Informational Q&A Webinar: NASHP Policy Academy on Rural Mental Health Crisis Services

June 24th, 2021
3:00 pm-4:00 pm EST

This webinar was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award under the National Organizations of State and Local Officials co-operative agreement.
Logistics

- Your lines will be muted during the webinar.
- To ask a question or make a comment, please use the Q&A function.
  - The “chat” function will also be available
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience.
- Thank you!
Today’s Speakers

Dr. Sylvia Fisher
Director,
Office of Research and Evaluation, Health Resources and Services Administration

Dr. Charles Smith
Regional Administrator,
Region VIII, Substance Abuse and Mental Health Services Administration

Kitty Purington
Senior Program Director,
Chronic and Vulnerable Populations, NASHP

Jodi Manz
Project Director,
Chronic and Vulnerable Populations, NASHP
What is NASHP?

- Non-profit, non-partisan organization with offices in Washington, DC and Portland, ME

- Dedicated to working with states across branches and agencies to advance, accelerate, and implement workable policy solutions that address major healthcare issues.

- Through NASHP’s unique cross-agency approach and deep policy expertise, states participating in previous technical support initiatives have made progress on key policy and programmatic milestones.
NASHP Policy Academy Team

- Kitty Purington, Senior Program Director
- Jodi Manz, Project Director
- Eliza Mette, Policy Associate
- Mia Antezzo, Research Analyst
State Mental Health Crisis Services Systems and the Importance of Capacity Building

- Rates of mental illness were steadily increasing across states prior to the COVID-19 pandemic.

- The Substance Abuse and Mental Health Services Administrations (SAMHSA) expects further increases in need as the nation emerges from social distancing and isolation measures.

- Mental health crises and needs of particular concern in rural areas, where two thirds of adults reported experiencing greater mental health difficulties during the pandemic than they had previously and resources may be more difficult to access.
U.S. Health Services and Resources Administration (HRSA): Behavioral Health

Sylvia Fisher, PhD, Director
Office of Research and Evaluation

Office of Planning, Analysis and Evaluation
HRSA
June 24, 2021
HRSA: Addressing U.S. Health Needs

• HRSA, an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.

• Tens of millions of Americans receive quality, affordable health care and other services through HRSA’s 90-plus programs and more than 3,000 grantees.

• HRSA programs help those in need of high quality primary health care, people with HIV/AIDS, pregnant women, and mothers. HRSA also supports training of health professionals, distribution of providers to areas where they are needed most and improvements in health care delivery.

• HRSA oversees organ, bone marrow and cord blood donation. It compensates individuals harmed by vaccination, and maintains databases that protect against health care malpractice, waste, fraud and abuse.
Vision: Healthy Communities, Healthy People

Mission: To improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs.

Goals
• #1: Improve Access to Quality Health Services
• #2: Foster a Health Care Workforce Able to Address Current and Emerging Needs
• #3: Achieve Health Equity and Enhance Population Health
• #4: Optimize HRSA Operations and Strengthen Program Management
Rural Mental Health

• According to Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, about 7.3 million nonmetropolitan adults reported having any mental illness in 2019, accounting for 21.2% of nonmetropolitan adults.

• Nearly 1.6 million, or 4.8%, of adults in nonmetropolitan areas reported having serious thoughts of suicide during the year.

• Despite similar prevalence of mental illness among rural and urban residents, available services differ substantially.
According to WICHE's *Rural Mental Health: Challenges and Opportunities Caring for the Country*, factors challenging the provision of mental health services in rural communities:

- **Accessibility** – Rural residents often travel long distances to receive services, are less likely to be insured for mental health services, and are less likely to recognize an illness.

- **Availability** – Chronic shortages of mental health professionals exist and mental health providers are more likely to practice in urban centers.

- **Acceptability** – The stigma of needing or receiving mental healthcare and fewer choices of trained professionals who work in rural areas create barriers to care.
HRSA Federal Office of Rural Health Policy (FORHP)

FORHP at HRSA:

• promotes better health care service in rural America and was established by Section 711 of the Social Security Act in December of 1987.

• informs and advises the Federal HHS on matters affecting rural hospitals and health care, coordinating activities within the department that relate to rural health care and maintaining a national information clearinghouse.

• works with federal, state and local governments and private sector associations, foundations, providers and community leaders to seek solutions to rural health care problems.
HRSA FORHP Charge

• Helps shape rural health policy
• Works with State Offices of Rural Health
• Promotes rural health research
• Funds innovative rural health programs
• Supports National Advisory Committee on Rural Health and Human Services
• Voice for concerns of rural hospitals, clinics and other rural health care providers
• Liaison w/national, state & local rural health organizations
• Works with minority populations in rural areas
• Sponsors a National Clearinghouse of Rural Health Information
The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services.

Telehealth is especially critical in rural and other remote areas that lack sufficient health care services, including specialty care.

Range and use of telehealth services have expanded greatly, along with the role of technology in improving and coordinating care.

Traditional telehealth models involve care delivered to a patient at an originating (or spoke) site from a specialist working at a distant (or hub) site. A telehealth network consists of a series of originating sites receiving services from a collaborating distant site.
Evidence-Based Telehealth Network Program (EB THNP) – FORHP

Program will expand access to health services in 3 clinical primary focus areas: (1) Primary Care, (2) Acute Care, and (3) Behavioral Health Care; awardees must provide Direct To Consumer (DTC) telehealth services to patients within established telehealth networks accomplished by

- Identifying/partnering w/local established health care facilities (especially primary care facilities) within service area, elevating trusted patient-provider relationship, access, & quality of care via telehealth.
- allowing for expansion of access to care in Medically Underserved Areas (MUA) and primary care or mental health defined Health Professional Shortage areas (HPSA).
- supports current or previously utilized network sites to efficiently and effectively pilot and/or expand DTC telehealth care.
- must utilize synchronous (real-time virtual visits) audio-visual technology and may include remote patient monitoring (RPM) to provide DTC telehealth care to patients.
HRSA Efforts to Address the Opioid Crisis

• Prevention and access to treatment for opioid addiction and overdose reversal drugs are critical to fighting this epidemic.

• Primary care settings have increasingly become a gateway to better care for individuals with both behavioral health (including substance use) and primary care needs.

• HRSA supports its grantees with resources, technical assistance, and training to integrate behavioral health care services into practice settings and communities.
HRSA Efforts to Address the Opioid Crisis (cont.)

• Expanding access through health centers and other primary care settings
• Using telehealth to treat opioid use disorder
• Connecting stakeholders to opioid-related resources
• Sharing best practices and regional approaches
• Increasing opioid use disorder training in primary care
• Informing policy and future investments
• Addressing opioid-related poisonings and overdoses
Rural Communities Opioid Response Program (RCORP)

• RCORP is a multi-year initiative supported by FORHP that addresses barriers to treatment for substance use disorder (SUD), including opioid use disorder (OUD).

• RCORP has five grant programs in HRSA-designated rural areas:
  - Planning grants
  - Implementation grants
  - Medication-Assisted Treatment (MAT) Expansion grants;
  - Neonatal Abstinence Syndrome grants
  - Psychostimulant Support
Rural Communities Opioid Response Program (RCORP) (cont.)

- RCORP funds three Rural Centers of Excellence on Substance Use Disorders. The Centers identify best practices for reducing SUD/OUD in rural communities.

- RCORP also provides a technical assistance portal with SUD/OUD resources.

- The RCORP impact on rural communities includes an investment of $298 million across over 1,420 counties since FY 2018.

- All domestic public or private, non-profit or for-profit entities can apply for RCORP including Faith-based and community-based groups and Federally-recognized tribes.
Rural Behavioral Health Workforce Centers – are part of the Rural Communities Opioid Response Program (RCORP), a multi-year HRSA initiative with the goal of reducing morbidity and mortality resulting from substance use disorder (SUD), including opioid use disorder (OUD), in high risk rural communities.

RBHWCS will advance RCORP’s overall goal by improving behavioral health care services in rural areas through educating and training health professionals and community members to care for individuals with behavioral health disorders, including SUD.
Behavioral Health Integration with Primary Care

• Integrated behavioral health results when a team of providers, including physicians, nurse practitioners, behavioral health clinicians, community health workers, home visitors, and other health care providers, work together to address patient needs to achieve quality outcomes for every individual in care.

• Safety net providers are utilizing a wide range of models to achieve integration, including care manager models, behavioral health clinician brief interventions, and models that support fully integrated behavioral/primary care health staff.
• HRSA has a “no wrong-door approach” to behavioral health services and emphasizes the availability of a highly skilled, professionally diverse and trusted workforce.

• The health care team provides screening, direct services and referrals in systems of care designed to address behavioral health concerns.

• Reduce stigma and discrimination;

• See cost benefits; and

• Promote improved patient outcomes.
HRSA Health Centers: Behavioral Health Services

• Health centers provide both mental health and substance use services.
• Screening for mental health and substance use disorders
• Developmental screenings
• Counseling and psychiatry
• 24-hour crisis intervention
• Medication assisted treatment for substance use disorders; detoxification, recovery support
Integrating Behavioral Health with Primary Medical Care: School-Based Service Sites

• Fiscal year (FY) 2021 School-Based Service Sites (SBSS) funding to be awarded for Health Center Program (HCP) award recipients on a competitive basis.

• SBSS funding will expand access to health center services by increasing the number of patients who access comprehensive primary health care services through HCP service delivery sites located at schools. Health centers will:
  ▪ add new Health Center Program service delivery sites at schools; or
  ▪ expand comprehensive primary health care services at existing HCP service delivery sites located at schools.
  ▪ services for mental health and substance use disorders
HRSA Health Centers:  
2019 Behavioral Health Uniform Data System Findings

- Completed over 11,989,271 million mental health visits
- More than 13,542.34 behavioral health FTEs to include psychiatrists, psychologists, social workers and substance use disorder specialists
- Mental health patients increased by 25.9% from 2017 (2,049,194) to 2019 (2,581,706)
- Depression screenings and follow-up measure for patients increased by nearly five percentage points from 2017 (66.2%) to 2019 (71.61%).
- Approximately 96% of HRSA health centers provide mental health services
EMSC Innovation and Improvement Center: Emergency Medical Services for Children (EMSC) has developed several programs to help develop education and resources focused on mental health emergencies including

• producing “Preparing for Pediatric Mental Health Crises in the Emergency Department One Pager”;

• preparing AK (Pediatric Education and Advocacy Kit) Mental health toolkit to be launched in July 2021;

• conducting a behavioral health collaborative with State Partnership grantees for 2022; and,

• conducting podcasts about screening for suicide in the ED and what ED should do if someone screens positive for suicide.
• Behavioral Health Workforce Research Center (HRSA) – Aims to strengthen the workforce responsible for preventing and treating mental health and substance use disorders by conducting studies to inform workforce development and planning efforts at federal, state, and local levels.

• The 21st Century Cures Act mandated that HRSA study the nation’s mental health and substance abuse disorder workforce.

• HRSA used the HRSA’s Health Workforce Simulation Model to meet this mandate.
Behavioral Health Workforce Projections

• This data helps policymakers and other stakeholders make decisions about behavioral health workforce education, training, and delivery of care.

• During the opioid crisis, HRSA continues to analyze the size and distribution of the behavioral health workforce, currently and in future years.

• Current patterns of health care use and delivery to future population estimates are applied to determine future supply and demand.
Demand and Supply of Behavioral Health Workers: 2030 Projections

- 3% increase in demand for adult psychiatrists (to 39,550)
- 1% decrease in demand for child & adolescent psychiatrists (to 9,190)
- 15% increase in demand for nurse practitioners (to 12,050)
- 8% increase in demand for physician assistants (to 1,670)
- 5% increase in demand for psychologists (to 95,600)

- 20% decrease in supply of adult psychiatrists to 27,020
- 22% increase to 9,830 child & adolescent psychiatrists
- 62% increase to 16,900 nurse practitioners
- 86% increase to 2,890 physician assistants
- 13% increase to 103,440 psychologists
- counselors
Demand and Supply of Behavioral Health Workers: 2030 Projections

• 12% increase in demand for social workers (to 268,750)
• 9% increase in demand for marriage & family therapists (to 57,970)
• 15% increase in demand for addiction counselors (to 105,410)
• 13% increase in demand for mental health counselors (to 158,850)
• 3% increase in demand for school counselors (to 119,140)

• 114% increase to 513,370 social workers
• 37% increase to 72,650 marriage & family therapists
• 3% increase to 93,880 addiction counselors
• 17% increase to 164,320 mental health counselors
• 88% increase to 218,130 school counselors
HRSA Behavioral Health Resources

• HEALTH CENTER RESOURCE CLEARINGHOUSE: https://www.healthcenterinfo.org/

• https://www.behavioralhealthworkforce.org/

• HRSA’s Health Workforce Simulation Model


• https://www.ruralcommunitytoolbox.org/

• Understanding the impact of suicide in rural America: Policy brief and recommendations (20018) - National Advisory Committee on Rural Health and Human Services (2017)

Questions?

*Sylvia Fisher, PhD, Director*
Office of Research and Evaluation
sfisher1@hrsa.gov

Thank you!
SAMHSA: Emerging Priorities & Opportunities

Charles Smith, PhD, MA
Regional Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

NASHP
June 24 2021
Behavioral Health – A National Priority

Among those with a substance use disorder:
- 2 IN 5 (38.5% or 7.4M) struggled with illicit drugs
- 3 IN 4 (73.1% or 14.1M) struggled with alcohol use
- 1 IN 9 (11.5% or 2.2M) struggled with illicit drugs and alcohol

Among those with a mental illness:
- 1 IN 4 (25.5% or 13.1M) had a serious mental illness

7.7% (19.3 MILLION)
People aged 18 or older had a substance use disorder (SUD)

3.8% (9.5 MILLION)
People 18 or older had BOTH an SUD and a mental illness

20.6% (51.5 MILLION)
People aged 18 or older had a mental illness

In 2019, 61.2M Americans had a mental illness and/or substance use disorder—an increase of 5.9% over 2018 composed entirely of increases in mental illness.
5 of 6 states in Region 8 recorded an increase in suicide rate of 38% or more
Mission - Reduce the impact of substance use and mental illness on America’s communities

BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH
PREVENTION WORKS
INTERVENTION IS CRITICAL
TREATMENT IS EFFECTIVE
PEOPLE RECOVER
SAMHSA’s Priorities

- Combating the **Opioid Crisis** through the expansion of prevention, treatment, and recovery support services
- Addressing **Serious Mental Illness** and **Serious Emotional Disturbances**
- Advancing **Prevention, Treatment, and Recovery Support Services** for substance use
- Improving **Data Collection, Analysis, Dissemination** and program and policy **Evaluation**
- Strengthening health practitioner **Training** and **Education**
1. Formula Grants
   a. Substance Abuse Prevention & Treatment (SAPT) Block Grant
   b. Community Mental Health Services (CMHS) Block Grant
   c. Projects for Assistance in Transition from Homelessness (PATH)
   d. Protection and Advocacy for Individuals with Mental Illness (PAIMI)
   e. State Opioid Response (SOR) / Tribal Opioid Response (TOR)

2. Discretionary Grants (examples)
   - Integrated Care
   - Systems of Care
   - Prevention
   - Workforce
   - Criminal Justice
   - Tribal BH
   - Recovery Support
   - Trauma
   - Opioid Overdose
   - School-based BH
   - Crisis Services
   - CCBHC
SAMHSA: Mental Health Technology Transfer Centers (TTCs)
### Grant/Program Funding

<table>
<thead>
<tr>
<th>Grant/Program</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Community Behavioral Health Clinics</td>
<td>$600,000,000</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>Emergency Response</td>
<td>$240,000,000</td>
</tr>
<tr>
<td>Community Mental Health Service Block Grant</td>
<td>$1,650,000,000</td>
</tr>
<tr>
<td>Substance Abuse Prevention and Treatment Block Grant</td>
<td>$1,650,000,000</td>
</tr>
<tr>
<td>Project AWARE (Advancing Wellness and Resiliency in Education)</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>National Child Traumatic Stress Network</td>
<td>$10,000,000</td>
</tr>
</tbody>
</table>

*SAMHSA FY 2021 Appropriation: $6,017,000,000*
# SAMHSA FY 2021 - American Rescue Plan Act: $3.56B

<table>
<thead>
<tr>
<th>Grant/Program</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block Grants for Community Mental Health Services</td>
<td>$1,500,000,000</td>
</tr>
<tr>
<td>Block Grants for Prevention and Treatment of Substance Abuse</td>
<td>$1,500,000,000</td>
</tr>
<tr>
<td>Community-Based Funding For Local Substance Use Disorder Services</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Community-Based Funding for Local Behavioral Health Needs</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>National Traumatic Stress Network</td>
<td>$10,000,000</td>
</tr>
<tr>
<td>Project AWARE</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Youth Suicide Prevention (GLS State, Tribe, and campus)</td>
<td>$20,000,000</td>
</tr>
<tr>
<td>Certified Community Behavioral Health Clinics</td>
<td>$420,000,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,560,000,000</strong></td>
</tr>
</tbody>
</table>
• **Regional Crisis Call Center:** *Someone to Talk to*
  – Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (call, text, chat)
  – *988 National Mental Illness and Suicide Crisis Line (7/2022)*

• **Crisis Mobile Team Response:** *Someone to Respond*
  – Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner;

• **Crisis Receiving and Stabilization Facilities:** *Somewhere to Go*
  – Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.
Certified Community Behavioral Health Center (CCBHC)

CCBHC program establishes the standard for comprehensive mental and substance use disorder treatment services:

- Patient/Family-centered care
- Trauma-informed
- Recovery-oriented
- Integrated with physical health care
- 24-hour crisis care,
- Evidence-based M/SUD care

Six program requirements

- Staffing
- Service Availability and Accessibility
- Care Coordination
- Scope of Services
- Quality and Other Reporting
- Organizational Authority and Governance

![Diagram showing services provided by CCBHC and DCOs]

- Targeted Case Management
- Crisis Services
- Treatment Planning
- Outpatient Mental Health & Substance Use Services
- Peer, Family Support & Counselor Services
- Rehabilitation Recovery Support Services
- Community-based Mental Health Care for Veterans
- Outpatient Primary Care Screening & Monitoring
- Screening, Assessment, Diagnosis & Risk Assessment
- Referrals

Must be provided directly by CCBHC

May be provided through formal relationships with Designated Collaborating Organizations (DCOs)

Referrals are to providers outside the CCBHC & DCOs
## SAMHSA CCBHC-Expansion Grants and Funding

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Funding</th>
<th># Grants Awarded</th>
<th>Project Start</th>
<th>Project End</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>96,718,053</td>
<td>52</td>
<td>9/30/2018</td>
<td>9/29/2020</td>
<td>CMHS Annual Budget Funds</td>
</tr>
<tr>
<td>2019</td>
<td>23,123,704</td>
<td>12</td>
<td>12/1/2018</td>
<td>11/30/2020</td>
<td>CMHS Annual Budget Funds</td>
</tr>
<tr>
<td>2020</td>
<td>196,814,768</td>
<td>102</td>
<td>5/1/2020</td>
<td>4/30/2022</td>
<td>CMHS Annual Budget Funds</td>
</tr>
<tr>
<td>2020</td>
<td>249,657,910</td>
<td>64</td>
<td>5/1/2020</td>
<td>4/30/2022</td>
<td>COVID Funds</td>
</tr>
<tr>
<td>2021</td>
<td>488,779,245</td>
<td>134</td>
<td>2/15/2021</td>
<td>2/14/2023</td>
<td>COVID Funds</td>
</tr>
</tbody>
</table>

**Total CCBHC-E Grants:** 365 (plus 75+ awards in 2021 and new CCBHC funding in ARP)

*Additionally, there were 8 CMS-CCBHC demonstration states grantees: MN, MO, NV, NJ, NY, OK, OR, PA*
Rural Barriers to Behavioral Health Services

Availability
County-Level Estimates of Mental Health Professional Shortage in the U.S. indicate that higher levels of unmet need for mental health professionals exist in counties that were more rural and had lower income levels.

Accessibility
Rural residents tend to have limited access to mental healthcare due to cost of services, insurance coverage, travel distance/transportation, and lower behavioral health literacy which allows mental health concerns to go unrecognized and/or untreated. Lower health literacy and not recognizing the signs of various mental health issues can serve as barriers to healthcare access in rural areas.

Acceptability
Rural residents are likely to experience self-stigma, fear, or embarrassment related to seeking out mental healthcare due to internal beliefs.

*When implementing rural mental health programs, community members and providers should consider how stigma may impact access and use of mental health services.
A Commitment to Behavioral Health

Emotional Health/Wellness     Access to Care     Integrated Care
Technology     Recovery     Workforce
Thank You

SAMHSA’s mission is to reduce the impact of substance use and mental illness on America’s communities.

Charles Smith, PhD, MA
Charles.smith@samhsa.hhs.gov

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)
NASHP Policy Academy on Rural Mental Health Crisis Services
NASHP is launching this Policy Academy to assist states in their work to address the challenges of expanding or developing mental health crisis services.

Through this opportunity, states will share strategies to implement and/or improve systemic approaches that support rural providers and stakeholders in mental health crisis service delivery.

NASHP will serve as a resource and convener to help policymakers connect with peers and experts, identify and share strategies and solutions, and provide insights for other state leaders.
State Policy Academy Overview

- Up to five state teams will be selected to participate in the academy by NASHP

- State teams will consist of up to five members including representation from at least two senior state officials

- States will receive 12 months of targeted technical support on policy goals and participate with one another in collaborative learning engagements, with the potential for in-person meetings.

**Key Dates:**

- **July 9**
  Applications due to NASHP

- **July 23**
  Notification of selection to states

- **August 2921**
  Policy academy begins
Technical Assistance and Resources

Guided by an analysis of state policy and regulatory barriers and a state-specific action plan, states will benefit from both individualized and peer-to-peer learning opportunities, including:

- One year of individualized monthly technical support from NASHP staff, and expert consultation from national leaders
- Assistance in developing work plans to support state priorities
- Collaborative learning engagements with other states at either virtual or in person meetings
Required:

- Identify and collaborate with five core team members to complete the RFA Application Questions. Team members should include:
  - At least 2 senior state officials or administrators (such as state Medicaid officials, governor’s health policy leaders, legislators, etc.)
  - Detailed outline of state needs and goals

Optional:

- Letters of support
Application Process

- Assemble core team and complete the application

- Send completed applications to Mia Antezzo (mantezzo@nashp.org) by 5pm ET on Friday July 9, 2021

- States will be notified of their application status no later than July 23, 2021
To ask a question, please use the ‘Q&A’ feature.
Access the RFA and application materials here:
https://www.nashp.org/nashp-policy-academy-on-rural-mental-health-crisis-services-request-for-applications/

For questions or more information, please contact Jodi Manz at jmanz@nashp.org