Expanding and Ensuring Access to Behavioral Health Follow-up Care

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Mira Wang:

Thank you for attending today's webinar, which will focus on Expanding and Ensuring Access to Behavioral Health Follow-up Care. This is the first webinar in the series titled Improving Behavioral Health Follow-up Care Learning Collaborative. Next slide, please.

Before we begin, we wanted to cover a few housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. If you have any technical issues, please use the Q&A window located at the bottom right corner of your screen. Please select “Host” in the drop-down menu and click “Send” to let us know how we can help.

We also welcome audience questions throughout today's webinar through the Q&A window. As a reminder, the Q&A window is located on the bottom right corner of your screen. If you'd like to submit a question, please select “All Panelists” in the drop-down menu and click “Send” to submit your question or comments. We will monitor the Q&A window throughout today's webinar, and we'll address as many questions as possible. Lastly, we want to let everyone know that this meeting is being recorded and will be posted to medicaid.gov after the webinar.

Now, I'd like to turn it over to Deirdra Stockmann from CMCS. Deirdra, you now have the floor. Next slide, please.

Deidra Stockmann:

Thank you, Mira. Hello everyone. I am very pleased to welcome you to the first webinar in our Improving Behavioral Health Follow-up Care Learning Collaborative series. This learning collaborative is one of our quality improvement initiatives at the Center for Medicaid and CHIP Services within CMS. The goal of our quality improvement work is to support state Medicaid and CHIP agencies and their partners, such as those other state agencies like behavioral health agencies, as well as health plans and providers, drive measurable improvement in quality of care and health outcomes for Medicaid and CHIP beneficiaries. Next slide, please.

First, let me briefly review the agenda for today's webinar. After this welcome and a little bit about the objectives for our webinar today, Michaela Vine from Mathematica will provide some context and data, particularly data from our Medicaid and CHIP Core Set, to show why we're focusing on improving follow-up care for people who visit an emergency department or are hospitalized for a mental health or substance use condition. Then, the core of our webinar will be presentations from two states on approaches they have taken or are now taking to improve that follow-up care. First, from Andrew Brown in Kansas and then from Melissa McEntire in Oklahoma. I'm thinking of it as dispatches from the Heartland. Then, we plan to have time for questions and answers, and discussion at the end of the presentations.

That said, as Mira has just mentioned, you can enter questions at any time and the panel on your webinar interface. Finally, Mira Wang will wrap us up and provide some details on the coming events in the learning collaborative at the end of this session. Next slide, please.

Over the course of this webinar series and the ensuing affinity group, we hope to provide state Medicaid and CHIP agencies and their partners in behavioral health with the information, examples, support, and tools you need to expand your understanding of data-driven interventions to improve timely and appropriate follow-up care. Through the affinity group opportunity, which you'll hear more about soon, states will develop, implement, and assess quality improvement projects, network with learn from and teach peers and advance your understanding and knowledge of quality improvement approaches and skills. Next slide, please.

Our objectives for the webinar today, as I've already alluded to slightly, are to provide a national context for behavioral health follow-up care based on states' performance on several Medicaid and CHIP Core Set measures. To highlight state initiatives to improve the availability of follow-up care through the use of telehealth as well as integrated care programs, including Health Homes. Then, of course, to have opportunity for questions and answers, and to review upcoming Learning Collaborative webinars and affinity groups.

Next slide, please. Well, with that, as you move to the next slide. I want to thank you again for joining us today and I'm very pleased to hand it over to my colleague at Mathematica, Michaela Vine, who will dig into that first objective and share why it is we've chosen to focus on Behavioral Health Follow-up Care. Michaela.

Michaela Vine:

Thank you, Deirdra. My name is Michaela Vine, and I'm a Senior Health Researcher at Mathematica and a member of Mathematica's QI TA team. In the next few slides, I'm going to provide some background on why Improving Access to Behavioral Health Follow-up Care is a priority for CMS and the focus of this new learning collaborative. Next slide, please.

As Deirdra mentioned, the improving Behavioral Health Follow-up Care Learning Collaborative will provide an opportunity for states to design and implement a data-driven quality improvement project to increase access to and coordination of Behavioral Health Care for Medicaid and CHIP Beneficiaries. As part of this work, states will consider their performance on several related quality measures and the Medicaid and CHIP Core Set, which they report to CMS on an annual basis to provide information about the quality of physical and mental health services received by Medicaid and CHIP Beneficiaries.

There are three measures in the Adult, Child, and Health Home Core Set that relate to the objectives of this learning collaborative. These include the Follow-up After Hospitalization for Mental Illness (FUH) Measure which is in the Adult, Child, and Health Home Core Sets; the Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Measure which is in the Adult Core Set; and the Follow-up After Emergency Department Visit for Mental Illness (FUM) Measure which is also in the Adult Core Set. These measures are indicators of whether beneficiaries are receiving the care they need after they leave the acute care setting, a particularly vulnerable time. Receiving timely follow-up care, defined as care within 30, or ideally seven, days of discharge, has been shown to improve health outcomes and prevent readmissions.

In the next few slides, I'll walk through state performance on these measures for the FFY 2019 reporting period for best-representing services the beneficiary feeds in calendar year 2018. I'm going to go through these data fairly quickly, but the FFY 2019 chart packs are available on Medicaid.gov if you want to look more closely at state performance on these and other Core Set measures. Next slide, please.

Now, this slide shows states' performance on the follow-up after hospitalization for mental illness or FUH measure in the Child Core Set. For FFY 2019, a median of 66 percent of children ages six through 17 who were hospitalized for mental illness or intentional self-harm had a follow-up visit within 30 days of discharge among the 44 states that reported this measure. While this slide shows states' performance on the 30-day FUH rate, states were also asked to report the rate of follow-up within seven days of discharge. For FFY 2019, the median for the seven-day rate was 42 percent, indicating that while some beneficiaries may not have received follow-up within seven days, they may have gone on to receive one or more visits within that 30-day period after discharge. Next slide, please.

For the Adult Core Set FUH measure, the median rate of follow-up after hospitalization was lower. 55 percent of adults ages 18 and older had a follow-up visit within 30 days of discharge and 32 percent had a follow-up within seven days of discharge among the 42 states that reported this measure. Although both the child and adult 30-day follow-up after hospitalization rates are over 50 percent, this does mean that a large number of beneficiaries are not receiving follow-up within 30 days, indicating that there is room for improvement here. Next slide, please.

For the Health Home Core Set FUH measure, a median of 60 to 63 percent of Health Home enrollees, ages six and older, had a follow-up within 30 days of discharge, and 45 percent had a follow-up within seven days of discharge. It's notable that the 30-day FUH rate among the 19 SPAs recording is somewhat higher than the Adult FUH rate of 55%, indicating that care coordination provided by the Medicaid Health Homes could be boosting access to and use of follow-up care. Next slide, please.

This slide shows states' performance on the Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Adult Core Set measure or FUA. For FFY 2019, a median of 22 percent of ED visits for adults with a diagnosis of alcohol or other drug abuse or dependence had a follow-up visit within 30 days among the 36 states reporting this measure and 14 percent had a follow-up within seven days. Next slide, please.

Finally, this slide shows states' performance on the Follow-up After Emergency Department Visit for Mental Illness Measure in the Adult Core Set, which was reported by 36 states for FFY 2019. Among these states, a median of 52 percent of ED visits for adults with a diagnosis of mental illness or intentional self-harm had a follow-up visit within 30 days, and 38% had a follow-up within seven days. Notably, this rate is quite a bit higher than the rate for the Follow-Up After ED Visit for Alcohol or Other Drug Abuse measure.

Through this learning collaborative, CMS hopes to work closely with states to improve rates of behavioral health follow-up for adults and children, which will hopefully result in improved performance on these three measures in the coming years. Next slide, please.

The slides that I went through just give a snapshot of state performance on the follow-up Core Set measures during the 2018 calendar year. As you can imagine, during the COVID-19 pandemic, use of behavioral health services declined dramatically and remains well below previous years' levels, presumably including use of follow-up care after hospitalization or ED visit. This slide shows that among children, there were about 35 percent fewer outpatient mental health services and services delivered by telehealth between March and July 2020 compared to March and July 2019. Next slide, please.

Similarly, among adults, there were about 25 percent percent fewer outpatient mental health services for adults, including services delivered by telehealth, between March and July 2020, compared to March and July 2019, representing about 7.8 million missed services. It's notable that use of telehealth services increased among both adults and children during the early months of the COVID-19 pandemic, but

eventually leveled off and ultimately did not make up for declines and outpatient service use during this time. This gap in services suggests that many Medicaid and CHIP Beneficiaries did not receive the care they needed during the early months of the pandemic and may currently not be getting the care they need to manage their behavioral health conditions. Another reminder of the importance of the work that states will be doing through this learning collaborative, and other state and federal initiatives to improve access to behavioral health services, including behavioral health follow-up care. Next slide, please.

We're going to shift gears now and hear from some states that are already doing interesting work in this area. First up, we'll hear from Andrew Brown, who is the Commissioner of Behavioral Health Services at the Kansas Department for Aging and Disability Services. Andy, the floor is now yours.

Andrew Brown:

Hi, everyone. Andy Brown, I'm the Commissioner for Behavioral Health Services at KDADS, and I want to say I'm very excited about this community practice opportunity, learning from other states is always very beneficial to us. I hope that everybody will get something out of it that they can use in their state. Next slide, please.

So, just a little background on Kansas Medicaid. While I work for the Behavioral Health Agency, KDADS, our Medicaid office is the Kansas Department for Health and Environment Division of Health Care Finance. And on average, we have about 360,000 Kansans that are enrolled in the programs. That's about 12 percent of our population. And currently, we have a waiver that we're working with, and it's the second version of that waiver that we've had with CMS. So, we're sort of on our KanCare 2.0 version. And we're getting ready to move into KanCare 3.0 here soon. So, we have three Managed Care Organizations, we are a Managed Care State. We're working with Aetna, United, and Centene. And then, similar to the other state you're going to hear from today, Oklahoma, we are a largely rural and frontier state. And we deal with a lot of the issues that come from having workforce shortages and those sorts of things. Next slide, please.

So, this map kind of highlights the Mental Health Professional Shortage Areas here in Kansas. The red counties have a score of 18 or higher. The yellow counties have a score of 17 or lower. Then, the white counties are the only ones that are not eligible for mental health, health professional shortage scores. That gives you an idea of just kind of how difficult it can be to access services in Kansas and do follow-up for folks that are in hospitals. We do, therefore, make a lot of use of telehealth or telemedicine in order to try to do those follow-ups and get people connected to services. Next slide, please.

Some assumptions from our waiver: we essentially told CMS that we felt like telemedicine would help enhance our access to care. We felt that that was true because of the shortages that we saw, and the ability for more convenience for the patient. In a lot of cases in Kansas things are so rural that if you're going to take time out of your schedule to go to an appointment, it might take you three or four-hours round trip commute in order to do that and eat up the majority of your day. For a single appointment, telemedicine seems to be a lot better for access to care. For telemonitoring, we really felt like telemonitoring would help improve our outcomes, both on the physical health side and the mental health side. Then, for tele-mentoring, what we really wanted to focus on there was trying to increase provider capacity, providing support and coaching to providers so that they can be more comfortable as generalists dealing with specific issues.

The goal of our follow-up telehealth really is that anytime there's been a psychiatric hospitalization, or an emergency room visit, is to try to facilitate a more successful community reintegration, especially in our rural and frontier communities. By that what we try to do is make sure that our MCOs are aware of when

those ER visits and hospitalizations occur. We make sure that when folks are screened for the state hospital or for a private psych hospital stay that the MCO is notified upon admission, in order to better help with their discharge planning and our reintegration into the community. We utilize telehealth to make sure because oftentimes folks will have to travel halfway across the state to get to a hospital. We use telehealth then to make sure that we're doing follow-up care while they're waiting for any outpatient services that they'll receive afterwards.

Then, because of the public health emergency, we really were prompted as state agencies to greatly expand telemedicine beyond our original intention. A lot of the services that we had prior to COVID, even though we are a rural state, a lot of our telemedicine was limited and required a number of different restrictions that were in place in the scope of what codes were available to be billed under Medicaid were more limited. When March hit last year, we started working to expand under the authority CMS gave us, those telemedicine codes that were available for folks. Also, we invested a lot in the technology needed in order to help providers adopt and shift to that. Where we're at today is much more expanded even than what was in our original waiver application. Next slide, please.

This is just an example of the impact that we've seen with our Telemedicine Follow-up Programs. Nationwide, Kansas has a higher hospital readmission rate than the national rate, and our hospitals are exempt from any readmission penalties, right? That doesn't mean that there are not additional costs associated with that, so we've targeted this follow-up program to help try to reduce those readmissions. We're looking at other things that cause readmission in Kansas, because it does lead to wait times and, since this management issue is at the state hospitals, we are really trying to put a dent in that.

In our rural and frontier areas with the telemedicine follow-up programs, and things that we've seen as a result, have been decreased in the psych hospital readmissions, around about 17 percent. Providers are reporting increased capacity to provide services and they are also reporting that there are fewer missed appointments by clients or patients. Patients are also reporting reduced symptoms and increased access to care. They also largely seem to be reporting that they would like to maintain the availability of these sorts of services even after COVID. We look at maybe like about a third, a third, and a third; where we got about a third of our patients that are very excited about telemedicine, about a third that prefer face-to-face, and another third that are in the middle that would like it to be available as an option. Next slide, please.

Things that we learned were that if the technology infrastructure exists, and providers are willing, then rural residents will demonstrate higher rates of use of telemedicine. We also have found that provider interest is keyed to what the potential expenses, or the viewed risk that they feel like they are taking on by doing that, whether that's for their scope of practice, care of the patient, those sorts of fears. Most utilization has been for Behavioral Health Services. We've seen, and I think that's part of the reason I was asked to do this as the Behavioral Health Director, but we've seen a fairly substantive increase in our behavioral health services use of telemedicine, while in our primary care side has been slower to be adopted. Patients need access to devices and broadband services. In rural areas, sometimes those aren't available and telephonic services are then used to help overcome that barrier. Next slide, please.

For next steps, these are things that we're looking at, right? It is, what's going to be the impact of the new 988 number on telemedicine follow-up opportunities. For those of you that might not be familiar, 988 is the three-digit number that's replacing the National Suicide Prevention Lifeline Crisis Centers. Those crisis centers will now be able to use this three-digit number as a way of reaching the public more directly, which means that they're likely to have increased call volume from people that are in crisis. We're currently working in our state to look at how we can tie that to our screening services and look at mobile crisis-type programs that can help meet with people in their homes and provide additional follow-

up care. Specifically, the call centers will then be in a position while there, they will be able to offer direct follow-up care over the phone to those individuals that contact them. And so, we're looking to see how we can tie that back into our mental health system as a referral and help with the follow-up process from hospitalizations.

Then, for maintaining telemedicine, we do feel like in Kansas that we've seen benefit from the additional freedoms we've been allowed under the public health emergency, and we would like to continue to advocate and look for ways that we can maintain those freedoms. We also are looking at how those Mobile Crisis Teams, I mentioned a minute ago, couldn't help with follow-up. We're looking specifically to see if we can build that into part of the structure that we use for mobile crisis, as we begin to build that system out. There are opportunities in the ARPA that I think allow for an enhanced FMAP for mobile crisis programs if states adopt those. We're looking into that and seeing whether or not we can include follow-up work by those team members, for those that they came into contact with, as well as our emergency departments.

I think it's important too to realize that there are a lot of opportunities under ARPA for states to look at what kind of infrastructure they might need to provide telemedicine. Specifically, there's a lot of funding available in ARPA for broadband access and increasing opportunities there, and then also opportunities for providers to get help with their own technology and infrastructure.

Lastly, we also see that there are limitations within our own state regulations. Looking at ways that we can adjust and make changes to our state statutes in order to support telehealth expansion more broadly, some of those things look like scope of practice with our regulatory boards for licensure and some of them look like ways that we can pass legislation to support funding and expansion of the system. Next slide, please.

This is my contact information. From here, I'm going to go ahead and turn it over to our next speaker.

Michaela Vine:

Thank you very much, Andy. Now, we're going to turn it over to Malissa McEntire, who's the Manager of Integrated Care at Oklahoma Department of Mental Health and Substance Abuse Services. Malissa, the floor is now yours.

Malissa McEntire:

Good afternoon, everyone. I am glad to be here today. I am Malissa McEntire, Manager of Integrated Care at the Oklahoma Department of Mental Health and Substance Abuse Services. We are the sister mental health agency to our Oklahoma Health Care Authority, which is our State Medicaid Agency. Just a little bit of state context for everyone on the call today, we are a non-expansion and non-MCO state at this time, and we're currently serving a Medicaid population of about 850,000 monthly. We are historically and unfortunately constantly at the lower end of most health rankings. We're typically 47, 48 for access, number of uninsured, and overall health outcomes, and as Andy mentioned previously, we are a very rural and frontier state. I'm here today to talk to you about some of the initiatives that we have taken in integrated care, health homes, and certified community behavioral health clinics. Next slide, please.

Oklahoma has always, within our mental health department, taken a fairly proactive approach to try to do some new programs and some innovative strategies to try to, again, tackle the health disparities that we see in our state. We were an early adopter of the Health Home, the Behavioral Health Home model, and we started that in 2015 with a state plan amendment. We started with 21 providers there. When the CCBHC or Certified Community Behavioral Health Clinic Demonstration Grants came out, Oklahoma

did apply and was awarded the Demonstration Grant. We are one of the handful of states to receive that. Then, there was a second step to that, which was the Planning Grant and Oklahoma was one of the eight states awarded the Planning Grant.

We had three of our larger agency providers, who previously served as Health Homes, who moved into the Certified Community Behavioral Health Clinic Model. We have seen quite a lot of success with that model. We think that starting with the Health Home, building up our care coordination, and our overall look at integrated care and health outcomes has really helped improve some of our quality measures. These programs are also a bundled payment system. We'll talk a little bit more about that. In 2019, we did move into a State Plan Amendment for Certified Community Behavioral Health Clinics. So, we have three providers serving under the demo of the Planning Grant. We have a handful of providers, we're up to three now who have come on board as fully state certified CCBHCs. Next slide, please.

This is a slide that just shows you all the full array of comprehensive services that are required within the CCBHC model. On this slide, the darker kind of teal-colored services are the nine core components that were identified by SAMHSA that were required in the CCBHC model. Oklahoma started with that in the demonstration because that was under the SAMHSA model. As we grew our model and moved into our state plan amendment, what we wanted to do was make sure that the core components of integrated care were also included in that model, and you can see that from the lighter shapes there. That's making sure that we want to have a full array and a fully comprehensive service array within this model. Care Coordination is highlighted because as you probably all know, Care Coordination is the linchpin of CCBHC, and also, hugely important in ensuring improved follow-up and decrease in hospitalizations. Next slide, please.

One of the innovations that Oklahoma has adopted is what we refer to as our "most in need" list. This was specifically to address hospital follow-ups and readmission, and it focuses on anyone within our system that has multiple encounters. As you can see here, from the requirements that place somebody on this list, these are people who are often going in and out and not receiving their follow-up care. This is a list that exists on one of our data sites and our providers have access to this list for their provider level, based on who that consumer last had contact with. They can go on there and actively work through these individuals and try to engage them. Of course, with the hope of getting them back into treatment, and decreasing these episodes. One thing that the CCBHC model does allow for, as I kind of previously mentioned, is that it is a bundled payment model. Anyone on this list is what we consider a special population. If someone from this list is engaged in services, they receive a qualifying service, and they do not go back into a hospital or crisis or emergency department within that month, then that provider is eligible for an enhanced payment on that consumer to help motivate and improve those services. Next slide, please.

Just a few more kind of innovative approaches that we have implemented. On the clinical side, "Dedicated Outreach Workers" is something that we wanted to really drive home to our providers. We wrote this into our administrative rules. We found that most people have outreach workers, but oftentimes, those individuals also carried a caseload. We really wanted to ensure that there were dedicated staff members – ideally, case managers and peers. We have a pretty robust peer recovery support system in Oklahoma as well, that really are dedicated to those outreach services, so they can really make the most of their time and their energy on that. Our Health Homes Initiatives and all our work that we did in the beginning, all the way back to 2015, and honestly, probably a little bit before that, in integrated care, shows up in the remainder of the list there and the clinical side.

Care Coordination has been, you know, something that we've worked on for many, many years now. Also, the clinical care pathways were something that we developed through our integrated care and health home initiatives and have carried them into our CCBHC model. Each provider has specific clinical care pathways that help them monitor and treat those individuals who are coming out of the emergency department, any hospital follow-ups, and then, also any suicide risk. We did a fair amount of work with the National Council in developing and implementing those care pathways. That's something we're really proud of.

On the technology side, as Andy talked in the previous session, we do use a lot of telehealth. We have also implemented quite a bit of iPad technology across the state. Many of our providers have purchased and utilized iPads in a couple of different ways, they do check them out to some consumers who maybe do not have any other access and it is a locked-down device. The only thing they can do on that device is connect to their provider, but it gives them prices, assistance, or just immediate access to that provider at the touch of a button 24/7. We've also implemented iPad services within police systems, and hospitals, and specifically emergency departments as well. So, on the police side, if somebody gets a mental health call, a crisis call, the officer can actually utilize an iPad to connect directly to a crisis counselor at the local provider level, to have a telehealth evaluation, to make a determination of what needs to happen with that individual before either taking them to the emergency department, or jail or wherever.

We also utilize CHESS Health. Some of you may be familiar with that. They're well known in the substance use world, but they have expanded their services, and they probably have more. We utilize three applications that they have. They have an E-Recovery, which is the substance use disorder app. No, I'm sorry, E-Intervention is the substance use disorder app. E-recovery is more on the mental health side. They also have what is called Connections App, which can help with peer-to-peer text messaging. There's all kinds of self-help, videos, resources. Also, the apps will help with referrals and tracking between providers. So more and more of our hospital systems and our sister agencies are coming on board with this application to help ensure that we can see and track those referrals throughout our system.

Couple of other things listed here on the technology side. These are all different data application tools, population health management tools that we have implemented since Health Home. And they were required within our Health Home model, and they continue to be required within our CCBHC model. Everyone has to have a Certified Electronic Health Record, they have to utilize our health information exchange, and they're required to utilize the Population Health Care Management tool. Oklahoma currently uses Relias Population Health Management tool and we have been with them since within the first couple of years of our Health Home implementation. That allows our providers to track and monitor hospitalizations, and ED visits through those patient registries, as well as any other high-risk diagnosis medications. Relias also gives two separate risks scores. So that's kind of another way that they can go in and monitor their population from a Population Health Management standpoint. Next slide, please.

I wanted to talk a little bit about a few of the Evidence-Based Practices that we have implemented to help ensure that we're doing the best we can on these follow-ups. You'll probably be familiar with a lot of these, I won't go through everything, but a couple of things that we have recently either implemented or tried to kind of beef up for lack of a better term. CTI or Critical Time Intervention – that was a newer model to me within the last like three years and we found that EBP is focused on transition. So, it's often utilized with individuals coming out of residential or out of jail. It is similar to Assertive Community Treatment. In some ways, it's an intensive team approach model, but it is time-limited. The intent of that critical time intervention is to help someone really get engaged in services, and it's kind of a stepped approach. At that point, once they kind of complete that, maybe nine months to one-year engagement

process, and really get to a better place, then they can be transferred to another more appropriate team at that point.

I mentioned the Assertive Community Treatment. Oklahoma has had, we call them PACT teams here, we add the P on the front. We've had PACT teams in Oklahoma for 20 years or so, but not completely statewide. They're more in our urban areas. We have a few in the rural communities, but we became aware of the Flexible ACT model. That model is actually, to my knowledge and the last time I researched this, I don't think anyone in the US is specifically using this. It's utilized a lot in Canada and also in Europe. It takes the Assertive Community Treatment model and kind of expands it out to where you can serve more individuals. It opens up the eligibility, so those of you who are familiar with ACT, it is a very specific intensive treatment meant really to target for psychosis. Typically, those with substance use, and personality disorders are excluded.

Flexible ACT kind of opens that up a little bit. It increases your numbers, it increases the staff and then it allows you to kind of manage within that population, who you're serving, and what they need. A little bit more flexible, hence the name. Some of our providers are moving to that. We find that that is helpful in managing our most in need, and some of our individuals who are coming in and out of hospital in crisis centers, because it allows the teams to work more appropriately for that individual. Especially in some of our rural areas, this seems to work better, because having that small intensive ACT team is just not feasible in some of our more rural communities.

Of course, motivational interviewing, and then with our integrated care model, pretty much all of our providers at this point, operate under a team-based care model. They're using interdisciplinary teams to try to ensure that they're best meeting the needs of those individuals. Next slide, please.

I have a few data measures here for you guys. The first two I have here are the CMS quality measures. This is our 30-Day Follow-Up after Hospitalization. The blue bar is for the adult, yellow bar there is for the children, and you'll see that DY1, DY2, because this is our CCBHC group, those are demo years. This is our demo CCBHC providers and their first, second, and third year of their program. I will say our numbers were already kind of high, and they've kind of consistently stayed high, and I think a lot of that just goes back to our intensive efforts in care coordination and integrated care. Next slide, please.

This is our Follow-Up after Emergency Department. Again, same thing. Demo Year, one through three, blue bar is seven-day follow-up and the yellow bars are 30-day follow-up. Of course, it goes up at the 30 day. These were things that we have been monitoring for several years throughout multiple programs that we've implemented. Next slide, please.

I got three more data points for you guys, which are actually on what we call our Data Dashboard. This is something we developed through our CCBHC model, which we have at the state level to look at this basically live data. We refresh it at minimum monthly. We can often go in, update, and look at specific targets. We wanted to drive down a little bit more specific on some of these measures on our data dashboard. The first one here is actually the percentage of clients admitted to inpatient care. This one's a little bit different, a little bit more specific than the previous data, and as you can see this shows our five providers, and the “Pre” would be the year before we started CCBHC running all the way through year four. As you can see, those numbers are all significantly going down for all providers. Next slide, please.

This one is percentage of clients admitted to crisis care. These are not necessarily as drastic, but still for the most part going down, moving in the right direction. Next slide, please.

It is a percentage of clients treated at emergency department. Again, looking good, moving in the right direction across all of our Certified Community Behavioral Health Clinics. These were just some things that we wanted to kind of drill down and look at a little bit more specifically. Next slide, please.

This brings me to the end. You have my contact information here. Just a couple of things, as far as lessons learned, or any successes, I will say I think that we built incrementally and started with the integrated care and with our health home. We just continued to build that up into the CCBHC model, which was beneficial for us. I will tell you; it's been a long road, and sometimes it's hard to see our progress until other people point out to me that it's there.

The other thing I will say is that you're never really ready to start to implement some of these changes. At some point, you just have to take the dive. We've notoriously said for many years now that we've built the plane, we're flying for the past 10 years and that's just the way these models work. My last comment on that is that it is also a lot of change management. That's something that we constantly try to address and work on with our providers, as well, because it can get tiresome and overwhelming to be constantly pushing forward.

I think our data is moving in the right direction, so I think it's a good thing that we've done these innovations. That's it for me.

Michaela Vine:

Thank you so much, Malissa and Andy, both for your presentations. We are actually going to move on now to questions and answers. Next slide, please. Okay, thank you. One more slide.

Just as a reminder, to submit a question, please type your question in the Q&A box within the WebEx, the Q&A box at the bottom right of your screen, and then select All Panelists in the dropdown. As a reminder, only the presentation team will be able to see your questions, so we'll do our best to get through as many during the time that we have.

I think that we've received a few questions through the Q&A around when the slide and recording will be made available. We will be posting the slides and recording from today's webinar on Medicaid.gov within a few days of the event. We have a link to that web page at the end of the presentation.

We have another question here for Kansas. Andy, this one is for you. Someone asked, does your state share Behavioral Health Inpatient Data with health plans via ADT? Do you find it to be helpful or a barrier?

Are you able to take that one?

Andrew Brown:

Yes. Right now, we don't from the state hospitals, and I think the barrier there is that Kansas hasn't had the opportunity to invest in the technology needed to do that yet. We're currently putting in an RFP for a statewide EHR that would help manage our behavioral health patients on both mental health and the SUD side that would then be linked to our state hospital systems. At that point, I do hope that we'll be able to share more in-patient data with the MCO's at that point. For right now, it's been a barrier in terms of ability to invest in it and it is one of the things that we're hoping to kind of be able to help push over the finish line here soon.

Michaela Vine:

Great. Thanks so much, Andy, and while we have you unmuted; we also received a question around the mobile crisis team. Someone asked, what are the mobile crisis teams, and what role do they or could they play in improving follow-up care?

Andrew Brown:

Sure. Mobile crisis teams are generally two-person teams of folks, that we try to combo them up with ideally maybe a peer and a qualified mental health professional, and they respond to folks that are having a behavioral health crisis. We're hoping that we can connect follow-up to those teams the same way that we do to emergency rooms, or emergency department visits. That follow-up can then continue, and they can be connected to services within the community without ever actually having to go to the emergency department.

The mobile crisis teams provide services in the home and have an opportunity for the community mental health centers, or the CCBHC's that run them, to integrate that person into their provider system. I think it's important that those crisis services that are trying to prevent or divert folks from hospitalization become an area where we start to do follow-up care in an intentional way, that we would have done had they been at the emergency room. I think that's important because we want to be able to capture all of that information and provide it to our MCOs, so that they can better manage their members' care.

Michaela Vine:

Thank you very much, Andy. We know you have another question that I think probably either of our state presenters could talk to around. What resources are you providing people in rural areas to connect to telehealth?

Malissa or Andy, would you like to take that one?

Malissa McEntire:

This is Malissa. I was thinking a little bit. I mean, we have gotten a little bit of assistance through grants. They're not super technology-heavy, but we have been able to add some of that to our provider network. I know that the providers themselves have filled out some very specific technology grants. Those are really the two examples I can think of.

Michaela Vine:

Thank you, Malissa. One other question for Oklahoma, actually, while we have you unmuted. This person asked for Oklahoma, where they took a more incremental process onboarding more programs over time, do you have any data that indicates increased reach that the programs were able to achieve? If so, how many more people were you able to reach as you added, Flexible ACT, CTI, etc.?

Malissa McEntire:

I mean we have a lot of data. I haven't looked at that specifically, and CTI has been newly implemented, so that would probably be coming up this year and next year to really see any improvement in that. That's something we could certainly look at. I don't have the numbers or anything off the top of my head. Sorry.

Michaela Vine:

Not a problem. That is okay.

Malissa McEntire:

You're welcome to reach out.

Michaela Vine:

That is okay.

Malissa McEntire:

You're welcome to reach out if you want and I'm happy to ask our data division to see if we can take a better look at those numbers.

Michaela Vine:

Thank you, Malissa. Malissa's email is in her section of the presentation and you're also always welcome to send a question to our team's mailbox. Then, another question for either the presenters. Do either of the presenter states focus efforts on prevention? In our state, we spend so much more on inpatient versus outpatient.

Andrew Brown:

Yeah. I will say, I think that prevention and diversion are very important for managing the system and I do think that the more we can do around building sort of integrated crisis service delivery programs, the less hospitalization we're going to need to do. There are several groups out there that are really working hard on this kind of topic. I did put a link in one of my responses to the toolkit that SAMHSA put out about crisis service array and the types of things that states can do to help prevent hospitalizations. I think that it's a very real thing that we spend a lot of time and energy, trying to figure out how to better direct Medicaid dollars.

So that is something that we work with our MCOs on is trying to look at how we can provide social determinants of health, in a way that help prevent mental health crisis's from occurring in the first place. Looking at housing, unemployment, a lot of the programs that Malissa highlighted – the IPS, for example, is a great model for supported employment and has really good indicators for preventing mental health crisis. Supported housing or housing first programs, again, have really good results at reducing readmissions to hospitals, and preventing crisis in the community. There's a lot of things that you can do. I would encourage people to look at those social determinants of health and the types of programs that Malissa highlighted in her presentation.

Michaela Vine:

Great. Thank you so much. I think that we actually do not have any more time for questions. I think that's about all the time that we have today. There were a couple questions that we didn't get to. If you asked a question that we didn't get to answer today, you can send the question to us at the QI TA mailbox at MACQualityImprovement@mathematica-mpr.com. Next slide, please.

Thank you all for your great questions and your engagement with our panelists today. To wrap up, Mira is going to summarize some upcoming events in the learning cooperative. Mira, I'll turn it over to you.

Mira Wang:

Thanks, Michaela. Next slide, please.

On this slide, you can see the dates of our upcoming webinars. On June 15 at 12 p.m., Eastern, we will host an information session on our upcoming Affinity Group and discuss the expression of interest form, which you can submit to join our upcoming Behavioral Health Affinity Group.

Next, we'll host a webinar on June 29, at 12:00 p.m. to discuss Leveraging Key Relationships and Improving Behavioral Health Follow-up Care. Finally, at our last webinar on July 15, we will discuss Using Data to Improve Access to Behavioral Health Follow-up Care. We have a number of state presenters lined up to discuss the strategies they use and are looking forward to sharing with you all. Please use the link on the slide to register for these upcoming webinars, and to view the webinar recording and slides, which will be posted after the webinar. Next slide, please.

For more information on our Affinity Group, and on the expression of interest form, please see the fact sheet that is linked on this slide. We've also posted the expression of interest form on Medicaid.gov, which is due by 8 p.m. ET on July 15. Please take a look if you'd like to apply to join our Behavioral Health Learning Collaborative, which will launch this summer. Next slide, please.

Finally, please complete the evaluation as you exit the webinar. As a reminder, if you had any questions that we didn't have time to address today, please submit them to the MACQualityImprovement@mathematica-mpr.com mailbox.

We do apologize that we couldn't get to them all but look forward to responding in full after the webinar. Please also feel free to send us any questions that you may have about our upcoming webinars or affinity group.

Thank you so much for attending and we look forward to seeing you at our next webinar.