New Opportunities for Occupational Therapy in Mental and Behavioral Health

AOTA 96th Conference and Expo: MM 206 AB
Saturday, April 9, 2:00 – 5:000 pm

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Roxanne Castaneda, MS, OTR/L
Katherine Burson, MS, OTR/L
Today’s Session

• Introduction
• Federal Legislative Update
• Primary Care and Behavioral Health Integration
• First Episode Psychosis and Early Intervention for SMI: ESSA program
• Olmstead Settlements
• Tying it all together at CCBHCs
• Break Out Group Discussion: Your current practice setting
• Report from groups
• Finding resources
• Large Group Facilitated Discussion: “Starting the conversation”.

Evidence & Outcomes: Empowering the Profession
Survey of Current Practice Settings

Hospital Based Mental Health
Community Based Mental Health
School System
Hospital – Not mental health specific
Community - Not mental health specific
Educator
Other
Changes to Mental and Behavioral Health – Attitudes and Delivery Systems

FEDERAL ENVIRONMENT
Evolving Goals of Care Delivery

• Triple Aim:
  – Care: Improving the Experience of care
  – Health: Improving the health of populations
  – Cost: Reducing per capita costs of health care

• New Emphasis:
  – Quality
  – Community
  – Prevention
SAMHSA Recovery Model

- SAMHSA has delineated four major dimensions that support a life in recovery:
  - **Health**—overcoming or managing one’s disease(s) or symptoms—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
  - **Home**—having a stable and safe place to live
  - **Purpose**—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
  - **Community**—having relationships and social networks that provide support, friendship, love, and hope
Affordable Care Act and MHPAEAA
Mental Health Parity, Increased Access

• Under ACA newly insured will now have access to mental health benefits.

• Some states are working on innovative mental health programs in Medicaid – traditional and expansion groups.

• New parity laws remove traditional barriers to mental and behavioral health services:
  – Higher copays
  – Prior authorization
  – Visit Limits

• Rules of coverage must be “at parity” with physical health benefits

• **Does not mean that if you** receive OT for physical health rehab you must be able to receive **OT for mental health rehab**
Congressional Focus

- Greater Focus on Mental Health by Washington:
  - 2008 - 1st Mental Health Parity Law - start of HCR debate
  - 2010 - Mental Health Parity in the Affordable Care Act
  - 2011 – DOJ enforcement of Olmstead Settlements
  - 2013 – President’s “Now is the Time” Initiative
  - 2014 – Excellence in Mental Health Act
Congressional Actions – Current Law

- Excellence in Mental Health
- 5% - 10% set-aside of the State Mental Health Block Grant for “the needs of individuals with early serious mental illness”;
- $40 million for Behavioral Health Workforce including Training Grants;
- $50 million for Primary Care Behavioral Health Initiative.
Excellence in Mental Health

- As part of the SGR/TX Cap extension bill, Congress passed the “Excellence in Mental Health”
- 8 state grants, 5 year Medicaid demonstration
- Better $$ to CMHC’s through an enhanced FMAP
- In exchange for:
  - Minimum set of very intensive community-based mental health services
  - Higher provider accountability
- Occupational Therapy included among possible staff
- *Continued talk of expanding past 8 states.*
First Episode Psychosis

- In FY 2014 Congress increased the State Mental Health Block Grants by 5%.
- This increase must be used to address early diagnosis and treatment of serious mental illness.
- Funds must be used for people who have already experienced an episode of serious mental illness.
- States are required to follow federal guidelines for Coordinated Specialty Care (CSC):
  - team leadership;
  - case management;
  - supported employment and education;
  - psychotherapy;
  - family education and support;
  - pharmacotherapy.
- 2016 – additional 5% increase – total of 10% of each state’s block grant must be set aside for these activities.
Behavioral Health Workforce Training Grants - $50 million

- Purpose – to increase behavioral health workforce
- Eligible entities for this program shall include accredited programs that train Master's level:
  - social workers, psychologists, counselors, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals.
- Ensure that funding is distributed relatively equally among the participating health professions
SAMHSA Primary Behavioral Health Care Integration Grants

• Program began in 2009.
• Funded at $50 million for 2016
• Funds projects to coordinate integrated health services;
• Co-locating of primary and specialty care medical services in community-based mental and behavioral health settings;
• Part of increased focus on integrating care for people with mental and behavioral health needs.
Occupational Therapy in Mental Health (HR 1761)

• Introduced this Tuesday by Rep. Paul Tonko (D-NY) and Rep. Mike Kelly (R-PA)

• Would modify 42 Section 254d – National Health Services Corps to read:

  (E)(i) The term “behavioral and mental health professionals” means health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychiatric nurse specialists [strike “and”], psychiatrists, and occupational therapists.

• Occupational therapists would be eligible to participate in the NHSC Scholarship and Loan Repayment Programs.
Why the National Health Services Corp?

1. Would encourage new occupational therapists to practice in mental or behavioral health, in high needs areas, through loan forgiveness.

2. NHSC designation would serve as a guideline for states and other federal programs, when they are defining qualified mental health professionals.
   - Only place in Federal Law where the term “behavioral and mental health professionals” is specifically defined.
Pending Law

CONGRESSIONAL ACTION
Senate action

• Mental Health Reform Act – S 2680
  – Makes some changes to SAMHSA including new evidence-based requirements
  – State Mental Health block grants – includes new focus on community based and early intervention services
  – Strengthens mental health parity requirements
“Mental Health Reform Act” - OT

- Makes occupational therapy higher education programs eligible for Behavioral Health Workforce training grants.
  1) Would help increase OT workforce going into mental health
  2) Includes OT among other MH providers in program of national significance.

Senate may vote on this bill next week
This year, two House bills out of Energy took a broad look at mental health.

- Tim Murphy (R-PA) “Helping Families in Mental Health Crisis”
- Gene Green (D-TX) “Mental Health Recovery and Reform Act”

OT in Mental Health was included in the bill “Mental Health Recovery and Reform Act”.

- Murphy had no opinion on our bill.
- The debate has been quite contentious.
- **House may looking to the Senate for a bi-partisan bill in this Congress**
Next Steps

• Ensure language stays in Senate bill.
• Include OT Provisions in any House bill that moves

• Continue to educate Members of Congress, their staff, and Committees about role of OT in mental health.

• Very positive response to OT’s potential for helping people achieve their recovery goals and maximize independence.
HEALTH INTEGRATION
What is Integrated Care?

“Integrated care is the systematic coordination of general and behavioral health. Integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.”

– SAMHSA-HRSA Center for Integrated Health Solutions
The Problem

- People with mental illness die earlier than the general population and have more co-occurring health conditions.
- 68% of adults with a mental illness have one or more chronic physical conditions.
- More than 1 in 5 adults with mental illness have a co-occurring substance use disorder.
Monthly expenditures for those with and without physical conditions

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Importance of Integrated Care

- Medicaid Population Data
- HHS/CDC Million Hearts Campaign
- Co-occurrence Between Mental Illness and Chronic Health Conditions
The Four Quadrant Clinical Integration Model

(Mauer, 2009)
SAMHSA – PBHCI Initiative

- Purpose of the SAMHSA Primary Behavioral Health Care Integration Initiative (PBHCI)
- Requirements and Expectations
- Data Collection
Data Collection and Outcomes
Success Stories
Discussion

• Occupational Therapy Role in community based integrated care?
• OT in Community based primary and behavioral health care?
  - Diabetes management and psychotropic medication
  - NEW-R: Nutrition and Exercise for Wellness and Recovery (Brown, et. al.)
  - Other?
• What is OT’s distinct value in providing integrated care?
Early Intervention/First Episode Programs
Rapids

Eddy

Distressed

Drop out of Educ’n

Family crisis

Isolated from friends

Suicide attempt

Mental illness

Offending behaviour

PC

Family

Youth worker

Rapids

Drugs

No money

Homeless

No job

Rapids

Family crisis

Isolated from friends

Drop out of Educ’n

Distressed

Suicide attempt

Mental illness

Offending behaviour

Youth worker

PC

Family

No money

No job
What OT does in these models

• Case management
• Assessment
• COTAs as Supported employment or work support
• COTA/OT as education support or liaison
• Skills training
• Engagement in age appropriate and developmentally appropriate activities
  • 1:1, group, etc.
  • Co-occupation.
• Let’s look at EASA fidelity guidelines later!
EASA
early assessment and support alliance

First programs began around 1990

Early psychosis intervention “standard of practice” in Australia, Great Britain, Canada, Scandinavia

BCN created Early Assessment and Support Team (EAST) in 2001 based on Australian guidelines (Early Psychosis Prevention and Intervention Center, Melbourne)

2007 Oregon legislature allocated $4.3 million to disseminate EAST; the Early Assessment and Support Alliance programs began in 2008
MISSION

• Keep young people with the early signs of psychosis on their *normal life paths*, by:
  • Building community awareness and
  • Offering easily accessible, effective treatment and support
    • Network of educated community members & highly skilled clinicians
    • Most current evidence-based practices
Growth and History

• 2007 legislature funded; re-funded in 2009: $4.3 million
• EASA (including EAST) currently available in 32 counties, covering 94% of population.
• Results so far have paralleled EAST’s
• Lane Co. involved in national RAISE study
• Greater Oregon Behavioral Health discussing expansion in Eastern Oregon beyond current sites (Union, Clatsop, Columbia)
• Jefferson and Benton discussing starting programs
• Referrals and enrollment steadily increasing statewide
Core Concepts

- Bringing in evidence-based practices as they develop
- Educated and mobilized community
- PARTNERSHIP!!!
- Assertive engagement
- Shared explanatory model
- Transdisciplinary
- Stress vulnerability model
- Cyclical response
- Transitional
Practice Guideline Elements

- Systemic change
- Prodromal focus
- Community education
- Accessibility
- Assessment and treatment planning
Practice Guideline Elements

- Treatment approach
  - Transdisciplinary team
  - Family partnership
  - Psychoeducation
  - Occupational Therapy
  - Counseling
  - Groups
  - Psychopharmacological
- Transition planning
- Least restrictive environment
- Non-English speaking
- Rural and remote areas
Occupational Therapy: Occupational therapy assessment and intervention supports individuals in maintaining engagement in everyday life to promote recovery. The diverse beliefs and values of the individual and his/her identity are respected in these interventions.

Principles:
“Occupational therapy is founded on an understanding that engaging in occupations structures everyday life and contributes to health and well-being” (American Occupational Therapy Association [AOTA], 2008, p. 628). Occupational therapy assessment and intervention supports individuals experiencing and/or recovering from psychosis and their families in successfully engaging in “desired or needed participation in home, school, workplace, and community life” (AOTA, 2008, p. 629).

“Occupational therapy involves facilitating interactions among the individual, the environments or contexts, and the activities or occupations in order to help the individual reach the desired outcomes that support health and participation in life. Occupational therapy practitioners apply theory, evidence, knowledge, and skills regarding the therapeutic use of occupations to positively affect the individual’s health, well-being, and life satisfaction.” (AOTA, 2008, p. 647).

Criteria/Strategies
11.1. Occupational therapy services are dynamic and evolve in real time along with the individual’s desires and needs.
11.2. The occupational therapist collaborates with the individual, individual’s family/support system, and other clinicians to include information gained through the occupational therapy assessment in the development and implementation of the overall recovery plan.
11.3. The occupational therapist may provide direct intervention services to the individual and his/her family and will provide consultation to other team members when developing educational supports (individual education plans [IEPs] or 504 plans) and determining vocational supports/services.
11.4. Occupational therapy assessment and intervention focuses on the complex relationship of factors influencing the individual’s ability to successfully engage in meaningful occupation. These factors include but are not limited to:
   a. areas of occupation the individual wants, needs, or is expected to engage in (i.e. activities of daily living; instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation);
   b. individual factors (i.e. cultural values, beliefs, and spirituality, mental functions, sensory functions and pain, etc.);
   c. activity demands (i.e. objects and their properties, space demands, social demands, sequence and timing, required actions and performance skills; required body functions);
   d. performance skills (motor and praxis skills, sensory-perceptual skills, emotional regulation skills, cognitive skills, communication and social skills
   e. performance patterns (habits, routines, rituals, roles).
11.5. The occupational therapist places special emphasis on sensory processing and sensory modulation techniques to help the individual to engage in meaningful occupations (Brown, Cromwell, Filion, Dunn, & Tollefson, 2002; Brown & Dunn, 2002; Champagne, Koomar, & Olson, 2010; Dunn, 2001; Kinnealey, Koenig, & Smith, 2011).
11.6. Occupational therapy techniques demonstrate cultural awareness by:
   a. occupational therapists pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision;
   b. occupational therapists seeking knowledge about cultural differences from appropriate individuals;
   c. including interpreters and translations for the preferred language of individuals and their families;
   d. identifying appropriate location of these activities;
   e. use of culturally relevant language and references;
   f. use of accessible communication styles.
Other areas OT is in with EASA

• Groups for families and participants that build problem solving
• Psycho-education
• Illness management and recovery
• Screeners using specialized tools
• Community education
• And many more!
“Transdisciplinary” Team

- Strong family focus
- Collaborative consultation
- Integrative approach
Transdisciplinary Team

- Individual & family
- Lead counselor
  - Takes lead on coordination for individual
  - Individual counseling
- Psychiatrist
- Nurse
- Occupational therapist
- Vocational/educational specialist
- Dual diagnosis
- Peer support/mentoring
Since March 2001

- **Over 1500** served

- **74%** symptom remission or only mild disruption by 1 year

- **91%** maintain strong family support & involvement

- **Consistently reduced** hospitalizations within first year
Preparing for the future....

• Robert Wood Johnson Foundation Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP)
  • 4-year national study looking at people at high risk due to lower level symptoms consistent with psychosis (possibly prodromal)
  • Now in year 3
  • We’ve learned a lot!
    • Lower hospitalization rates; easier to engage; less disability
    • High risk identification still needs refinement
Discussion/Reflection

• How is occupation at the heart of this program?
• What is OT’s distinct value in the provision of these services?
Olmstead Settlements, Consent Decrees, and Systems’ Challenges
At its core, the landmark civil rights case of *Olmstead vs. L.C.* is about occupational justice, occupational performance and occupational participation.
The Supreme Court explained that its holding "reflects two evident judgments."

First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life."

Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

http://www.ada.gov/olmstead/olmstead_about.htm
Olmstead Legal Action

- Nursing Facilities (FL);
- Board and Care Facilities and Adult Care Facilities,
- Mental Health Facilities;
- Institutions for persons with intellectual and developmental disabilities;
- Children (FL);
- Education;
- Sheltered Workshops and segregated day services;
- Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment Services (FL);
- Persons at Risk for Institutionalization (FL);
Typical Olmstead Requirements

- Majority of LTC supports provided in integrated settings
- Community integrated day
- Permanent supportive housing
  - Tenancy, no more than 4 unrelated persons sharing apartment, no more than 25% of units in an apartment building for persons with disabilities
- Employment
- Modify services and service system
Key Olmstead Outcomes

- Cost neutrality
- ↓ nursing home and/or institutional levels of care (workshops, board and care homes, state hospitals, large residential settings).
  - Narrow the front door
  - Rapid return to community
- ↑ community tenure
- ↑ ability to care for health and well-being

- ↑ integrated community participation/involvement
- ↑ social networks
- ↑ safe affordable non-institutional housing
- ↑ employment
- ↑ prevention of disability
- ↑ health
- Improved metabolics
- ↑ access to services, supports, and community participation
- ↑ experience of care/satisfaction

Evidence & Outcomes: Empowering the Profession
Olmstead Settlements – Mental Health Facilities

Illinois’ Consent Decrees and Systems’ Challenges

Williams
Colbert
Ligas
Williams vs. Quinn

- Class Action Law Suit – 4,500 Class Members
- Filed in 2005; Settled in 2010; duration 5 years
- Applies to residents in one of 24 nursing facilities (NF), designated as Institutes of Mental Disease (IMDs), and
- **Adults, diagnosed with a Serious Mental Illness**
Transition all consenting Class Members, by 2016, from the IMDs to the community into Permanent Supportive Housing (PSH):

1. Lease held apartments
2. Full rights of tenancy
3. Services elective (wrap-around) and not a condition to maintain the apartment
4. Affordability through a Bridge Subsidy
Colbert vs. Quinn

• Class Action Law Suit – 17,000 Class Members

• Filed in 2007, Settled in 2011, duration 5 years

• Applies to residents in all non-IMD nursing homes located in Cook County, across disability populations: elderly, physical disability and mental illness
PURPOSE:

- Class Members should have opportunities to receive the full array of supports and services in the most integrated settings appropriate to their needs;

- Promote the development of integrated settings that attempt to maximize individuals’ independence, choice and opportunities to develop and use independent living skills.
“Affords opportunities to live their lives similar to individuals without disabilities”.
Challenges

• Array of housing stock, access (area of preference) and affordability
• Community reintegration and wellness stability
• NIMBYISM and discrimination
• Combating loneliness and isolation
• Inability to take care of basic subsistence needs
• Maintaining good neighbor etiquette
• Co-morbid/complex medical conditions or medication non-compliance
• Illness self-management
Common Chronic Conditions

- Obesity
- Diabetes
- COPD
- Asthma
- Arthritis/chronic pain
- Hypertension
- CHD
- Cancer
- Acquired brain injuries (ABI/TBI)
- Mental illnesses
  - Mood disorders
  - Psychotic disorders
- Substance Use Disorders
Common themes across the Decrees

- Individuals are transitioning from institutional settings to community-based settings and/or their own apartments,
- Individuals have varying:
  ✓ Strengths
  ✓ functional capabilities
  ✓ ADLs and IADLs skill sets
  ✓ insight into their disabilities and/or
  ✓ coping abilities to manage their disabilities
Common themes

✓ Many are moving to the community with limited understanding of independent living expectations.

✓ Many will require specialized assistance and training to support independence.
Immediate Priority Needs for persons diagnosed with SMI

- Comprehensive skills level assessments and functional capabilities
- Introduction to basic skills development techniques
- Reintroduction of formerly learned skills that were dormant due to institutionalization
- Systematic approaches to independent living and illness self-management
Immediate Needs

- Incorporating family members and significant others into the skills development or enhancement processes.
- Promote Class Members to embrace healthy living practices and navigate and socialization outlets

Barbara K. – “I want to learn how to interact with people who do not have a mental illness, but I do not know how and am afraid to do so”.
Williams Issues and Challenges

“As a major part of the November 2015 Implementation Plan (I.P.), the Parties have agreed to language regarding the “Unable to Serve” population. These are Class Members who have said they want to move out of the IMDs and have been assessed as appropriate for community living, but community agencies have concluded that the services they provide are not sufficient to meet the needs of these Class Members.”

Specialized Assessments

For those identified as “unable to serve”

- Neuropsychological assessments for persons who may have severe cognitive impairments or possible dementia.
- Occupational Therapy assessments targeted toward Class Members who may have cognitive impairments and/or possible limited Activities of Daily Living (ADL) skills

Court Monitor Report “the larger question remains whether Class Members who desire are being given full opportunity for community placement.”

Independent Case Reviews

Design (40 individuals)

• Consultant reviews
  – 15 received strength based assessments by experts external to Illinois

• Permanency board
  – 30 received interdisciplinary chart reviews
  – Membership: psychiatrist, nurse, certified recovery support specialist, occupational therapist, social worker, psychologist
Service Enhancements

• In-Home Recovery Supports (certified recovery support specialists)
• Enhanced Skills Training and Assistance (occupational therapy practitioners)
• Integrated care (advanced practice nurses)
• Supported Employment

Note: Culture change is a significant issue for all of these services, except for the advance practice nurses.
Narrowing the Front Door – Choice and Community Alternatives

• Requirement that by July 1, 2016 all people seeking admission to an IMD will be offered alternative community services and housing.

• 4-month pilot initiative targeting two acute care hospitals in Chicago that have had historically high levels of referrals to IMDs;
  – DMH will establish an interim position of Transition Coordinator to work with hospital personnel toward the goal of offering community alternatives to potential IMD admissions.

• State will (by June 2016) develop a concrete plan intended to redirect interested persons to community-based services in lieu of any form of long term care (LTC).
  – convene a cross-agency group to examine the multiple issues involved and also involve necessary community stakeholders.
Williams Community Tenure

- Nearly 50% of Class Members (524 total) who have transitioned to the community have now lived in a community setting for over 690 days (1.9 years).
- Another 21% are between the 1 year and 1.9 year mark.
- The overall percentage of persons who remain continuously in the community remains above 85%, evidence of significant success for transitioning class members.

Discussion/Reflection

- How is occupation at the heart of Olmstead?
- What is Occupational Therapy’s distinct value in promoting the goals of Olmstead, as well as ensuring that the requirements of Olmstead are met?
Certified Community Behavioral Health Centers

Opportunity for Occupational Therapy

December 9th, 2015

Prepared for
The American Occupational Therapy Association

HealthManagement.com
CCBHC OVERVIEW
What is a CCBHC?

- A well-funded, coordinated, fully integrated comprehensive community-based provider of culturally and linguistically competent services that serves anyone, of any age, with a BH challenge while focusing on the needs of people with SED, SPMI and chronic SUD.

- An always available single point of access and accountability for any member of the community who needs substance use or mental health treatment and support.
Impact of CCBHC

“This is a game changer”

CMHCs have struggled for decades to offer comprehensive care. CCBHCs represent an opportunity to:

• Establish a behavioral health safety net
• Integrate and coordinate care for mental health, substance abuse, and primary care
• Promote access to improve care via standards for quality and accessibility
• Expand care coordination for all
April, 2014: PAMA signed into law
May-August, 2015: States respond to CCBHC Planning Grant RFP
October, 2015: states selected to receive planning grants
October 2015: October 2016--Planning Grant Phase
October, 2016: states apply for Demonstration Grant
State Awardees:
Minimum Standards

• The Act establishes standards in six areas that an organization must meet to achieve CCBHC designation
  – Staffing
  – Accessibility
  – Care coordination
  – Service scope
  – Quality/reporting
  – Organizational authority
Staffing Standards

• Diverse backgrounds
  – Psychiatrist Medical Director
  – Psychiatric Nurse
  – Credentialed Substance Abuse Counselor
  – MH professional who can perform psychological testing
  – Case management and family support staff
  – Peer specialist/recovery coach
  – **Optional**: LCSW, LMHC, Psychologist, LMFT, OT
Federal Match for States

• Federal Match (FMAP) follows beneficiary eligibility:
  – Regular Medicaid: Enhanced FMAP
  – Expansion population: 100% now, down to 90% by 2020
  – Medicaid CHIP Expansion: Enhanced FMAP +23%
  – Served by Indian Health Services Clinics: 100%

• **State plan authority not necessary for payment** for CCBHC services delivered by certified clinics

• Prospective Payment System Means no FFS
What’s Next?

• AOTA is supporting these 24 state associations in advocating for the inclusion of OT in each of the state’s CCBHC plan.

• CCBHC Ambassadors in each of these states

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ROLE OF OCCUPATIONAL THERAPY IN CCBHC
Service Scope Standards

• Crisis services
• Screening, assessment and diagnosis, including risk assessment
  – Direct provision for behavioral health conditions (updated monthly)
    • Assessment includes comprehensive social services needs
  – “Formal arrangements” are permitted for specialized screening
• Patient-centered treatment planning
  – Includes consumer
  – Family of child/adolescent consumer
  – Adult consumer’s family per consumer’s preference
Service Scope Standards (cont.)

• Evidence based/informed outpatient mental health and substance use services
  – Individual, group and family therapies
    • First episode psychosis
    • Motivational interviewing
    • Youth services (including youth in foster care)
  – Medication evaluation and management
  – Intensive services
  – Prevention services
Service Scope Standards (cont)

• Primary care screening and monitoring of key health indicators and health risk
  – At a minimum, BMI and blood pressure at intake and annually (directly by the CCBHC)
  – Either directly or through formal arrangement the CCBHC must assure that key screenings are done and follow up

• Targeted case management
  – Up to and including ACT

• Psychiatric rehabilitation services
  – Psychoeducation
  – Personal care and ADL
  – Supported housing
  – Supported education
  – Supported employment
Service Scope Standards (cont)

• Peer support and family support
  – Family psychoeducation
  – Parent training
  – Family-to-family

• Services specifically targeted at veterans and members of the armed services
  – Military cultural competence
  – Coordination with TRICARE
  – Coordination with VA
### OT can contribute to many CCBHC goals:

<table>
<thead>
<tr>
<th>Span the gap between CCBHC Services and Daily Living:</th>
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<tbody>
<tr>
<td>• Facilitate the development of day-to-day independent living skills for those with SMI</td>
</tr>
<tr>
<td>• Teach compensatory strategies that mitigate the impact of mental illness</td>
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<tr>
<td>• Help people with serious BH challenges translate coping skills into daily lives</td>
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<tr>
<td>• Reduce the symptoms of mental illness by engaging in healthy roles and routines</td>
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<table>
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<tr>
<th>Promote emotional wellness by enhancing people’s skills and competencies</th>
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</thead>
<tbody>
<tr>
<td>Address the physical, cognitive, and sensory functioning of people with chronic behavioral health challenges</td>
</tr>
<tr>
<td>Promote health and wellness through the use of everyday activities</td>
</tr>
<tr>
<td>Help people improve critical reasoning skills</td>
</tr>
<tr>
<td>Address the social determinants of health</td>
</tr>
<tr>
<td>Span the boundary between behavioral and medical fields</td>
</tr>
</tbody>
</table>

*Help people identify and achieve outcomes that are important to them*
Group Discussion

• Think about your current practice setting, how can you bring these specific concepts into where you work and who you currently work with?
  – Integration of physical and mental health
  – Early Intervention for serious mental illness
  – Community first

• How can these concepts inform your current practice?

• What are your action steps to incorporate them into your work?

Think of it as doing a SWOT analysis and report out on what steps you could take.
Integration

• For questions about the PBHCI program contact:

• Roxanne Castaneda MS OTR/L
• Public Health Advisor, SAMHSA, Center for Mental Health Services

• Roxanne.Castaneda@samhsa.hhs.gov (preferred)
• 240-276-1917

• SAMHSA/HRSA Center for Integrated Health Solutions:
• http://www.integration.samhsa.gov/
Websites/Programs and their manuals/resources

• RAISE study and project
  • NAVIGATE manual
  – http://navigateconsultants.org/
  – http://raiseetp.org/

• Early Assessment and Support Alliance, Oregon
  – http://easacommunity.org/
  • EASA Fidelity guidelines
  • School Professionals and Teachers resource
    – http://easacommunity.org/featured-resources.html

• http://www.schizophrenia.com/earlypsychosis.htm#
• Australia’s youth and EI/FEP resources

• United Kingdom
  –  http://www.iris-initiative.org.uk/iris/

• Portland Maine and the PIER model
  –  http://www.piertraining.com/
  –  PIER Occupational Therapist
    •  http://www.piertraining.com/about-us/faculty/donna-downing/

• Foundation for Excellence in Mental Health Care
  –  http://www.mentalhealthexcellence.org/
  –  Early intervention programs resource list
Article Links


Websites for Teens/Youth/Young Adults

- www.strongmindsproject.org
- http://partners4strongminds.org/
- http://www.youthmovenational.org/
Resources - Olmstead

- Department of Justice: Civil Rights Division- Olmstead
  - [http://www.ada.gov/olmstead/index.htm](http://www.ada.gov/olmstead/index.htm)
- Olmstead Enforcement by State
  - [http://www.ada.gov/olmstead/olmstead_enforcement.htm](http://www.ada.gov/olmstead/olmstead_enforcement.htm)
- Settlements by issue type
  - [http://www.ada.gov/olmstead/olmstead_cases_by_issue.htm](http://www.ada.gov/olmstead/olmstead_cases_by_issue.htm)
CCBHC information

- The Substance Abuse and Mental Health Services Administration recently posted materials to support the state planning grant process including CCBHC criteria, Certification Resources and Guides, and other resources at: http://www.samhsa.gov/section-223
- The Center for Medicare and Medicaid Services (CMS) has posted resources, specific to Financing and Reimbursement here: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html
- The National Council for Behavioral Health published a Toolkit for State Planning grant Applicants that includes further detail http://www.thenationalcouncil.org/topics-a-z/state-planning-grant-toolkit/
Resources – Making the Point

• **AOTA Official Document:**
  Specialized Knowledge and Skills: Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice:

• **AJOT Systematic Reviews of the Evidence:**
  OT interventions for Employment and Education for Adults with Serious Mental Illness:
  [http://dx.doi.org/10.5014/ajot.2011.001289](http://dx.doi.org/10.5014/ajot.2011.001289)

  OT Interventions for Recovery in the Areas of Community Integration and Normative Life Roles for Adults with Serious Mental Illness:
  [http://dx.doi.org/10.5014/ajot.2011.001297](http://dx.doi.org/10.5014/ajot.2011.001297)

  Systematic review of occupational therapy and mental health promotion, prevention, and intervention for children and youth:
  [http://dx.doi.org/10.5014/ajot.2013.008359](http://dx.doi.org/10.5014/ajot.2013.008359)

• **Evidence Based Practice Guideline**
Policy Resources

• Legislative Action Center:
  – www.aota.org/takeaction

• AOTA Federal Policy Blog:

• Congressional Affairs:
  – www.aota.org/Advocacy-Policy/Congressional-Affairs