and our county officials and police officers and EMS and fire departments to partner with us, instead of passing people off from one assessment to another group of people that are assessing. We're asking them to come together and do one assessment that incorporates all of our disciplines to get better

care to that person, so that they really feel like they're not getting assessed, assessed, assessed. They're getting treatment once they get assessment that makes sense to them in their life. So, it's a huge culture shift for us in our community, and I think, in the profession as a whole. The people that are receiving the services are seeing a difference, too, I think. We're asking them to be a part of their treatment as opposed to telling them what treatment we are going to be giving them. So just changing that conversation is, it's hard to do but I think it's really helped with the engagement, and it really does support person-centered care and trauma-informed care. I think it's been really, really beneficial.

Of course, you know we are not there yet, by any means, but we're on our way. That's what the conversations are about is how we can better work together. What do we really want to look like in our community? What do we want to tell people in our community that have a mental health condition, or a substance use condition? How do we want to incorporate them into being a part of the community where before, I think, really stigmatizing and isolating to have an illness that the community doesn't really know how to treat or respond to. So, we're doing a lot of education. We're really seeing a lot of interest in our communities around learning more about suicide prevention using mental health first aid and using ASSIST training has been something powerful. I think the word of mouth is spreading. And so I'm really encouraged about that Some of it is like kind of building the plane while we're flying it, and it's getting a little bit easier to fly.

Sam Shore: I'm aware that no one agency can be all things to all people, and there are a lot of people in communities that are interested in some of the same goals that I hear you talking about in terms of people's overall health and wellness, and staying out of hospitals with possible emergency departments, and certainly out of jails when treatment is needed. It would be great to hear about some of the partnerships that you have developed, and I know from other work that the whole concept of a CCBHC involves a lot of care coordination in collaboration with other entities that have shared interest to serving people with behavioral health disorders. So, it'd be great if you could talk some about partnerships that the Texas Panhandle Centers has developed as part of becoming a CCBHC.

Karla Carrizales:

So, as Libby mentioned, you know, we do work a lot with the county judges. The sheriffs, the chief of Police, hospitals, fire departments. So, it's very interesting whenever we go into their community, and we talk to each community, and what they need, what their needs are in that community. So, what the need might be needed and Perryton might not be the same or Dumas, so it's very tailored to the needs now in our communities. And I think with CCBHC we have created some great partnerships, not only with the justice

system, our fire departments, we've also created community partnerships with other non-profit organizations.

So then, we think about PASO, the Panhandle Aids Support Organization. They offer education and training in our community, and they also provide the emotional support to the individuals who have been infected with the HIV or AIDS. And PASO offers treatment to those individuals. So, what we're doing is we're bringing PASO to those underserved communities. So, before they were not able to come to Amarillo to get that treatment, to get that testing, to get that education. So now we're running PASO to them. PASO does provide services in the twenty-one counties, but what we're doing is we're trying to partner with PASO and come together so that services can be provided as a whole.

So, it goes back to that holistic approach. And how we're not just thinking about the mental health we're thinking about their physical health. We're thinking about every other aspect – you know family involvement. We want to be able to provide services not only to the individual, but to their support system. So, who is providing that support for the individual and being able to give them those resources? And then we created, you know, partnerships with Panhandle Community Services. It's really interesting to see us as an agency when they came and talked about the services that they're able to provide.

We never thought, you know, someone who has a part time job with no health insurance. What PCS has been able to offer to them and helping them navigate those health insurance options. So, PCS has also come with us to events, and we're partnering with them and building really good collateral with them where we can all engage and focus as a whole. So, it's really nice to be able to see the services that they have to offer for those individuals, and then they also have housing, utility, assistance. So, we go into underserved areas where not only being able to find employment is difficult, but being able to pay for their you know, month to month bills becomes a challenge, so we are able to connect them to Panhandle community services. And of course, they've been a big part in helping us with transportation. So, because we cover such a wide area in the Panhandle for individuals who have Medicaid, we connected them to be able to have that transportation piece so they can get to those appointments here in Amarillo, Plainview, and Lubbock. So, it's not just them coming to Amarillo for treatment. It's them coming to Lubbock, them coming to Dallas for service.

And then, of course, we've got our veterans service program. That's with Tasha Barnes. She's been great at coming out and partnering and providing education, training, peer-to-

peer support, linking our veterans and providing them with the resources that they need, so they can live a healthy life out in our community and their families. So, it's not just our veterans. It's veterans and their families.

TPC has also been working alongside with family support services, and meeting with them. They've got a new program or a new grant that was just given to them. It's RISE, and this is a migrant program, and they're able to provide services to our migrant workers. This came up whenever we started to notice that vaccines were a very, very important piece of of their daily lives. So what RISE has been able to do is come out to the migrant – it's again meeting them where they're at. So, coming out to the farm they're working on and being able to talk to them and talk to their families about the resources that are available, being able to get them connected to get those vaccines that they never had or never were even probably intending on getting, and now that they have that opportunity to have access to. The partnership from CCBHC has been, has been great. It's been growing, and I think that other agencies are starting to now just look at this person as a whole and say, "Okay, well, I'm not just going to provide services to educate them about HIV/AIDs. Now we need to talk about mental health. Who are we partnering?" So, they're also starting to realize we need to be able to come together and provide these resources as a whole to the person. We've been also able to meet in their community with linking them to get lab work done, to get resources for people who don't have the financial means, insurance, and we're able to look into what services are available for indigent individuals. So, I think that the partnership has really grown with TPC and other nonprofit organizations.

Sam Shore: Well I know that Texas is one of the states that has not expanded its Medicaid program, and so when you refer to the indigent population I'm thinking you're referring to the medically indigent who don't have an insurance program to pay for their healthcare, therefore it's out of pocket, or low cost, or charity care that they can get for whoever happens to offer that in the community.

So, the other thing you're talking about are the social determinants of health. It was exciting to hear that. When you talk about transportation and jobs and housing and various kinds of public health services, that's really exciting that you're able to pull together with those partners and go out and meet with those people to provide that service. You mentioned going to Lubbock, or to Dallas for services, which are considerably further from the panhandle than Amarillo. We're talking anywhere from 2 to 3 or 4 hours and for people who don't often have transportation resources, vehicles to take, or these days, the money to pay for the gas to make that kind of trip, so that's

exciting to know that you've created partnerships to treat people closer to where they actually live.

It would be great to hear some about what you've been seeing in terms of the impact on peoples lives now that you've been serving them as a CCBHC.

Karla Carrizales:

You know, the focus for our wellness clinic program is that we're going out and meeting with them. As Libby mentioned earlier, you know, we've have our psychiatric nurse practitioner. She's able to travel and go into their homes and provide that treatment in their home. So, I think that in itself has caught has brought a lot of changes because you know before we were seeing, "well this person keeps missing those appointments and if they keep missing then eventually are they going to be discharged? Are they getting the care that they need." And so now we'll be able to address – well it's because they don't have that transportation it's because they don't have the money to get to drive to one of their nearest clinics. So, our nurse practitioners able to go out to their home and provide the treatment in their home. A lot of individuals that are receiving that service are really excited they are finally getting the treatment that they that they need.

We've also got our qualified mental health providers and they're going out and providing skills training psycho-social rehabilitation and they're also doing this in their home. So, we're able to work with those individuals in their home and provide some of those treatments that they didn't have before.

We have a few individuals who have never received treatment, I mean for physical for mental. You know we have one individual that lives in Shamrock, for instance, and Shamrock – they don't have anything nearby. Everything that we're providing for this individual is either coming to Amarillo us going to them. You know, when we first encountered her, she was very petite needed some help with not only to address her Depression and anxiety, but also needed help with resources to apply for food stamps being able to address her physical health and for instance with her we've been able to connect her to physical health services.

So now she's able to see a doctor she's seeing getting treated for her depression, for anxiety. Her quality of life is improving, because we're able to get her those services that she needs in a very underserved community.

For instance, with this individual she had some issues arise with her landlord, her landlord was you know, taking advantage of her. And when TPC intervened, we were able to advocate for the client because there was also a language barrier. And so, we were able to get in and be that voice for the individual. And we advocated for resources on how can we get her rent paid because she was behind during the time that she had to be hospitalized due to psychiatric reasons, so we wanted to make sure that all of that was taken care of because whenever a financial burden is over, you not that it just feels like you're digging yourself into a deeper hole than feeling like you're able to come out of it, so we didn't want her to feel that being in a facility and where she's getting psychiatric treatment was only a bad decision for her to only come out and say okay "Well now, I thought you know I'm behind on my rent, I'm not going to be able to work, I can't afford it, I was out of work." So, we were able to help with some of that.

At one point we had to work with her to be able to get her clothes, because she had got down to like 67 pounds because of her eating disorder and also, she was just afraid that if she ate she would leave with her children without food, so, then we started working on resources. How can we get food boxes to this individual who lives in Shamrock where they only do the food boxes once a month in their local community, so we had to get very creative and be able to provide that service, not only for her, but for her family.

Sam Shore: That's a wonderful example of care coordination, where you're having to connect with other agencies that provide resources to people. sounds like this person wasn't able to advocate, on behalf of herself and her family, to make that happen, but your care coordination staff could step in and make those connections to help her out again with social determinants of health, such as food and other types of care.

Libby Moore: Yeah, you know she's a good example, we are getting her connected to our integrated care program so where she will be able to finally get that PCP to follow up you know to treat the chronic illness and be able to get her to where she doesn't feel like she's doesn't have energy throughout the day, not only because of her mental but because of her physical health and in that process we help walk her through and coordinate with you know integrated care with other agencies, and I think the the coordination part is really what's making that difference Because before it was like "oh here you go - go ahead and follow up with this person and good luck!" No. Now it's like, "let me make those phone calls with you, you don't speak English, let me help you because I know what language to use to be able to get you in to treatment, so let me help you with that." And so now we're making phone calls, we're doing a lot of background with the client behind the scenes,

working with them, so I think that care coordination piece is really, really vital. Whenever we think about the services that we provide.

Sam Shore: Well, it really sounds like your care coordination folks are able to act like travel companions rather than a travel agent.

Karla Carrizales: Mmhmm, yes.

Sam Shore: So taking the person, hand in hand and showing them the way working with them, those are excellent examples of how you do that.

Karla Carrizales: Yes.

Sam Shore: We've got just a few minutes left -anything that we haven't talked about that you think would be useful that's come up?

Libby Moore: We were talking about the transportation need and maybe looking at how we go about treatment now is really looking at hat Maslow's hierarchy of needs right? What's, the most important thing for that person, where did they feel safe and if they don't feel like they have those basic things to feel safe in their community everything else that we think that person needs is really it hadn't been successful.

Meeting a person where they're at and really understanding what they want, what they need to be able to start building a life that they want. I think that's a skill that hasn't really been refined in our education. It comes from field experience and so we're noticing that. We're seeking out those experts that can help us really build the skill sets that we need to make that human connection and then apply that to the social work and in psychology and psychiatry of all of this and the physical health needs. So it really is a different skill set that we're looking at in our providers now.

And people being willing to share the responsibility –that's important in our workforce to I think going forward if if these kind of models are going to be successful.

That is something that that we're really working on is is how do we get better at doing this service, how do we teach new social workers how to do it, how do we teach psychiatry has advanced nurse practitioners and and everybody else, that would be considered a first responder in that person's life.

But transportation needs are, I think we're really seeing that. People are so isolated. We all have to make those choices on where we going to pick to go, and where are we going to pick to spend our time getting help with because it's hard.

Telehealth has created a whole new opportunity for us to communicate without that person having to leave their home environment. Without providers having to leave their home environment, but we also are seeing those rural communities shrink and so you know that social isolation – I think the pandemic brought that out – here's still just a real need to help people connect with each other, because the peer support that we're seeing has really been a powerful tool that has been under-utilized before we were a CCBHC. I think we're really seeing the value in that.

Sam Shore: So you've talked about partnerships that you've developed and from previous conversations with you all, I understand you've developed kind of the workforce initiative, if you will with a couple nursing programs to bring people into the mental health environment out into the field to work alongside you and learn what the work is like. Can you talk just a little bit about those programs and how you're thinking those will benefit mental health services in the Panhandle area?

Libby Moore: Yeah so we have a West Texas A&M university and they recently started an advanced nurse practitioner program for mental health and we we saw a lot of nurses wanting to go into that program. They were having a problem finding preceptors to do the mental health field work sitting in with counselors as well as prescribers. And so our nurse practitioner in our wellness program is able to provide some of that preceptor support, and we've been able to build that partnership with them and get them connected to see what we're doing out in the field and – and we're getting a good response from those advance nurse practitioners. Where they would have maybe shied away from mental health, they're seeing the connection between the physical and the mental health and just the impact that you can have on somebody's life when you're there with them. So we see that the relationship building.

We also have in Amarillo, it's Amarillo college. It's a community college and it has a two-year program for RN's and we've been able to jump in that rotation, so that they those new nurses come through our clinics and see what we do. We've paired them with the two grants that we've been talking about so that they can see on the ground, what Karla and her folks are doing and in the better living program what we do when people are in respite care or going to group or interacting with peers. And we're seeing some interest with our new nurses, where I think traditionally people that went into nurses went

in there to do physical health care and now it's sparking an interest because it's early on into their school that they're seeing how mental health and physical health are connected. So they're getting interested in providing mental health services or behavioral health services. And so we think that's going to be something that that catches on, I think the first rotation that we had with Amarillo college we had 11 students and this fall we're looking at rotating 65 students through there. And the intent from a college is to put a mental health component in any rotation they go through. So, if they're going to go through a rotation with I don't know just a general hospital, the teachers are going to keep that mental health thread going through their education.

We really see a lot of promise with that and I think we'll be able to build some workforce that way. The students that go to Amarillo college and the students that go to WT – a lot of times they're in those rural communities so maybe they'll see a need in their home community instead of saying "Okay, now that I've got my degree I'm going to move." Maybe they'll see a connection and want to stay. We don't know yet, it's early on, but but that's what we're hoping to build.

Sam Shore: Will Libby and Karla this has been a wonderful opportunity to hear about the journey, the Texas Panhandle Centers has been on for a while to become a CCBHC, so I want to thank you both very much for taking this time out and sharing your experience with that.

Libby Moore: Thank you, Sam.
Karla Carrizales: Thank you, Sam!

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.