Ohio Community-based Comprehensive Behavioral Healthcare Model Request for Information (RFI) #52

Request for Information Issued: April 19, 2024

Submit your response to this RFI via email to: BHWI@mha.ohio.gov by May 31, 2024, at 5:00 p.m.

1. **Request for Information:**

Background:

Since the beginning of his administration, Governor Mike DeWine has prioritized the health and well-being of Ohioans, making historic and meaningful investments in strengthening Ohio's behavioral health infrastructure, workforce, and services for citizens of all ages. In alignment with the administration's priorities, and in partnership with the Ohio Department of Medicaid (ODM), the Ohio Department of Mental Health and Addiction Services (OhioMHAS) is seeking responses from nonprofit entities certified by OhioMHAS for both community mental health and community addiction services to help inform Ohio's approach to develop and implement a community-based, comprehensive behavioral healthcare model (hereafter referred to as "Ohio's model"). OhioMHAS is interested in receiving responses from providers that have experience implementing behavioral healthcare delivery consistent with the core principles of the federal Certified Community Behavioral Health Clinic (CCBHC) model, including coordinated, person-centered care with a comprehensive service array that integrates mental health, substance use disorder treatment services, and primary care. Using the federal CCBHC model as a framework, Ohio's model will be developed to align with current needs and priorities, with careful consideration of Ohio's existing and future services and delivery systems. More information about the federal CCBHC model can be found at https://www.samhsa.gov/certified-community-behavioral-health-clinics.

In March 2023, Ohio was one of 15 states to receive the CCBHC Planning Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). During the planning grant period, Ohio conducted extensive stakeholder engagement to gather feedback from a wide array of stakeholders, including behavioral health providers, advocacy organizations, state agencies, persons with lived experience, and veterans. Two committees and five sub-committees were formed to discuss the federal CCBHC model and gather feedback on its design components. Provider organizations that are current or past SAMHSA grantees were also engaged in discussion to understand operational best practices. In addition, OhioMHAS and ODM met regularly to work through policy considerations in the federal model, analyze stakeholder feedback, and identify alignment with other parallel initiatives. In light of learnings from stakeholder feedback and interagency policy work, Ohio made

the decision not to apply for the SAMHSA CCBHC Demonstration in 2024, but Ohio is committed to continue work to develop a plan to build and implement Ohio's model in the future.

The ongoing work to develop Ohio's model will be led by OhioMHAS and ODM in collaboration with stakeholders. The information collected through this RFI will be used by OhioMHAS and ODM to better understand the current landscape of community-based comprehensive behavioral healthcare in Ohio. By responding to this RFI, providers will indicate future interest in working with OhioMHAS and ODM by providing the requested information, which will be utilized in the development of Ohio's model. However, responding to this RFI does not guarantee that your organization will be selected to participate in Ohio's model in the future, as no funds will be awarded as a result of this RFI.

Respondents to this RFI may be invited to participate in future activities related to the development of Ohio's model, including cost report activities, implementation, operations, and readiness. Working sessions may focus on topics such as implementing care coordination, operationalizing evidence-based practices (EBPs), and training to support practice transformation.

The first activity to occur subsequent to this RFI process will be collecting cost reports and supporting financial information from RFI respondents about provider expenses and revenues. The cost report process is intended to be educational, informative, and collaborative for the respondents and will help provide OhioMHAS and ODM with important information necessary to develop a sustainable financing approach to support Ohio's model. To begin cost reporting efforts, an initial cost report will be collected in summer of 2024 (dates to be determined). The initial cost report will be developed using the Centers for Medicare and Medicaid Services (CMS) federal CCBHC template as a framework. The intent of the initial cost report will include educating providers on cost reporting and collecting readily available data and information to support state decision-making, such as staffing-related costs and CCBHC versus non-CCBHC expenses. Support for respondents will be provided through detailed instructions, training sessions, a dedicated email inbox, FAQs, a cost report observation process, and technical assistance. A full cost report is anticipated to be collected in 2025 once the Ohio model has been finalized. The full cost report will include all applicable information necessary to support the payment model and state/federal oversight on an ongoing basis.

Respondent Qualifications:

To be eligible to respond to this RFI, your organization must:

A. Be a nonprofit organization, exempt from tax under Section 501(c)(3).
B. Be certified by OhioMHAS as both a community mental health services provider and community addiction services provider and be certified and in good standing with OhioMHAS for the following four services:
    1. General Services as defined in OAC Section 5122-29-03 – your organization must provide both Mental Health (MH) and Substance Use Disorder (SUD) services covered under General Services.
    2. Community Psychiatric Supportive Treatment as defined in OAC Section 5122-29-17.
    3. Therapeutic Behavioral Service and Psychosocial Rehabilitation as defined in OAC Section 5122-29-18.

4. SUD Case Management as defined in OAC Section 5122-29-13.

C. Be enrolled with ODM as both a Medicaid provider type 84 (community mental health agency) and 95 (community substance use disorder treatment agency).

2. **Questions, Technical Assistance, and Updates:**

Questions may be sent to: BHWI@mha.ohio.gov no later than May 3, 2024, at 5:00 p.m.

3. **Request for Information (RFI) Response Content**:

Please send an e-mail to BHWI@mha.ohio.gov if your organization has experience in implementing community-based comprehensive behavioral healthcare models (i.e. CCBHC or CCBHC-like models) and is interested in participating in future activities related to the development of Ohio's model, including implementation, operations, and readiness. In the email, please include an attachment with responses to the following questions. (Please follow the exact sequence of questions/prompts):

Overview
Please provide:

1. Organization name;
2. Organization primary business office address;
3. Contact information for Executive Director/Chief Executive Officer or designee;
4. Organizational structure including Medicaid provider types in addition to community mental health agency (provider type 84) and community substance use disorder agency (provider type 95), sites/service locations, and lines of business.

Please indicate:

5. If your organization is designated as a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), or FQHC look-alike;
6. If your organization is part of a hospital or health system;
7. If your organization is or was a recipient of a SAMHSA CCBHC grant. If so, indicate for which years.

8. Services

#	Location Address	Medicaid Provider ID	Medicaid NPI	Was this site ever a SAMHSA CCBHC grant site?	Is this site an FQHC, RHC, or FQHC look-alike?	Mental Health services provided *(Please list)*	Substance Use Disorder (SUD) services provided *(Please list)*	Physical health services provided *(Please list)*	Population Served (e.g., youth, adults, etc.)
1									
2									
3									

Specify the counties that you serve and provide physical location address or addresses where you provide care. Please fill out the table below to specify if any locations are designated as a FQHC/RHC/FQHC look-alike, provide physical health services and whether you have a partnership with another provider for provision of behavioral health or physical health services. Add additional rows, as needed.

9. Please discuss how your organization provides, either directly or through collaboration, the below listed services. (Please note some of these are the CCBHC core services and may not directly correlate with behavioral health services certified by OhioMHAS and/or currently distinctly covered by ODM).

    a. <u>Screening, Assessment, and Diagnosis:</u>
        i. Please list any standardized or custom screening, assessment, and diagnosis tools, including level of care tools, used to assess for level of acuity throughout services including, but not limited to, suicide risk, overdose risk, risk of violence, substance use, substance intoxication and withdrawal risk, cognitive impairment, physical health, and mental health needs. (For example, currently on the SUD side, providers are required to use ASAM. For mental health, examples may include LOCUS or PHQ-9).

Tool Name	Yes/No	Population Used For	Information Storage Location	Additional Information
American Society of Addiction Medicine (ASAM) Adult Criteria Intake Assessment Form				
Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS)				
Level of Care Utilization System (LOCUS)/Child and Adolescent Level of Care Utilization System (CALOCUS)				
Patient Health Questionnaire (PHQ-9)				
Screening, Brief Intervention and Referral for Treatment (SBIRT)				
Time to Services (I-SERV)				
Depression Remission at Six Months (DEP-REM-6)				
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)				
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)				
Screening for Social Drivers of Health (SDOH)				
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)				
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)				
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)				

Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)				
Controlling High Blood Pressure (CBP-AD)				
Custom or Other Tools (Please Specify)				

ii. If willing to share, please include any custom tools as an attachment.

b. Evidence Based Practices and Prevention

i. In the table below, please select whether or not your organization utilizes the given EBP. If there are other, not listed, EBPs that your organization uses, please list and specify the name of the EBP. If there is a specific medication or long-acting injectable, please specify in the "Additional Information" column.

EBP	Yes/No	Additional Information
Motivational Interviewing		
Cognitive Behavioral Therapy (CBT)		
Dialectical Behavior Therapy (DBT)		
Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)		
Seeking Safety		
Assertive Community Treatment (ACT)		
Forensic Assertive Community Treatment (FACT)		
Long-acting injectable medications to treat both mental and substance use disorders		
Multi-Systemic Therapy, Functional Family Therapy (FFT), and/or Intensive Home-Based Treatment (IHBT)		
Cognitive Behavioral Therapy for psychosis (CBTp)		
High-Fidelity Wraparound		
Parent Management Training		
Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation		
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)		
Other – please specify		

ii. What prevention practices is the organization currently engaged in providing?

c. Person-Centered and Family-Centered Treatment Planning:

i. Describe how individualized treatment plans are developed for persons served.

ii. Please specify if your organization develops plans in collaboration with the person receiving services and their significant other(s) (which may include people who are not in the traditional definition of family) and any strategies for enhancing engagement.
iii. Please provide a sample of a person-and/or family-centered treatment plan. Please redact any identifying patient information in the sample treatment plan.
iv. Treatment planning is not a distinctly billable Medicaid service. Please describe how your organization uses the existing billing infrastructure and/or other funding sources to account for staff time spent on treatment planning.

d. Peer Supports, Peer Counseling, and Family/Caregiver Supports:
   i. Describe the services and supports that are provided by those who are Certified Adult, Youth, or Family Peer Supporters under OAC Section 5122-29-15.1. (Services must be provided in accordance with the OhioMHAS peer support service as defined in OAC Section 5122-29-15 and certified by OhioMHAS.)
   ii. Please include any services offered through a partnership with another organization that provides peer support services as described above.

e. Targeted Case Management (TCM) Services:
   i. How do you determine who receives more intensive case management? For this question, please refer to the Appendix for a definition of TCM Services.
   ii. What funding sources are used for intensive case management? Does the provider use existing Medicaid billing infrastructure? If so, which codes? What other sources are used? (See the Appendix for a definition of "Targeted Case Management")

f. Psychiatric Rehabilitation Services (PRS):
   i. Please describe how you are providing PRS services, as defined in the Appendix: Terms and Definitions of this RFI. Please note, this definition includes a broad range of service activities that may include components of existing services such as Community Psychiatric Supportive Treatment (CPST), Therapeutic Behavioral Service (TBS), and Psychosocial Rehabilitation (PSR).
   ii. How do you use existing Medicaid billing infrastructure to provide PRS today? Include a description of who receives PRS and the criteria used.

g. Outpatient Clinic Primary Care Screening & Monitoring:
   i. In addition to the information provided in the above services table, is there anything you would like to share regarding how you provide outpatient primary care screening and monitoring services? Or the provision of other physical health services?
   ii. Are there any screenings that you conduct that you did not include in the list regarding screening and assessment tools?
   iii. Can you describe how you coordinate with other providers to address physical health needs?

iv. Please describe how you provide comprehensive care coordination with other providers to address physical health needs outside of screening and monitoring.
v. In addition to the services listed above, are you providing any additional physical health services? If so, how?

h. Crisis Behavioral Health Services:
    i. Include a description of how your organization supports the safety and wellness of people seeking services during a mental health and/or substance use crisis.
    ii. Are you a 988- call center? If not, please describe how you collaborate with the 988-call center for your community.
    iii. Please provide more details as requested below:
        1. Are you involved with 988? If so, how?
        2. Do you provide mobile crisis response? If so, how and what hours are you operating?
        3. Do you provide crisis receiving/stabilization services that include at a minimum, urgent care/walk-in mental health and substance use disorder services? If so, how and what hours are you operating?
        4. Please describe how you ensure follow-up and continuity of care after resolution of a crisis event in a timely manner.

i. Intensive, Community-Based Behavioral Healthcare for Members of the Armed Forces and Veterans:
    i. Describe how veteran status is identified screened and documented, and if any coordination is pursued. Include a description of how you assure coordination of care with the veteran's network of health care providers to reduce or eliminate any potential for conflict or duplication.
    ii. Please describe how your organization provides services when a veteran needs or elects to receive services. Note that the care provided to veterans is required to be consistent with the minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of the VHA.

Population Served

10. Please describe the population your organization typically serves.
11. Describe the current demographic breakdown of population served (including but not limited to race, ethnicity, other demographic information, diagnosis breakdown, developmental disability, rural, etc.).
12. Describe your organization's understanding of the populations being served including health disparities and inequities present within these populations.
13. Describe outreach methods you use to effectively reach specific populations.
14. Describe how you strive to ensure equity in access and outcomes within your organization.

Integrated Care

15. Please specify how integrated care is implemented at your organization. For purposes of this question, integrated care means mental health, substance use disorder, and primary care or other physical health.
16. Please list any local, state, or federal grants your organization has received to implement integrated care models (MH, SUD, and/or primary care/BH).

Implementation

17. If available, please provide any existing documentation of process or workflow at your organization. This would include information on how a client moves through the intake, screening, assessment, treatment planning, intervention, reassessment, discharge/termination etc. Please include any information on flags or indicators used for follow-up.
18. Describe your existing care coordination and service partnerships and how you are utilizing those effectively with your care coordination activities. Partnerships would include entities that provide medical services, social supports, managed care plans, and other services that impact the individual's health, safety, and welfare.
19. The State expects that EBPs are used to align to the needs of the population served. Please list the EBPs your organization is using or planning to adopt.
20. Please describe any provider partnerships you have to provide any of the above core CCBHC services. If so, please indicate which services. Please describe how you formalize the partnership (e.g., MOUs, etc.)? Do you have a contract for a non OhioMHAS certified entity for CPST in accordance with OAC 5122-29-17? How do you provide oversight or ensure quality of care in partnership arrangements?
21. Any respondent that has a contractual relationship with any or all of Ohio's Boards of Alcohol, Drug Addiction, and Mental Health Services (ADAMHS Boards) as defined in Ohio Revised Code chapter 340, please indicate which if any ADAMHS Boards you have consulted with about pursuit of implementation of community-based comprehensive behavioral healthcare model, such as CCBHC or similar models.

Staffing and Training

1. Describe your organization's current staffing plan. What does a person-centered, integrated care staffing plan look like?
    - Please include how it supports integrated care for individuals with co-occurring SUD and MH disorders. How many staff (excluding QBHS and peers) in the organization have dual scopes of practice to address individuals with co-occurring MH and SUD treatments?
    - How do you use non-clinical staff to support administrative needs in your practice?
2. Describe how the organization's staffing plan is reflective of populations served.
3. Describe ways that your organization is prioritizing and operationalizing cultural humility.
4. Does your staff receive training specific to diversity, equity, and inclusion?
5. Describe how your organization has implemented a culture of trauma-informed care through all levels of staffing.
6. Describe your organization's process for onboarding new staff. How long does it take to onboard staff? When do they start providing billable services?

Data

7. If you are collecting, monitoring, and using any of the federal CCBHC clinic collected measures, please describe how they are captured and used, if applicable. If there are other measures that your organization is using, please describe them as well.
8. Describe your organization's electronic health record (EHR) capability and health information exchange (HIE) integrations (or plans) to support care coordination.
9. Please answer the following questions regarding your EHR system and vendor:
    a. What is the name of your organization's EHR vendor?
    b. What is the name of the software?
    c. How long has your organization been using it?
    d. Does your organization's EHR allow enhancements?
    e. How timely is your vendor at releasing upgrades?
    f. How responsive are they to customization requests?
10. Please answer the following questions regarding connectivity to HIE:
    a. Does your organization have the ability to communicate bidirectionally with other healthcare entities externally through HIE?
    b. Which of Ohio's HIE entities is your organization using: CliniSync or The Health Collaborative?
    c. How long has your organization been using it?
    d. Is your organization able to share health records with external providers for purposes of care coordination?
    e. What are barriers to communication?
    f. What are other methods your organization uses to communicate?
11. How does your organization demonstrate oversight of quality of care and ensure continuous quality improvement?

Attachments

Before submitting your response, please ensure you have attached the following materials:

- Required Attachments
    - OhioMHAS Certifications
    - Sample Person- and/or Family-Centered Treatment Plan (redacted)
- Optional Attachments, if available:
    - Community Needs Assessment
    - Workflow/process documents
    - Custom Screening, Assessment, and Diagnosis Tools

Appendix: Terms and Definitions

Term	Description
Behavioral Health	Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders.
Care Coordination	Care coordination applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each person receiving services as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.
Community Needs Assessment	A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served.
Community Psychiatric Supportive Treatment (CPST)	Services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents, and families and will vary with respect to hours, type, and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.
Cooccurring Mental and Substance Disorders (COD)	Co-occurring disorders may include any combination of two or more substance use disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR).
Crisis Response	A quality crisis services system provides needed assistance to Ohioans and their families before an emergency occurs, rapidly responds to and stabilizes the person while they are in crisis and makes strong connections to community-based treatment services and needed supports after a crisis occurs.
Cultural Humility	Cultural humility is active engagement in an ongoing process of self-reflection, in which individuals seek to: • Examine their personal history/background and social position related to gender, ethnicity, socio-economic status, profession,

	education, assumptions, values, beliefs, biases, and culture, and how these factors impact interpersonal interactions. • Reflect on how interpersonal interactions and relationships are impacted by the history, biases, norms, perception, and relative position of power of one's professional organization. • Gain deeper realization, understanding, and respect of cultural differences through active inquiry, reflection, reflexivity, openness to establishing power-balanced relationships, and appreciation of another person's/community's/population's expertise on the social and cultural context of their own lives (lived experience) and contributions to public health and wellbeing. • Recognize areas in which they do not have all the relevant experience and expertise and demonstrate a nonjudgmental willingness to learn from a person/community/population about their experiences and practices.
Electronic Health Record (EHR)	EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.
Family-Centered	The Health Resources and Services Administration defines family-centered care, sometimes referred to as "family-focused care," as "an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals.
Peer/Family/Caregiver Support	A person who uses their lived experience of recovery from mental or substance use disorders or as a family member/caregiver of such a person, plus skills learned in formal training, to deliver services to promote recovery and resiliency.
Person-Centered Care	"Person-centered planning (care)" is a process directed by the person with service needs which identifies recovery goals, objectives, and strategies.
Practitioner or Provider	Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).
Psychiatric Rehabilitation Services (PRS)	PRS includes evidence-based rehabilitation services provided for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment.

	Psychiatric rehabilitation services must also support people receiving services to: participate in supported education and other educational services; achieve social inclusion and community connectedness; participate in medication education, self-management, and/or individual and family/caregiver psychoeducation; and find and maintain safe and stable housing.
Targeted Case Management (TCM)	Targeted case management services assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC targeted case management should also be used accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition.
Therapeutic Behavioral Service (TBS) and Psychosocial Rehabilitation (PSR)	An array of activities intended to provide individualized supports or care coordination of healthcare, behavioral healthcare, and non-healthcare services. TBS and PSR may involve collateral contacts and may be delivered in all settings that meet the needs of the individual.
Trauma-Informed	A trauma-informed approach to care realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in people receiving services, their families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[6] Trauma-Informed Care (TCC) is an approach that explicitly acknowledges the role trauma plays in people's lives. TCC means that every part of an organization or program understands the impact of trauma on the individuals they serve and adopts a culture that considers and addresses this impact.