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Delaware Needs Assessment

Part One: Foundation

The Needs Assessment Structure

The Story Being Told

1. An introduction and executive summary
2. Description of the Delaware behavioral health system.
3. Elements of a high functioning system of care.
4. Description of the key demographics of Delaware's population and each of the counties.
5. Behavioral health prevalence data.
6. Data regarding other contributing factors including social risk and health factors; insurance rates; employment; housing; and graduation.

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The Needs Assessment Structure

The Story Being Told

7. Review of staffing and workforce challenges and opportunities.
8. Identify gaps, unmet needs, and underserved populations.
9. Input from people with lived experience.
10. Strengths, weaknesses, opportunities and threats (SWOT) analysis of the system.
11. Conclusions by making connections between the information to establish decision points and best next steps to improve the system and implement CCBHC.
12. Recommendations and next steps with strategic questions to support leadership in making next step decisions.

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The Needs Assessment Intends To Provide:

- Information to further the design and implementation of the Delaware CCBHC model and to support a county and provider level needs assessments.
- Data to understand all the various populations in Delaware
- A full review of the behavioral health system
- A common understanding of the system and its strengths and challenges to implement a CCBHC model.
- An inventory of the funding mechanisms and resources and mechanisms with highlights of potential improvements for simplification and maximization of resources.
- Opportunities for using the CCBHC framework to address the challenges and improve treatment.

Overall Additional Context

- Attempting to “paint a picture” not make definitive statements about the system.
- There is a lot of data and some can seem contradictory at times
- We are considering what we heard from the providers about their challenges during the CCBHC planning year.
- We are identifying county level info where we can find it
- There are reasons things have evolved they way they have in current design and need to be considered in future design.

The Resources for the Following Slides

Elements of a High Functioning System

- How to Transform the U.S. Mental Health System: Rand
- Policy Issues and Statements: Mental Health America
- Certified Community Behavioral Health Clinic - criteria March 2023
- NAMI_2022_State_Legislation_Report.pdf

National Data

- 2021-2022 NSDUH: Model-Based Estimated Prevalence for States | CBHSQ Data (samhsa.gov)
- https://www.americashealthrankings.org/explore/measures/CHC/DE
- Mental Health America | Homepage | Mental Health America (mhanational.org)
- State-level Data for Understanding Child Welfare in the United States - Child Trends – ChildTrends
- https://www.kff.org/
- 2022 Child and Adult Health Care Quality Measures Quality (medicaid.gov).

MCO Scorecard

- Health Plans - NCQA

Core Data Set and CCBHC State Required Measures

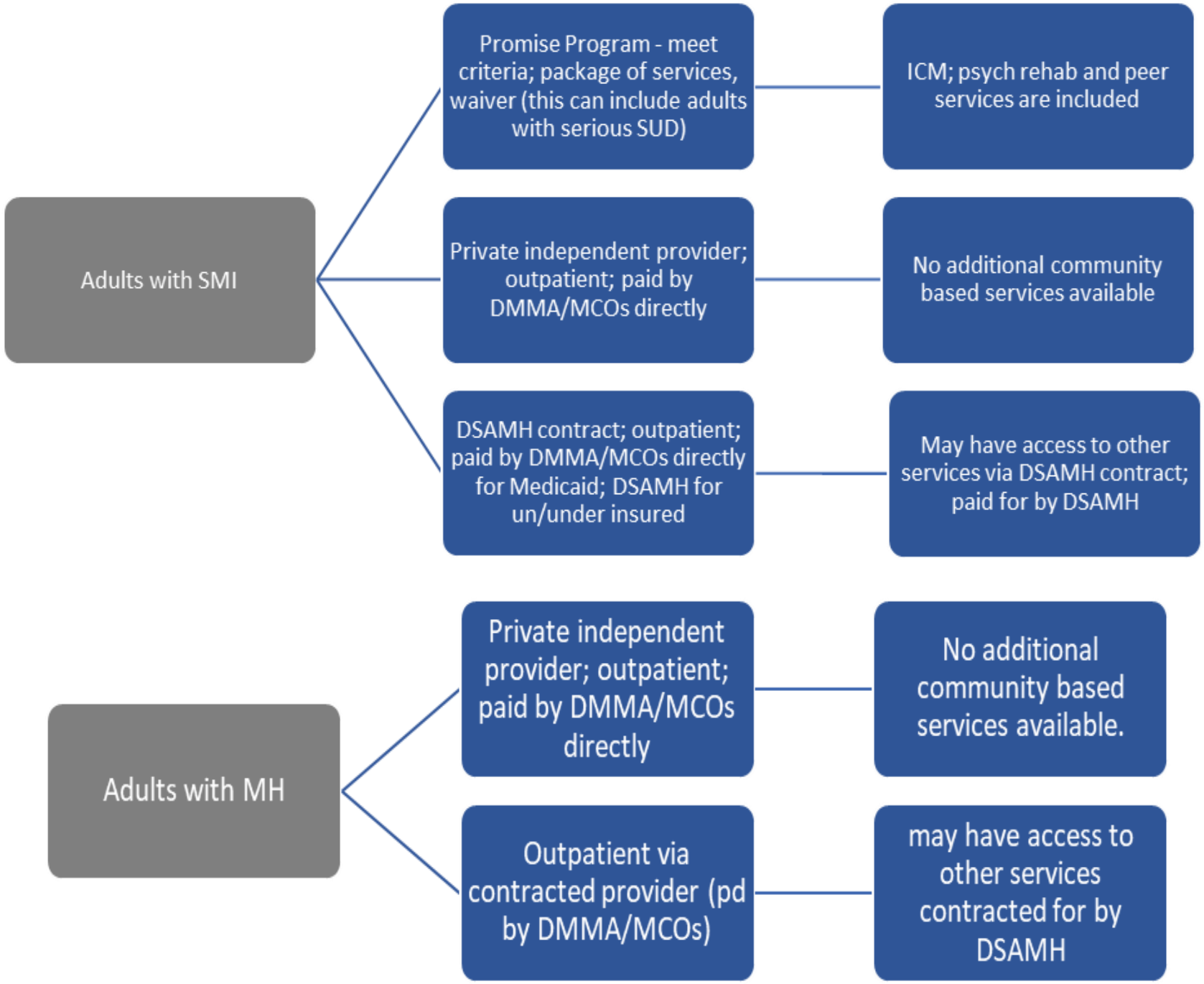
- 2022 Child and Adult Health Care Quality Measures Quality (medicaid.gov).
- ccbhc-criteria-2023 (1).pdf

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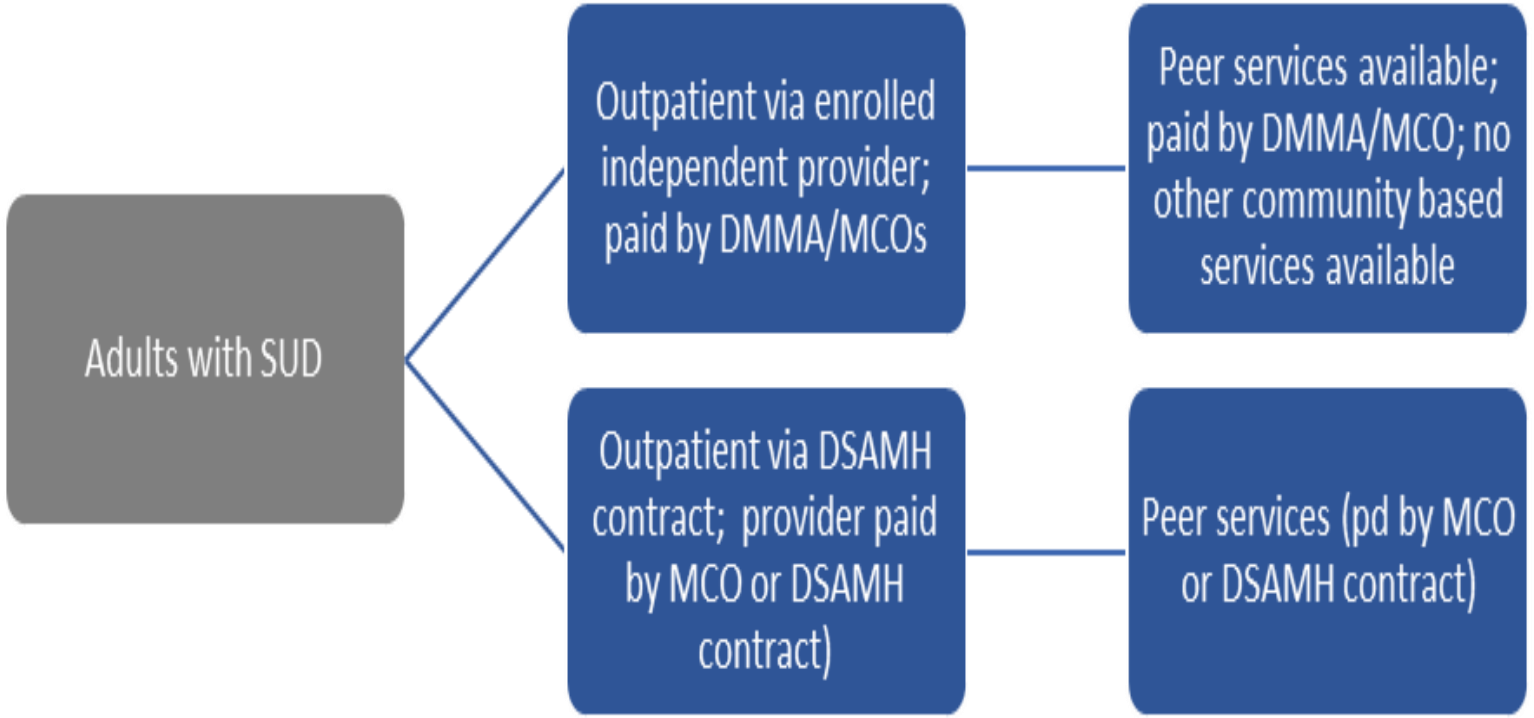
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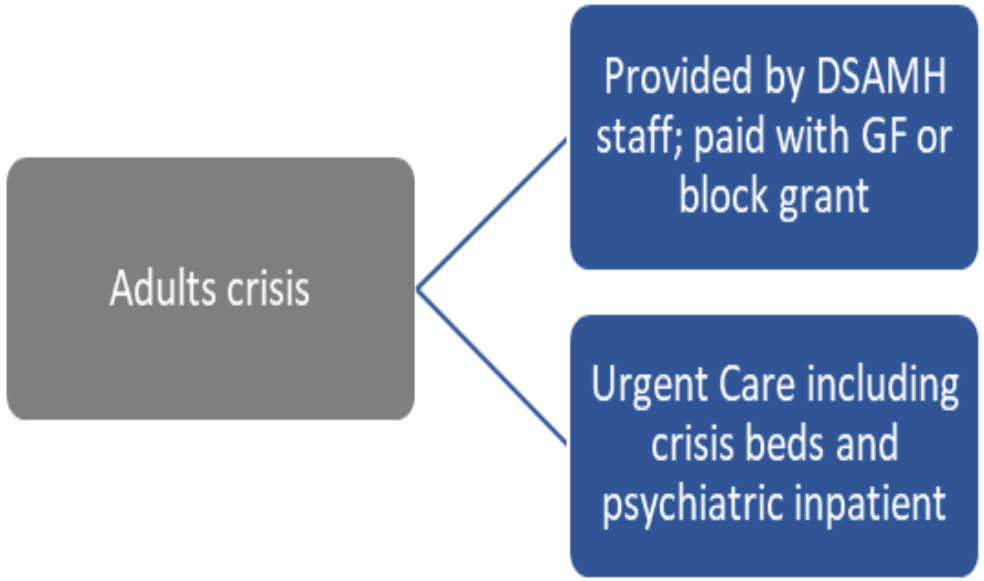
The Current DE Behavioral Health System*

*All information on current system is a draft and work in progress



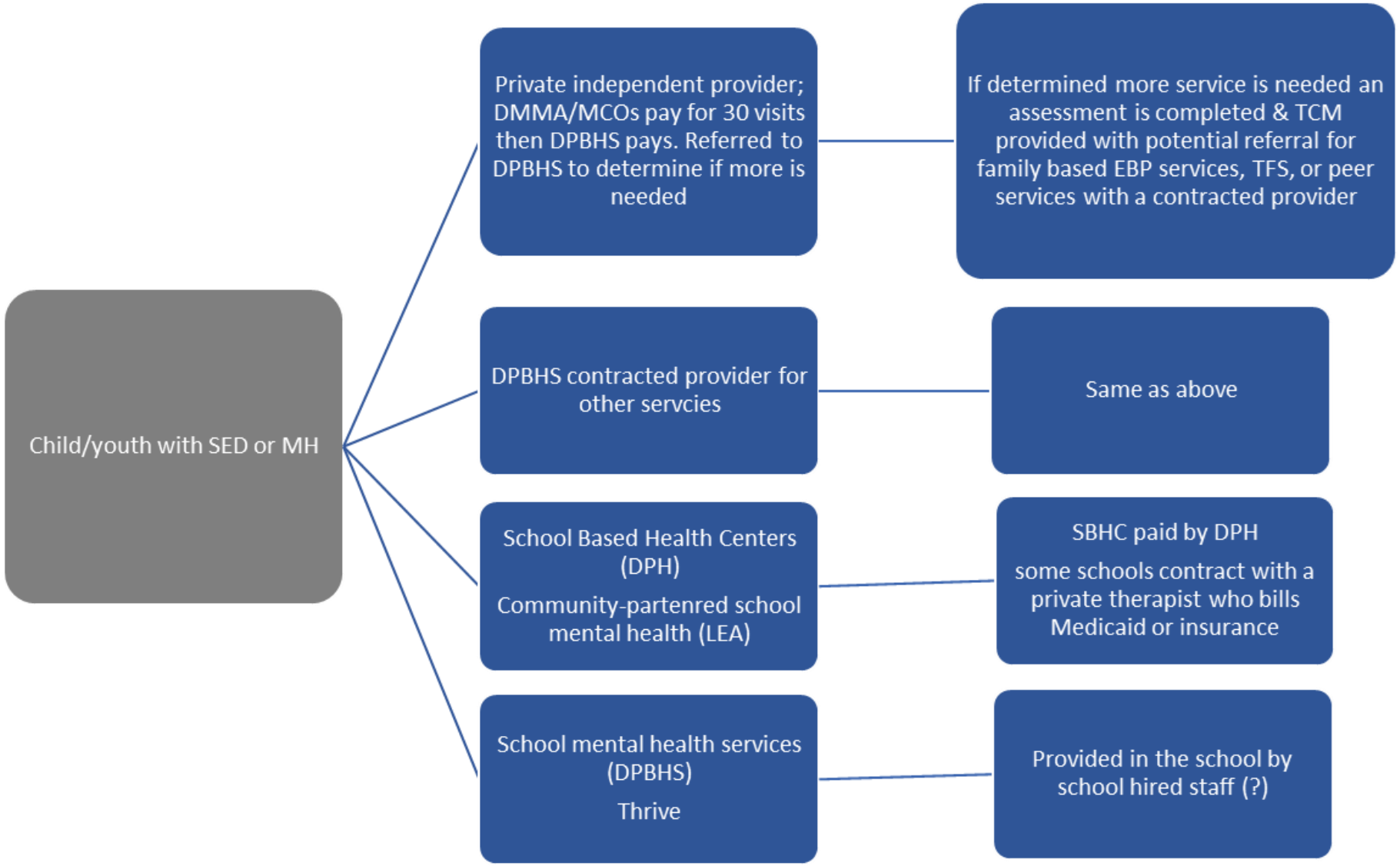
Adults with Serious Mental Illness or Mental Health Conditions



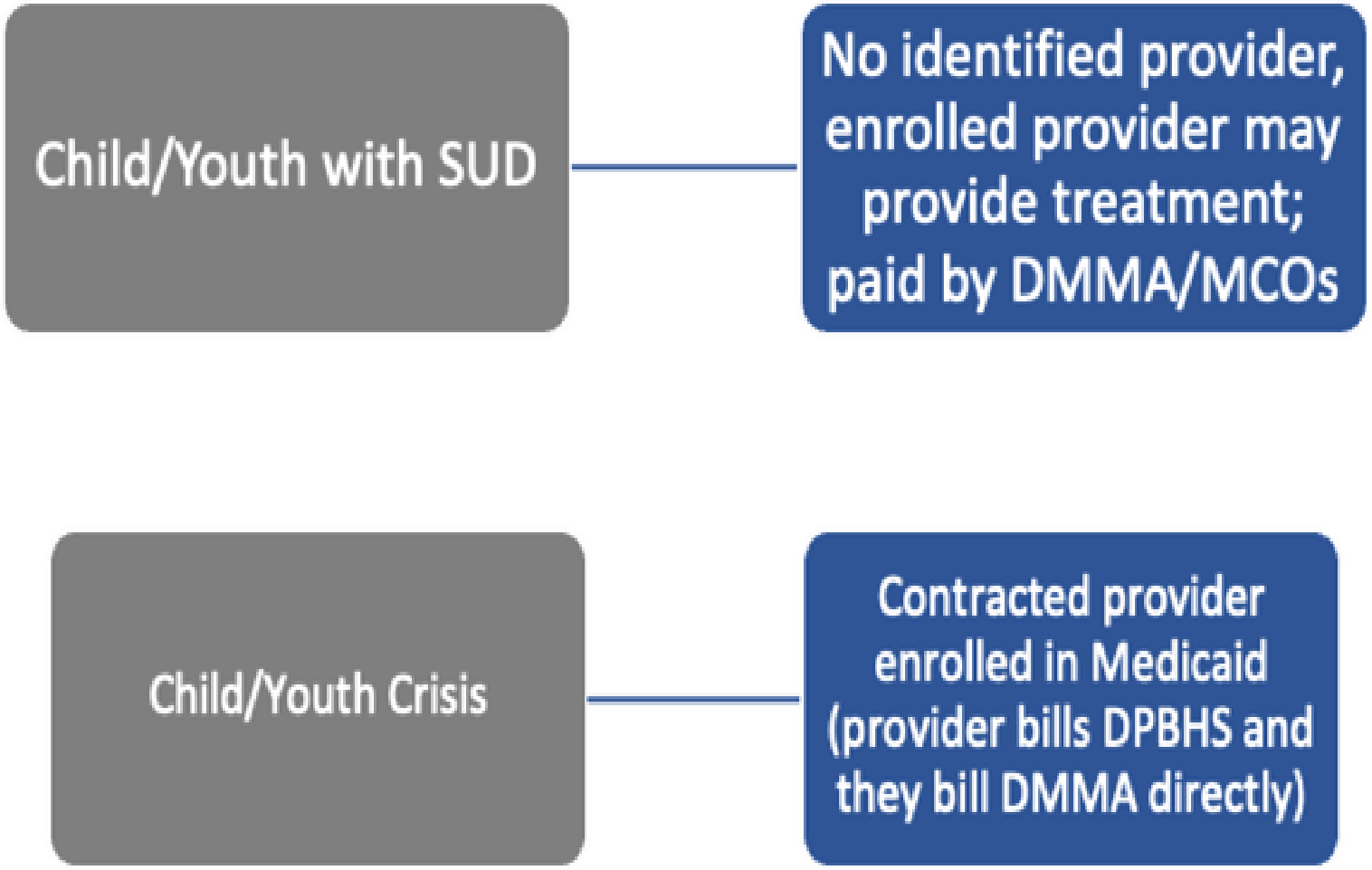


Adults with Substance Use Disorders

Adult Crisis Services



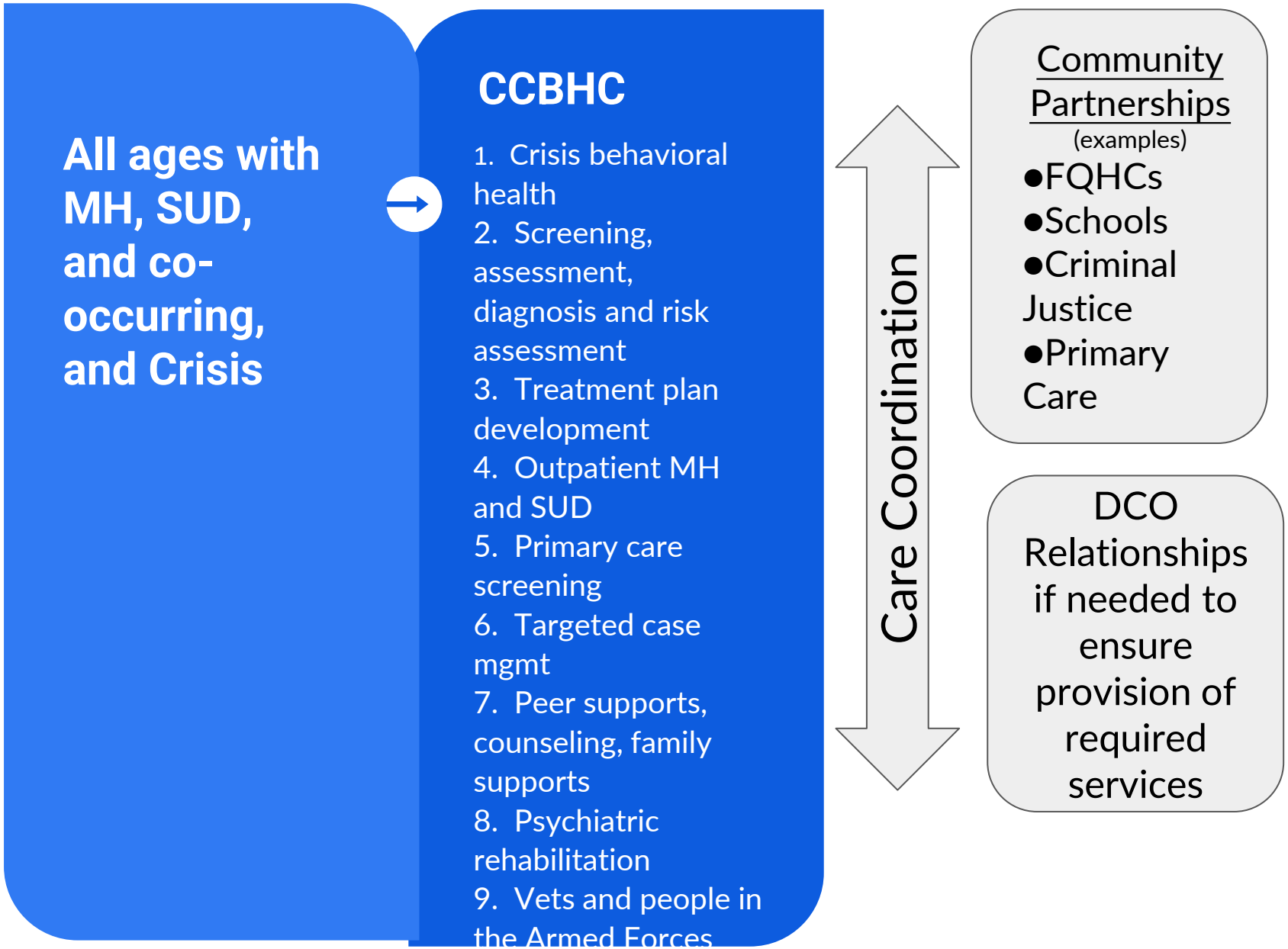
Children, Youth with Serious Emotional Disturbance and Children and Youth with other Mental Health Conditions Includes their Family



Children, Youth with Substance Use

Children, Youth and their Families Crisis Services

CCBHC System Design



All informed by the Community Needs Assessment and State priorities

Elements of a High Functioning System of Care

Element	Example of CCBHC Alignment
Timely and Easy (low-barrier) Access to Care	Expected timelines related to time of first appointment; crisis response; clearly advertising how to access services.
Comprehensive Assessment and Individualized Care Plan	Requirement to provide an assessment that covers a wide-variety of needs and to develop a care plan based on that assessment and with individual or family input.

Element	Example of CCBHC Alignment
Community-based and Preference for Lower Levels of Care	CCBHC is solely focused on providing services in the community although there is an expectation to coordinate with inpatient, residential, criminal justice, etc.
Effective Treatment	Evidence based practices are required and should be aligned with the needs identified in the needs assessment. Regular training is a component.
Integration of Behavioral Health, with Physical Health, and Other Community and Social Services	Coordination with other community entities including physical health, social needs, schools is a requirement. Including care management and formal MOUs.

Element	Example of CCBHC Alignment
Care Transition Support and Pathways	Care coordination to support people as they step down from higher-levels of care, are moving to other services or discharging from services.
Equity	Expectations that populations with health disparities and other social equities are a special consideration. The needs assessment should also highlight these populations and their needs.

Element	Example of CCBHC Alignment
Workforce Adequacy	Using the needs assessment ensure the CCBHC is hiring the right types of staff and those staff are trained.
Sustainability	The PPS allows for costs to be covered by a daily or monthly rate paid by Medicaid. CCBHCs can build in costs associated with meeting the CCBHC requirements.

Element	Example of CCBHC Alignment
Accountability	Required state and clinic collected measures. The state also can add additional measures and a quality bonus payment.
Coverage	All people seeking care are to be served. If they are uninsured or underinsured those costs can be considered in the next payment rebasing.

National Data

High Level Review of the Demographics

Demographic	Information
Overall population size	Delaware has **1,031,890** total residents, with **575,494 in New Castle** County, **255,956 in Sussex County**, and **186,946 in Kent County**. All **three** counties in Delaware are considered a **Medically Underserved Area (MUA).**
Age	0-5 y.o. = 5.3% of the population 6-17 y.o. = 20.4% of the population 18-64 y.o. = 53.5% of the population and 65 y.o. and older = 20.8%
Race/ethnicity	Delaware's population is predominantly White (68%), followed by 23.8% Black/African American, 4.4% Asian, 0.7% American Indian and Alaska Native, 4.9% other race, and 3.0% two or more races. 10.3% reported Hispanic/Latino origin.
Language	13.9% of Delaware residents speak languages other than English at home, with the most common languages being Spanish, Chinese, and Haitian-Creole.

High Level Review of the Demographics

Demographic	Information
Socioeconomic status	The median household income is $79,325, the per capita income is $42,180 and the poverty rate is 9.4%..
Without health insurance	6.9% of the population doesn't have health insurance.
Medicaid enrollment	In Jan 2024, a total of 285,691 individuals in Delaware were enrolled in Medicaid, with 227,140 enrolled in a managed care organization (MCO); 16,080 in an MCO-plus; 42,471 in fee-for-service; and 43,449 disenrolled due of unwinding (source: Total Medicaid Enrollment by Month | Delaware Open Data Portal).
LGBTQ+	Delaware has a significant LGBTQ+ population, with 7.5% of adults identifying as LGBTQ+. This is significantly higher than the national average of 5.5%.

Adults with Substance Use Disorders Data Sample

Strengths - Delaware vs. National	DE	US
Drug Use Disorder in the Past Year	9.07%	9.41%
Individuals (18+) Reporting Needing but Not Receiving Treatment for Alcohol Use in the Past Year, 2019-2020	10.1%	10.7%
Percentage of adults who reported binge drinking	14.4%	Ranked 9th
Challenges - Delaware vs. National		
All Drug Overdose Death Rate (per 100,000 population) (CDC)	54	32.4
Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths	89%	76%
Alcohol Use Disorder in the Past Year	12.26%	11.28%
Percentage of adults who reported using prescription drugs non-medically	13.5%	Ranked 23rd

High-Level Summary

Delaware's adults experience:

- About the same amount of substance use as the national average
- However, DE has also experienced more overdose deaths especially with opioids.

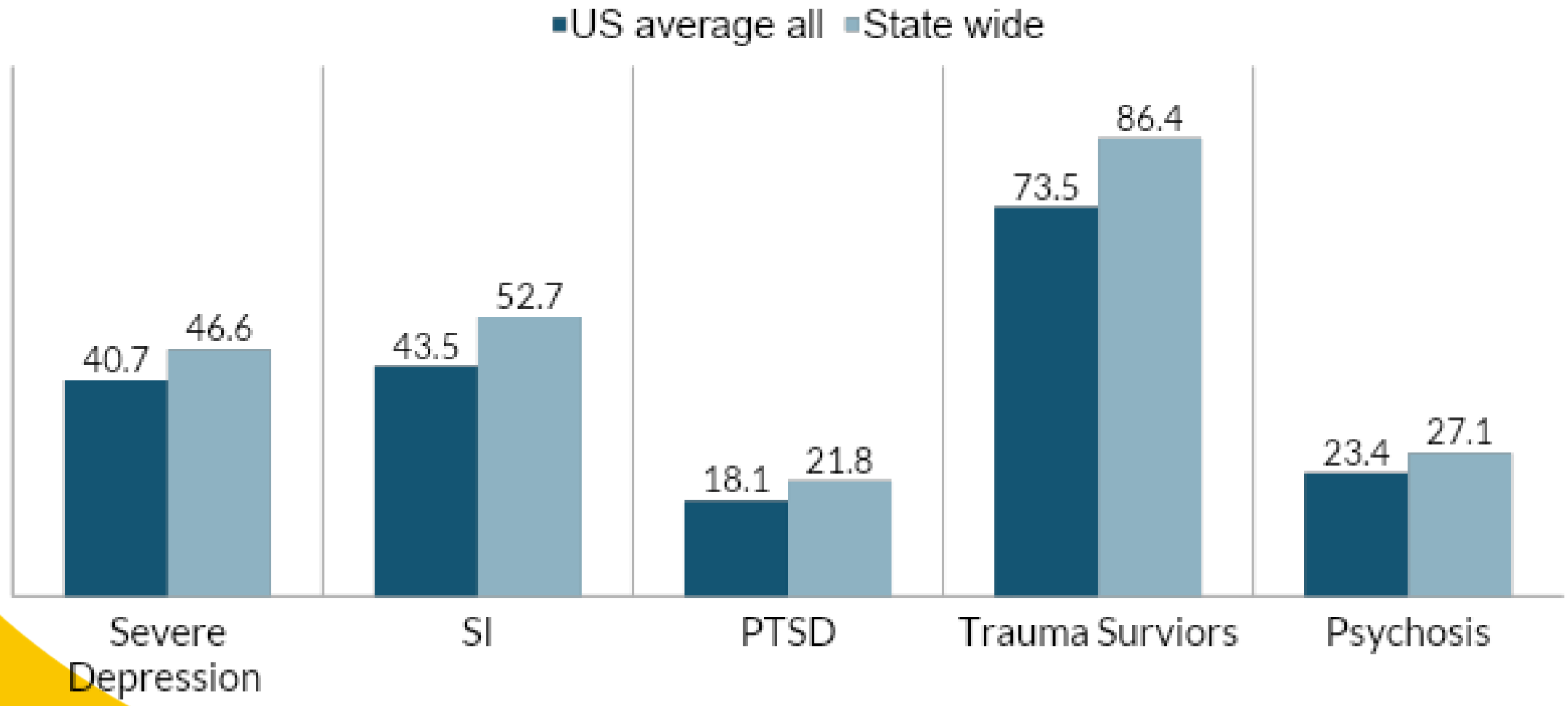
Additional Context:

DE has focused intently on increasing access to treatment for SUD, specifically OUD and that focus is starting to have an impact by Delaware moving from the 2nd state with the most OD deaths to 5th.

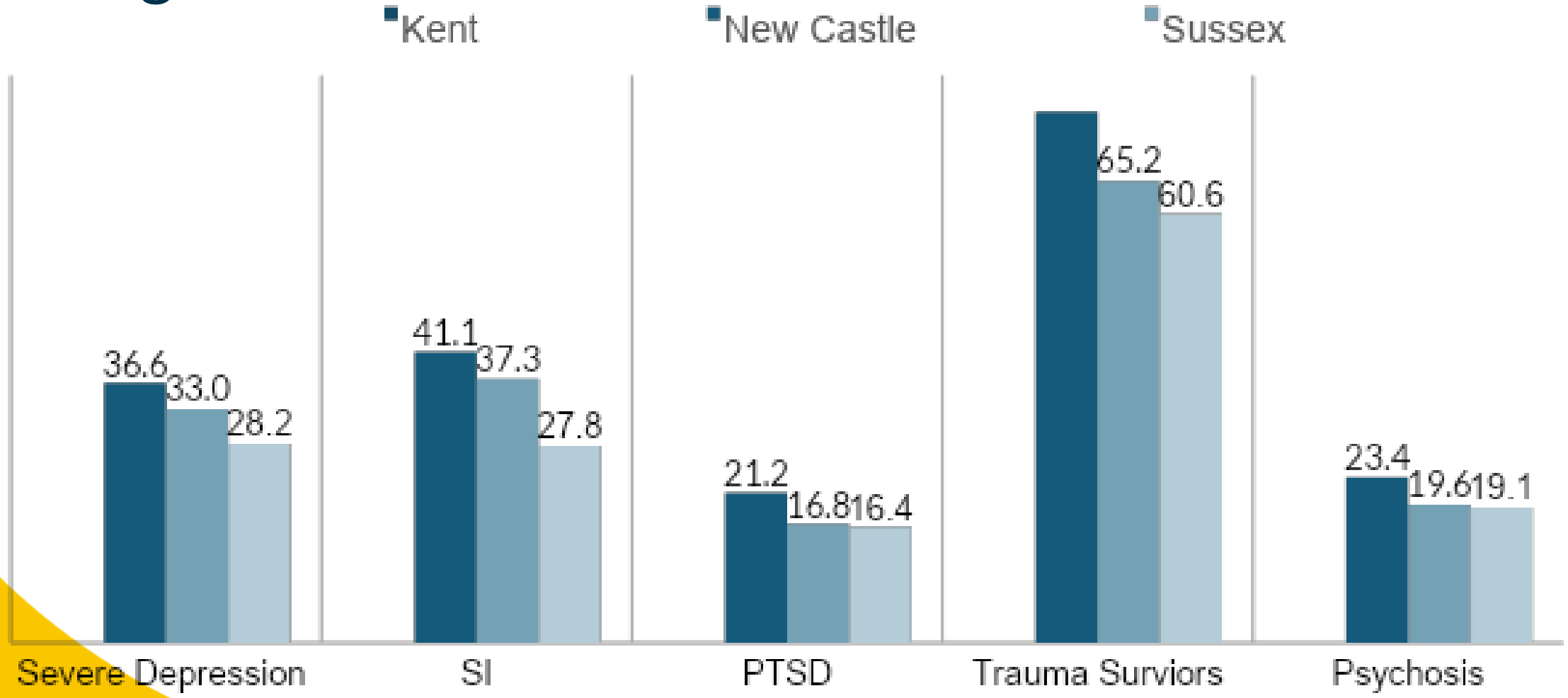
Adults with Mental Health Needs Data Sample

Strengths - Delaware vs. National	DE	US
Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days	14.4%	Ranked 9th
Number of deaths due to intentional self-harm per 100,000 population	13.7%	Ranked 9th
Percentage of adults who reported binge drinking	15.2%	Ranked 8th
Challenges - Delaware vs. National		
Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 population (1-year)	52.4	Ranked 46th
Adults Reporting Unmet Need for Mental Health Treatment	8.1%	7.4%
Adults Ages 18+ Reporting a Major Depressive Episode in the Past Year	9.1%	8.1%

Delaware's Average of Various Mental Health Needs Compared to the US Average



Delaware's Counties' Average of Various Mental Health Needs Compared to the US Average

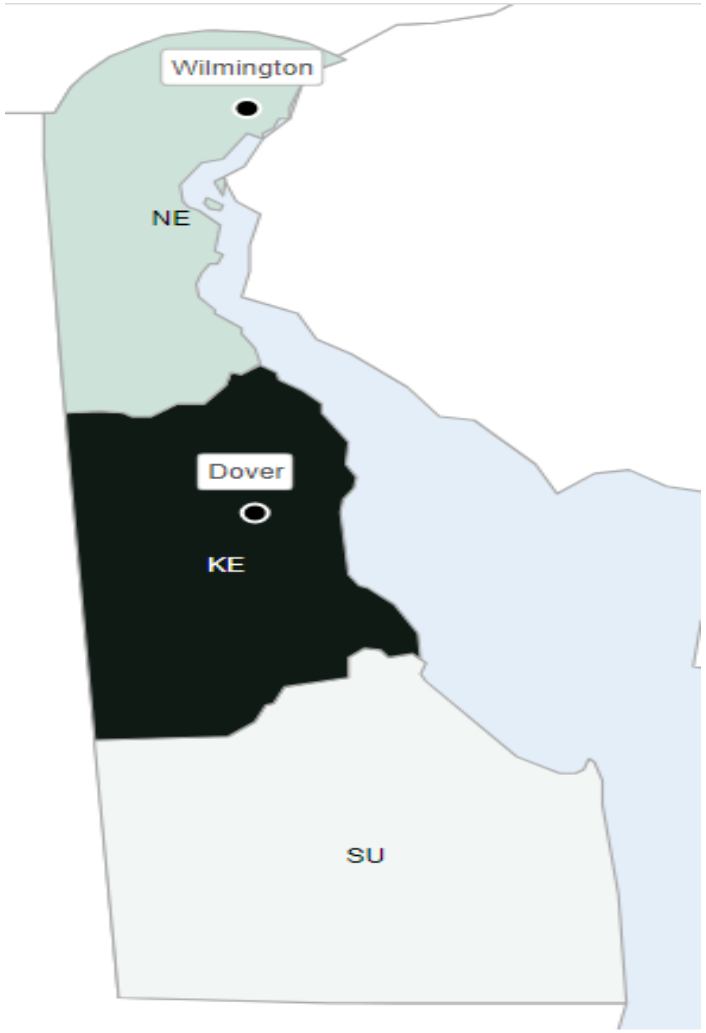


Average number of mentally unhealthy days reported in past 30 days

New Castle: 4.7

Kent: 5.3

Sussex: 4.6



High-Level Summary

Delaware's adults experience:

- There appears to be some MH needs even though reporting about mental health and deaths by suicide are below the national average.
- Reports of severe depression, SI, PTSD, trauma and psychosis are higher than national averages.

Additional Context:

Since DE has focused so much on SUD it may be more difficult to focus on other MH needs outside of SI. Additionally DE has traditionally used private community therapist to address non-PROMISE levels of need.

Older Adults with Substance Use Disorders and Mental Health Needs - Data Sample

Strengths - Delaware vs. National	DE	US
Percentage of adults ages 65 and older who reported being told by a health professional that they have a depressive disorder, including depression, major depression, minor depression or dysthymia	9.4%	Ranked 2nd
Percentage of adults ages 65 and older who reported having physical, mental or emotional problems or difficulty remembering, concentrating or making decisions	5.9%	Ranked 3rd
Challenges - Delaware vs. National		
Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults ages 65 and older (3-year estimate)	10	Ranked 23rd
Percentage of adults ages 65 and older who reported binge drinking	8.9%	Ranked 44th
Percentage of adults ages 65 and older who reported a time in the past 12 months when they needed to visit a doctor but could not because of cost	3.4%	Ranked 32nd
Percentage of adults ages 65 and older who reported having a personal doctor or health care provider	13.5%	Ranked 23rd

High-Level Summary

Delaware's older adults experience:

- More binge drinking.
- They also report more challenges getting access to primary care.

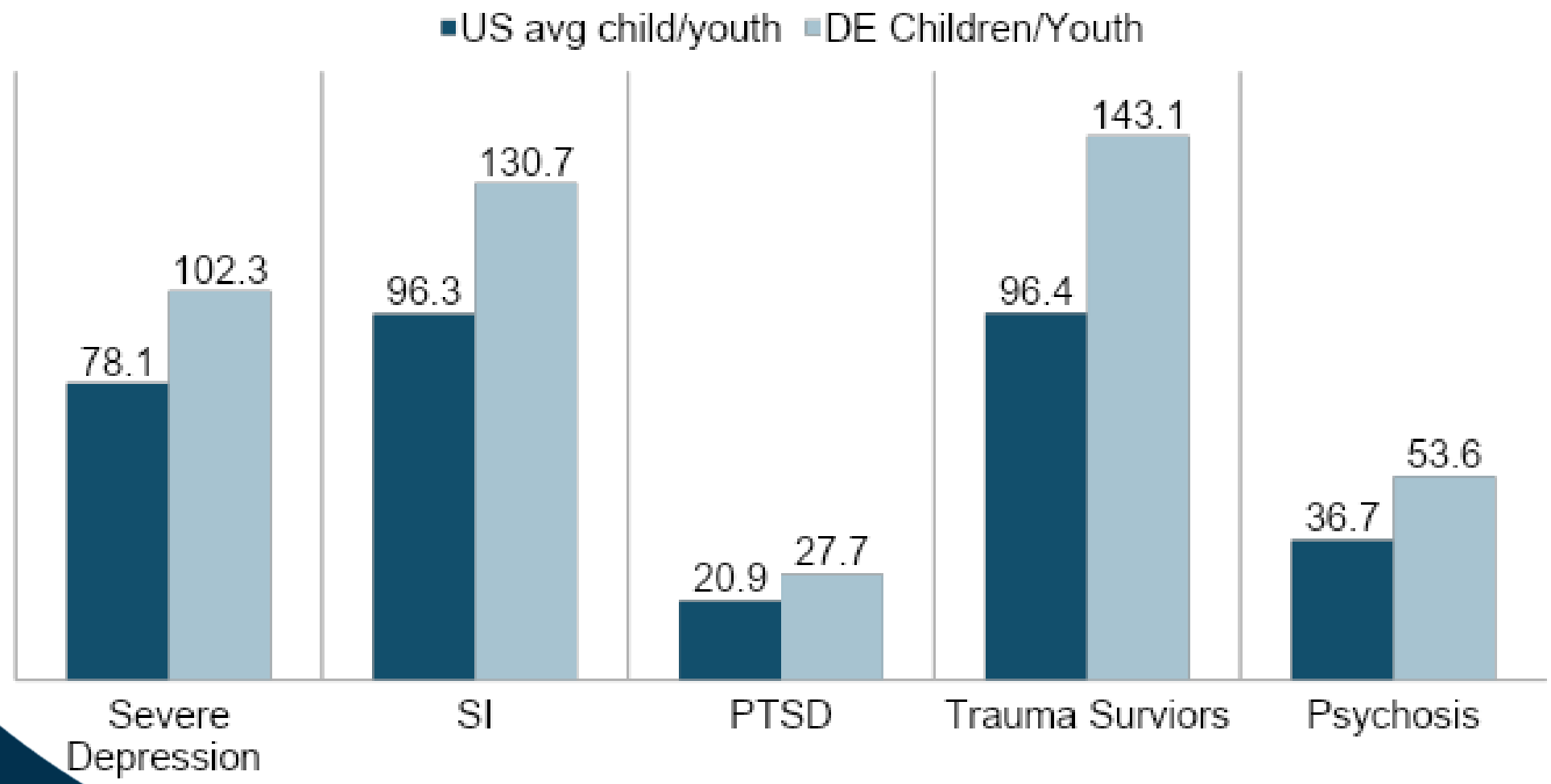
Additional Context:

There is limited information about older adults from the national data. State data may provide more insight to this population.

Kids with Mental Health Needs Data Sample

Strengths - Delaware vs. National	DE	US
Had Serious Thoughts of Suicide in the Past Year	13.06%	13.16%
Challenges - Delaware vs. National		
Children/Youth with Anxiety or Depression (2020) (Ages 3-17)	13%	11.8%
Children/Youth Reporting a Severe Depressive Episode in the Past Year	12.8%	10.6%
Other - Emotional Disturbance		
Children with Serious Emotional Disturbance	7%	X
Students K+ with an emotional disturbance for an IEP	8.56%	7.18%

Summary Kids MH



High-Level Summary

Delaware's children experience:

- Higher rates of mental health diagnosis compared to the national average.
- In addition to diagnose, there are also significantly higher rates of trauma and PTSD.

Additional Context:

Higher rates may be a result of better use of assessment and identification of children in need. In addition to services provided by DPBHS, all 32 public/non-charter high schools in DE operate a school-based health center that includes behavioral health providers.

Kids with Substance Use Disorders Data Sample

Strengths - Delaware vs. National	DE	US
Opioid Misuse in the Past Year (12-17)	1.69	1.85
Alcohol Use Disorder in the past year	3.16	3.32
Challenges - Delaware vs. National		
Classified as Needing Substance Use Treatment in the Past Year	14.22%	11.50%
Youth (12-17) Reporting Needing but Not Receiving Treatment for Alcohol Use in Past Year, 2019-2020	3.2%	2.8%
Substance Use Disorder in the past year	9.09%	8.95%

High-Level Summary

Delaware's children experience:

- Higher rates of SUD compared to the national average, with the exception of alcohol.
- Higher rates of needing SUD treatment than the national average.

Additional Context:

There is an identified lack of SUD treatment services in the state resulting.

Kids Wellbeing (Child Protection) Data Sample

Strengths - Delaware vs. National	DE	US
Children who were maltreated per 1,000	5.4	8.1
Percent of referrals that met the criteria for an investigation or assessment	25%	51%
Percent of recurrence of maltreatment within 6 months	<1%	3%
Challenges - Delaware vs. National		
Number of victims who received post-response services	28%	58%
Number of non-victims who received post-response services	9%	26%
Number of child fatalities per 100,000	3.4	2.4

Kids Wellbeing (Child & Family)

The Annie E. Casey Foundation (AECF) ranks Delaware in the bottom half of all states in overall child wellbeing at 34th in the nation [2023]. This is a drop from ranking 30th in the nation in 2022.

Among the 2023 indicators, Delaware ranked:

- 28th for Economic wellbeing, with no change from 2022
- 41st in Education, down from 27th in 2022
- 31st in Health, down from 30th in 2022
- 28th in Family and Community, up from 30th in 2022

High-Level Summary

Delaware's children experience:

- DE ranks in the bottom half of all Child and Family Wellbeing categories.
- Lower rates of overall child maltreatment but not enough post-response services.

Additional Context:

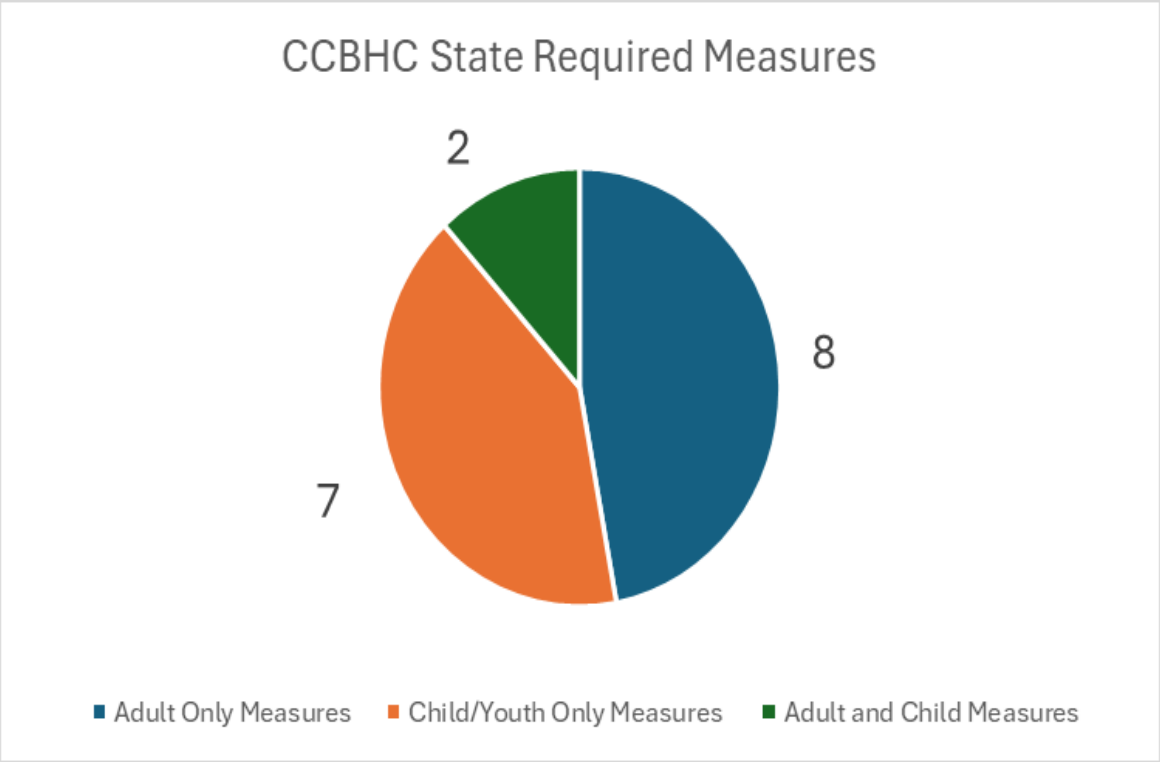
Additional data of child maltreatment does identify variation in physical abuse, psychological abuse, neglect, etc.

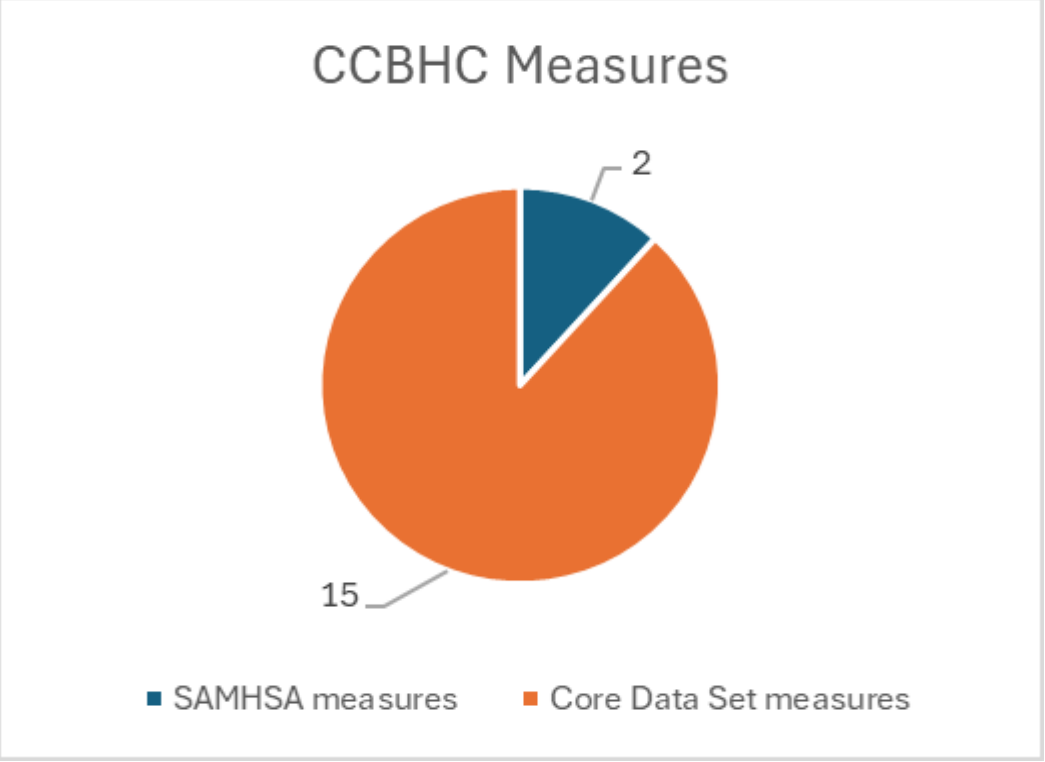
Core Data Set and the State Required CCBHC Measures

Core Data Set and CCBHC State Required Measures

- The Core Data Set is reported each year to CMS by DMMA
- There is overlap of the Core Data Set and the CCBHC state required measures.
- CCBHC has 13 required measures broken down by child and adult, 2 for both children and adults and 2 option measures for children for a total of 17 possible measures.
- Optional measures include:
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) and
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

Core Data Set and CCBHC State Required Measures





Core Data Set and CCBHC State Required Measures - Adults

Core Data Set (higher number is better)	DE Medicaid Rate	U.S. Median
Antidepressant Medication Management (at 12 weeks)	56.9	58.8
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 Days	11	15.5
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of **Alcohol Abuse or Dependence** who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	45.5	42.1
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of **Opioid Abuse or Dependence** who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	39.1	29.5

Core Data Set and CCBHC State Required Measures - Children and Youth

Core Data Set (higher number is better)	DE Medicaid Rate	U.S. Median
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17	54.4	62.6
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase	33.5	43
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 Percentage on Antipsychotics Percentage on Antipsychotics who Received Cholesterol Testing: Ages 1 to 17	53.9	35.3
Delaware did not report on these three measures: 1. Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (DE does not report on this measure) 2. Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (DE does not report on this measure) and 3. Follow up after Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	n/a	1. 54.6 2. 47.9 3. 10.6

Additional Core Data Measures for Children and Youth

Core Data Set - Additional Measures (higher the number the better)	DE Medicaid Rate	U.S. Median
Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist: Ages 3 to 21	57.5	47.6
Developmental Screening in the First Three Years of Life: Ages 0 to 3	82.5	34.7
Well-Child Visits in the First 30 Months of Life: Percentage of Children who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life	61.8	57.5
Well-Child Visits in the First 30 Months of Life: Percentage of Children who had 2 or More Well-Child Visits with a Primary Care Practitioner during the 15th to 30th Months of Life	74.1	65.1

Summary MCO Data

Scoring	***Highmark (# and %)***	***Amerihealth (# and %)***
Scored Well	4 out of 16 or 25%	4 out of 16 or 25%
Scored Average	3 out of 16 or 19%	5 out of 16 or 31%
Scored Poorly	9 out of 16 or 56%	7 out of 16 or 44%

MCO Scorecard on Behavioral Health

Ranking 1-5 (1 worse - 5 best)	Highmark	Amerihealth
Care Coordination		
Follow-up after hospitalization for MI	2	2
Follow-up after ED for MI	2	2
Follow-up after ED for SUD	3	3
Follow-up after high-intensity care for SUD	4	4
Medication Adherence		
Adherence to antipsychotic medications for individuals with schizophrenia	3	3
Patients with a new episode of depression—medication adherence for 6 months	2	3
Patients with opioid use disorder—medication adherence for 6 months	4	4
Access, Monitoring and Safety		
Cholesterol and blood sugar testing for youth on antipsychotic medications	4	4
Continued follow-up after ADHD diagnosis	2	3
Diabetes screening for individuals with schizophrenia or bipolar disorder	1	1
First-line psychosocial care for youth on antipsychotic medications	3	2
Substance use disorder treatment engagement	4	5
Risk Adjusted Utilization		
Plan all-cause readmissions For members ages 18 to 64,	1	1
Overuse of Opioids		
Avoiding opioids at high dosage	2	3
Avoiding opioids from multiple prescribers and multiple pharmacies	2	2
Avoiding potentially risky continued opioid use	2	2

Next Steps

- Review Delaware specific data recently provided.
- Obtain updated University of Delaware SUD Prevalence Study (due Mid May) and the HMA Children and Youth SUD Prevalence Report.
- Meet with State Advisory Group to gather their input.
- Complete analysis, present information and conclusions related to next steps for CCBHC development.

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Delaware Needs Assessment

Part Two

State Data and Information

Child and Youth Mental Health and Substance Use Disorders

Examples of Data and Information



The URS data on co-occurring indicates 2% in 2022 and 1% in 2023; national average is 13.5%



Drop off in services for transition age youth example: 2023 Block Grant had 18.6% 13 to 17 years old served and only 3.2% 18 to 20 years old



EBPs not universally available across the state: DPBHS reported no availability of MST or FFT for the majority of 2023 (captured by week) and no new availability of wraparound services in Kent Co. from Nov-Dec of 2023

Take Care Delaware

Take Care Delaware provides the school with a “heads up” by law enforcement when a child has been identified at the scene of a traumatic event.

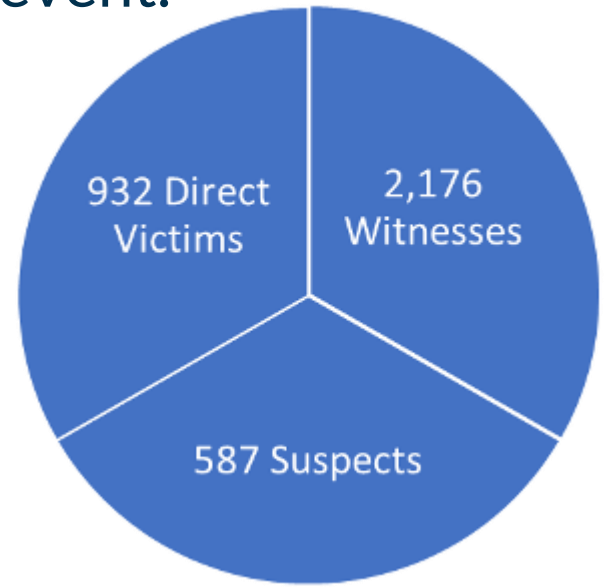


Figure 8: 2022-2023 School Year; 2, 253 notices were sent covering a total of 3,695 students



Figure 9: 2023-2024 School Year (Aug-Dec 2023); 1,063 notices were sent covering a total of 1,695 students

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School-Based Health Services

Provides school-aged youth with comprehensive physical, behavioral, and preventive health services in school settings.

As of 2021, there were 39 total SBHCs, with 32 SBHCs operating in high schools (all public/non-charter).

Seven of the SBHCs operating in high schools also serve attached middle schools.

Include behavioral health providers as part of the state model and state law requires school-based health centers to provide behavioral health services and referrals.

Graduation Rates

Student Group	Students in Cohort	Graduates	Graduation Rate
All Students	10,987	9,645	87.79%
By Residence			
Foster Care	88	48	54.55%
Homeless	459	322	70.15%
Migrant	*	*	33.33%
Military Family	403	379	94.04%

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Poverty – Children

Data from the 2024 Kids Count Data Profile shows 26,000 children living in poverty.

Children in Poverty

	Delaware	National
2019	16%	17%
2022	13%	16%

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Child Welfare Overview

Child Maltreatment Victims (does not include children with dispositions of alternative response)	1,131
Foster Care Entry Rate (per 1,000 children in the state population)	1.4%
Children in Foster Care on 9/30	444
Children Adopted	88

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Foster Care – Race/Ethnicity

	Entering Foster Care in FY 2021	In Foster Care on 9/30 (2021)	Existing Foster Care in FY 2021
Alaskan Native/ American Indian	0	0.2	0
Asian	0	0	0
Black	44.6	47.7	41.8
Native Hawaiian / Other Pacific Islanders	0	0	0
Hispanic (of any race)	9.2	8.1	15
White	42.9	38.5	37.9
Two or more races	3.4	5.4	5.4

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Foster Care – Exit

2021

Adoption	30.7
Guardian	22.9
Reunification	27.9
Other	18.6
Total Number	280

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Adult Substance Use Disorder and Mental Health

Examples of Data and Information



State data shows higher OD deaths rates than the US average and there is a reduction in OD deaths in DE showing efforts are working.



Mobile crisis intervention service calls: 2020-2023

6-8% related to SUD and 92-94% related to non-SUD related needs



Co-occurring diagnosis in claims data is less than national average 2% for MH with an SUD; national average is 18.2%

Inpatient Discharge

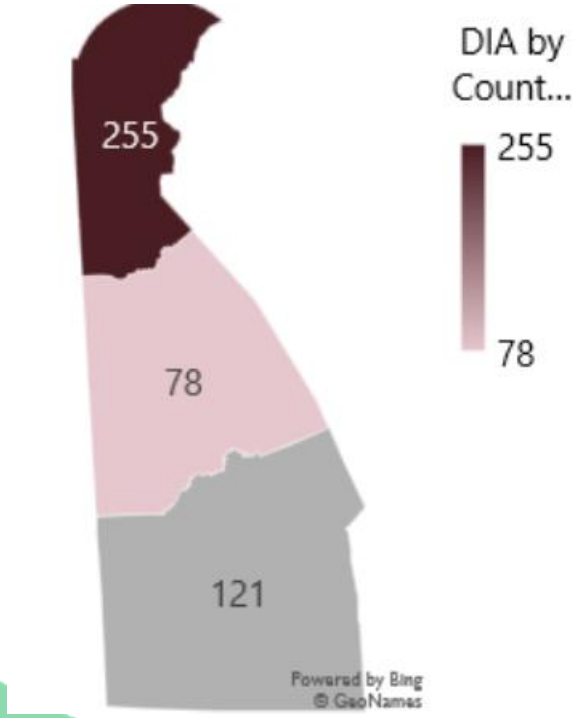
- A 2021 review of the provision of SUD services for patients at the Delaware Psychiatric Center (DPC) with co-occurring MH/SUD identified SUD service gaps both within DPC and in the community.
- Needs included a better process for DPC to identify SUD services in the community, including providers who can provide services for individuals with co-occurring diagnosis, including SPMI and co-occurring SUD.
- Based on this service gap identified at discharge planning DPC expressed a need to support mental health providers in adding SUD services for this population.

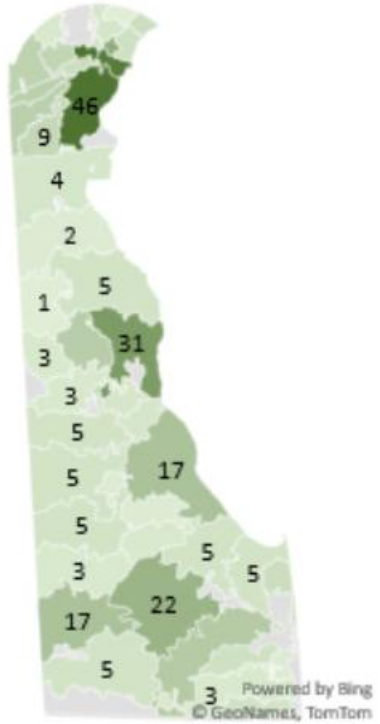
Incarceration Rates

Facility	Mentally Ill (MI)	Seriously Mentally Ill (SMI)	SUD	Co-Occurring	Total	**% of Total Facility Population**
Baylor Women's Correctional Institution (BWCI)	27	48	12	105	192	**81.7%**
Howard R. Young Correctional Institution (HRYCI)	136	115	208	402	861	**68.9%**
James T. Vaughn Correctional Center (JTVCC)	257	331	48	81	717	**42.1%**
Sussex Correctional Institution (SCI)	102	34	305	60	501	**45.0%**
Total	**522**	**528**	**573**	**648**	**2,271**	**52.8%**

Death Investigations

The Division of Substance Abuse and Mental Health (DSAMH) receives a Death Investigation Alert (DIA) when the cause of death of a Delawarean adult (18+) is suspected to be caused by a drug overdose. The following maps highlight the areas of the state with the highest number of overdose deaths. (n=454)







Poverty - Lifespan

Delaware has a higher median household income ($82,174) than the national average ($74,755). Delaware also has a lower percentage of people living in poverty at 9.4% compared to the national average of 12.6%. People in Delaware have a greater chance of living in poverty the younger they are.

Poverty by Age

Under 18 Years	12.9%
18 to 64 Years	8.7%
65 Years and Over	7.7%

Workforce

- Shortages
- Opportunities and Solutions

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Workforce Shortages

State	Psychiatrists (total #)	Psychiatrists (per 100,000 population)	Psychologists (total #)	Psychologists (per 100,00 population)	Social Workers (total #)	Social Workers (per 100,00 population)
Delaware	**95**	**9.47**	**729**	**74.24**	**1913**	**194.83**
District of Columbia	332	49.55	1765	258.36	2422	354.53
Maryland	1196	19.40	5602	91.11	9780	159.06
New Jersey	1223	13.20	9104	98.59	18532	200.69
New York	4777	24.08	26379	131.14	60526	300.90
Pennsylvania	1800	13.88	10209	78.71	30146	232.42
Virginia	1054	12.20	5678	66.16	13691	159.52
West Virginia	190	10.66	1060	58.85	2872	159.46

Rate of Psychiatrists by County

County	Total Number	Rate per 100,000 population
Kent	13	7.06
New Castle	69	12.07
Sussex	13	5.25

Workforce Survey

- Among behavioral health professionals surveyed by the National Council for Mental Wellbeing, more telehealth options (46%) was the highest ranked action to help reduce challenges in the mental health/substance use field.
- This was followed by apprenticeship programs (42%) and student loan forgiveness (37%).
- The same survey showed that 38% said less time spent on administrative tasks would help them better serve their clients.[1]

Delaware's Workforce Shortage Solutions

As of March 2024 Delaware has:

- Entered and is participating in interstate compacts for nurses and psychologists.
- Passed legislation to enter in interstate compacts for mental counselors and physicians and enacting rules to participate in both compacts.
- Has not introduced legislation to enter or participate in new interstate compact for social workers.
- Codifying expanded telehealth rules following the end of the Public Health Emergency, to include synchronous and asynchronous modalities, video and audio and audio-only, and to prescribe medications.
- Exposure of behavioral health professional scopes through mentorships and shadowing; and recruitment of high school students into higher education programs, including scholarship opportunities.
- Expanded use and scope of non-licensed and para-professional staff, with a focus on prevention strategies.

Summary of Findings

Strengths

Delaware has put a lot of effort and resources into supporting people with SUD the last several years. Data shows an impact and improvements for this adult population.

Increase in the type of providers engaged to serve the SUD population (Bridge Clinics, Primary Care/FQHC, various other community partners)

The call center and mobile crisis response services for children and youth are available seven days a week, 24 hours a day across the state.

School-based health centers are required by state law to provide mental health and substance use disorder assessments, crisis intervention, individual counseling, and referrals and connections to community behavioral health care.

Challenges

The behavioral health providers are designed more as “specialty providers” that serve a specific diagnostic criterion/single population rather than as “comprehensive providers”.

This prevents individual providers and the system in building the necessary infrastructure to support the key elements of a high functioning system of care.

Makes serving an entire family, to address all needs, more challenging.

Creates more opportunities for people to disengage in services if their needs can’t be met comprehensively in one setting.

Doesn’t support more robust active working relationships.

Needs to be more data and outcome driven for CCBHC operations.

Funding flexibility is limited.

Provider-Specific Challenges for CCBHC Implementation

- Many competing demands and struggle to dedicate time or resources to related tasks.
- Tended to be single population focus and therefore did not have required services, staff, or policies/procedures across the lifespan, as required by a CCBHC.
- No provider completed a community needs assessment (CNA).
- Lack EHR and infrastructure requirements, as well as staff trainings and supervisions needed to adhere to CCBHC criteria and enhanced service array.
- Providers were challenged to identify the best DCO types of relationships that would support their work.
- Providers demonstrated limited ways to establish meaningful participation by people with lived experiences in their governing board.

Crisis-Specific

- Crisis services for both adults and children are not currently meeting the CCBHC criteria.
- Decision needs to be made to either address the gaps or make an exception request to HHS.

Observations and Opportunities

1. System designed diagnostically and by age

Full integration of the mental health and substance use disorder system to address co-occurring conditions, provide a full family continuum of services, and provide treatment to transition aged youth.

Children and youth are part of families and often addressing parental or caregiver needs supports the success of children and youth while addressing children and youth behavioral needs can better support adult caregivers.

2. No identified catchment areas

Using CCBHC locations as hubs by establishing *catchment areas* will create a centralized intake, a core set of available services, access to DCO services with a care coordination model, accountability for services being provided and outcomes being achieved for all Delawareans.

3. No common “Delawarean“ experience

A core set of services, such as those in the CCBHC model, should be available to everyone in the state. Right now, many of the services are available but not always in a coordinated manner. This can create gaps in care and transitions from one service system to another, creating opportunity for disengagement or people’s needs not being identified and addressed by the system.

4. Oversight of the providers could increase focus on quality and outcomes

The CCBHC model provides an opportunity to move from “is the criteria met” to a focus on “are the outcomes we want being achieved”?

5. Diagnosis driven services rather than care coordination across all needs and all services.

Viewing the behavioral health system through a *collective lens* should lead to improved outcomes and *maximization of the funding*, including maximization of Medicaid therefore freeing up other resources for services and supports that either don't have or have limited funding (i.e. housing, transportation, other social drivers).

6. Crisis services provided through various pathways

Using the current work for 988 and mobile crisis to ensure the required *crisis services* aspect of the CCBHC criteria is addressed.

7. Streamline payment model and use payment mechanism to drive quality

The PPS funding model provides additional flexibility and funding for the types and quality of services the state seeks.

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Thank You!