PCSS Medications for Opioid Use Disorders

Providers Clinical Support System

From Crisis to Care: A Case Study of How a CCBHC is Revolutionizing MOUD Access

August 14, 2025

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Housekeeping

- Today's webinar is being recorded and all participants will be kept in listen only mode. There will be an opportunity to ask questions at the end of the webinar, so we encourage you to please submit your questions throughout the webinar in the Q&A box located at the bottom of your screen.
- The recording and slides will be made available on the PCSS-MOUD website within 2 weeks.
- Within 48 hours of today's session, you will receive an email from granteducation@aaap.org with evaluation and certificate claiming information.

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PCSS Medications for Opioid Use Disorders — Providers Clinical Support System

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- PCSS-MOUD aims to increase the knowledge and skills of healthcare and counseling professionals about available evidence-based treatment approaches for substance use disorder (SUD) with a particular focus on opioid use disorder (OUD). PCSS-MOUD provides free training and mentoring to practitioners on the use of medications for OUD (MOUD) and the integration of these services into mainstream healthcare.

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All disclosures have been reviewed, and there are no relevant financial relationships with ineligible companies to disclose.

All speakers have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in patient care. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis.

Educational Objectives

- Discuss the value of the Certified Community Behavioral Health Clinic (CCBHC) model in the delivery of MOUD services and sustaining OUD treatment.
- Describe the successful programmatic and service delivery attributes of a CCBHC Crisis Center that focuses on SUD and a collaboration between a CCBHC and Residential SUD Treatment Facility.
- Outline how CCBHCs implement evaluation processes, including tracking service models and utilizing data.

Today's Speakers

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Chief Clinical Officer – Tulsa
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How Much Do you Agree with the Following Statement?

I am familiar with the CCBHC model:

- Strongly agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

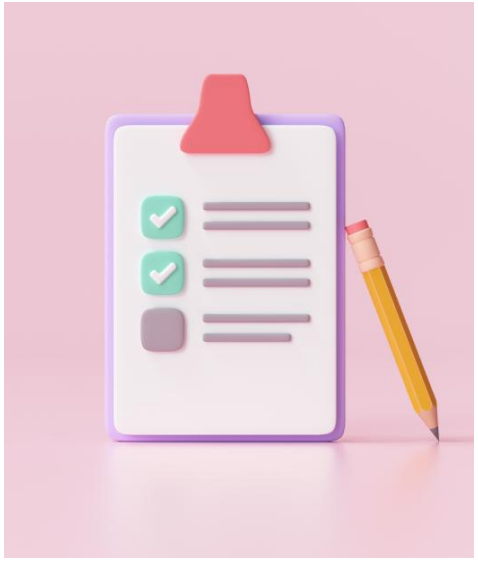
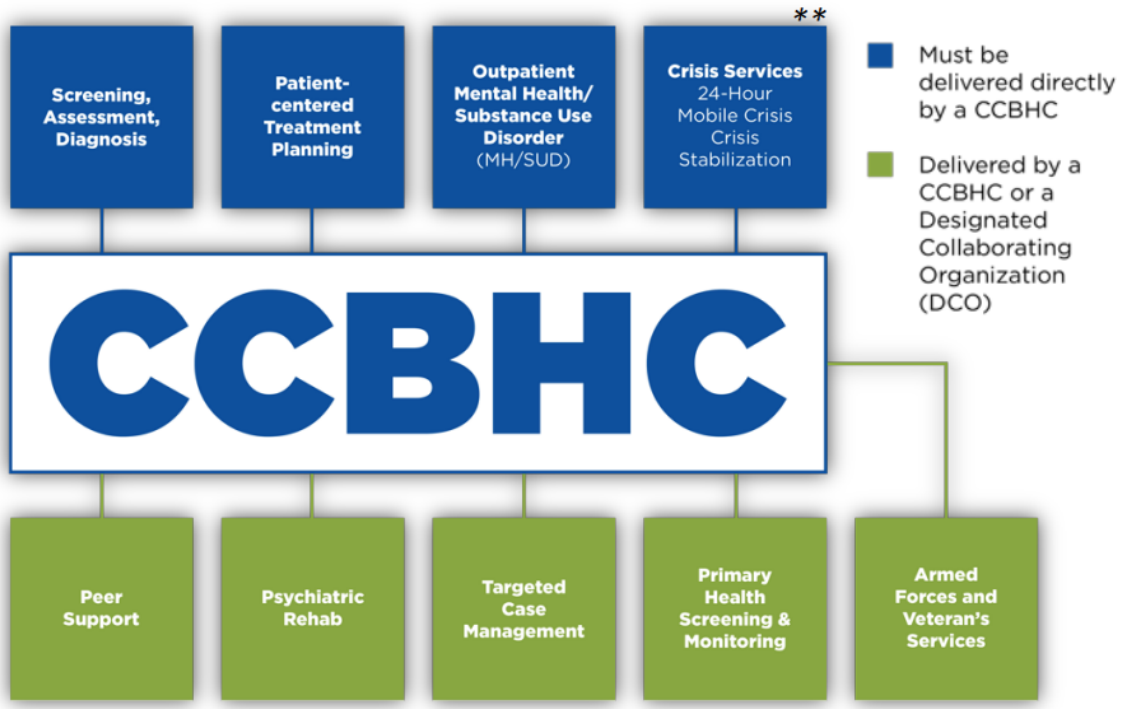


Image source: PowerPoint, 2024

What is a CCBHC and Why Does it Matter for MOUD

Core features:

- No-wrong-door access
- 24/7 crisis care
- Comprehensive care *(mental health, substance use disorder, physical health)*
- Enhanced reimbursement = sustainability



National Council for Mental Wellbeing, 2023

Utilization of MOUD in Mental Health Treatment Facilities

Despite its effectiveness MOUD remains underutilized in mental health services and treatment facilities.

- In a national cross-sectional study[1] of 450 community mental health centers (including 152 CCBHCs), **only 34% offered MOUD**.
- However, the 2024 CCBHC Impact Report[2] found that out of 314 CCBHCs,
  - 87% of CCBHCs (273) offer at least 1 type of MOUD, compared to 64% of substance use treatment facilities nationwide.
  - 62% (196) offer 2 forms of MOUD, compared to 49% nationwide.
  - 14% (44) of CCBHCs directly offer all three forms, compared to 4% nationwide.

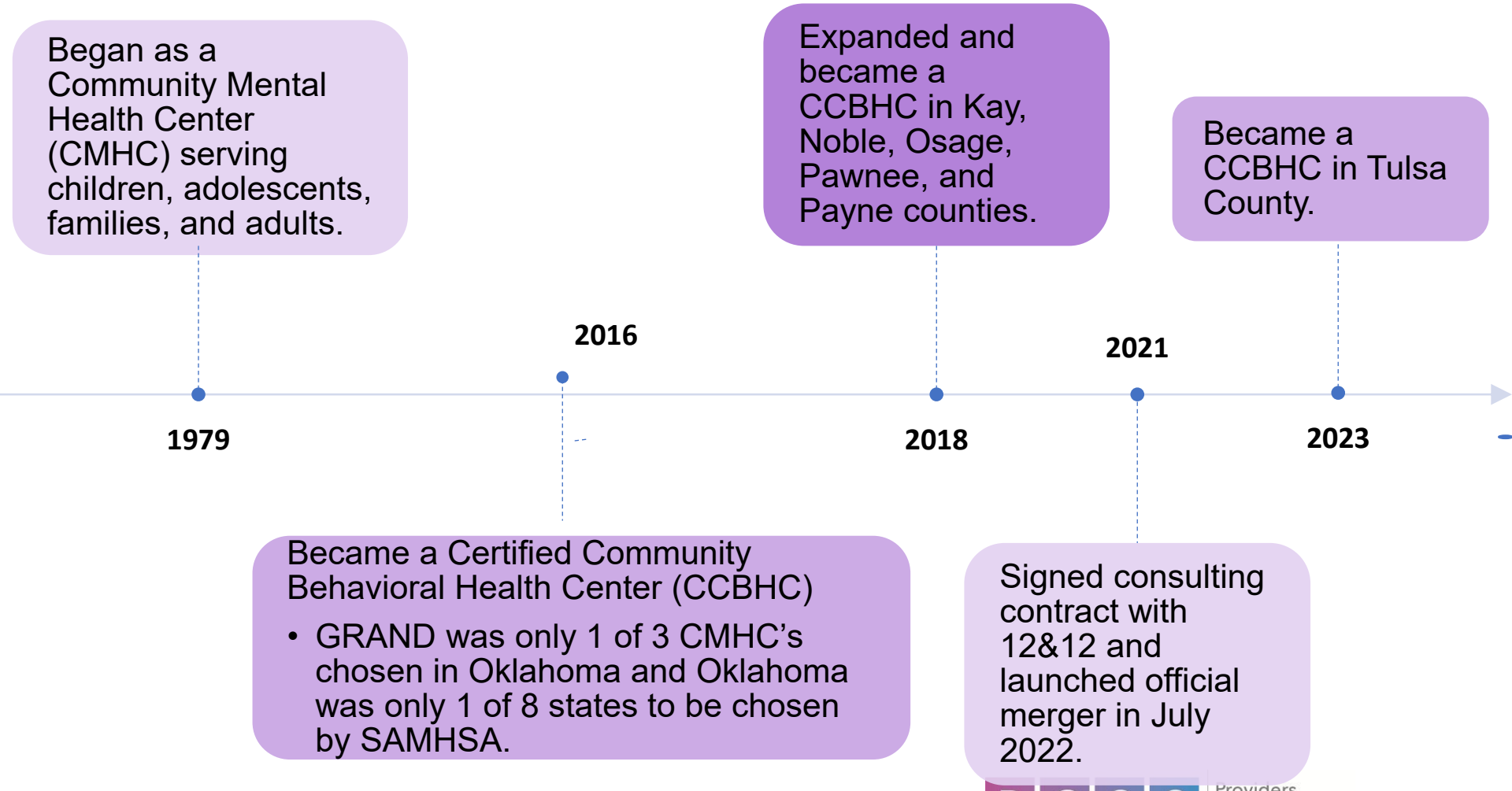
Staff, from prescribers to care coordinators, can benefit from clear guidance on embedding MOUD into existing CCBHC workflows and mental health treatment facilities more broadly.

Sources:
(1) https://pmc.ncbi.nlm.nih.gov/articles/PMC11185975/
(2) https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

GRAND Mental Health

A CCBHC in Oklahoma

GRAND CCBHC Background



Our Program:
Medication Access Made Practical

Low-barrier intake process

Same-day or rapid MOUD initiation

Staffed with prescribers, care managers, peer support

Coordination with pharmacy

GRAND Whole-Team Approach

- Every role at GRAND plays a distinct and critical part in the continuum of care.
- The CCBHC model works because of the full team.
  - Each role brings unique expertise, perspective, and purpose.
- True whole-person care requires a whole-team approach. No single role stands alone.
- Collaboration is our strength.
- When each team member operates at the top of their role, client outcomes improve across the board.

Images source: PowerPoint, 2024

GRAND Population Served

- Age range – birth through the lifespan
- Varying clinical needs – SMI, Serious Emotional Disturbance (SED), SUD, and Co-Occurring
- Underserved and high-need communities
- Specialized populations – justice-involved, unhoused, those in crisis
- Whole-person, family-inclusive approach

GRAND Data Tracking System

Integrated EHR – Outcome-based Treatment Plan

- Key Performance Indicators (KPIs):
  - Time from referral to initial appointment
  - Follow up within 7 days of hospital or crisis discharge
  - Engagement in care post-crisis
  - Readmission and recurrence rates
  - Access to SUD and MOUD services
- Utilization and outcomes dashboards
- Client-level data for population health
- Collaboration with state and federal entities
- Culture of data-informed practice

Image source: PowerPoint, 2024

From Data to Action: How GRAND Implements What We Learn

- **Integrated EHR + Dashboards**
  - Real-time tracking of client outcomes, service utilization, engagement trends, and other KPIs.
- **Quality Review Cycles**
  - Monthly interdisciplinary reviews to identify gaps and adjust workflows.
- **Population Health Lens**
  - Data disaggregated by geography, justice involvement, housing status, etc., to better understand the population served.
- **Rapid-Cycle Implementation**
  - Data insights → workflow changes → staff training → outcome monitoring.

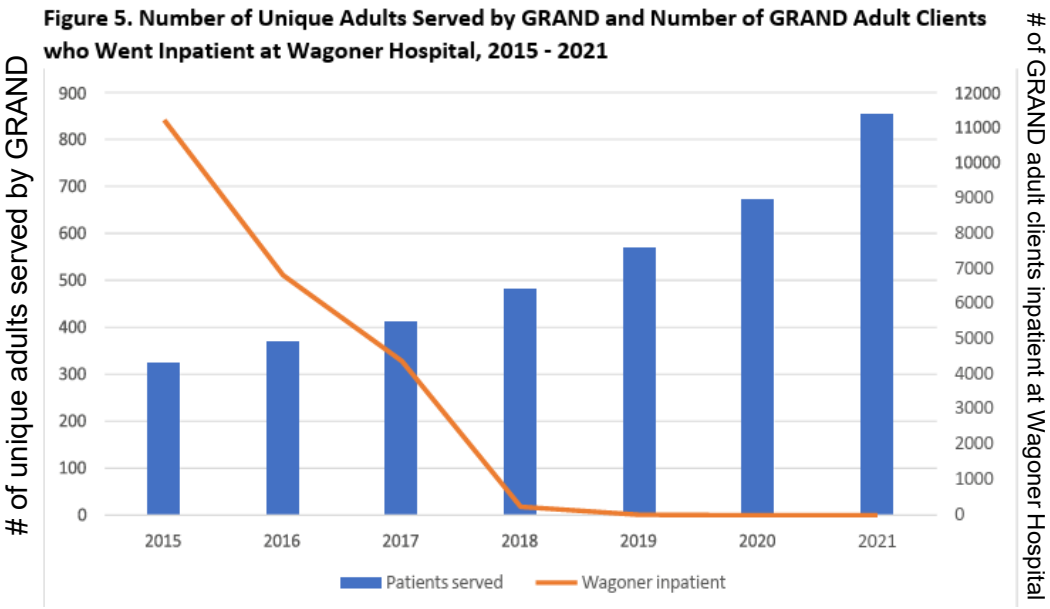
GRAND Utilization + Outcomes Dashboard

In Tulsa County alone, 87% of adults needing SUD treatment remain untreated (ODMHSAS data). Efforts are underway to expand MOUD access and close this gap.

Key indicators tracked:

- MOUD start to retention (30, 90, 180 days)
- Outreach-to-Crisis-to-Outpatient linkage rates
- ER diversion stats (NRI Report)

Dashboards, EMR reporting, quality review cycles



Source: https://nri-inc.org/media/qa2k0wdf/grand-model-evaluation_june2022_v2.pdf

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GRAND Lessons Learned

1. **Challenge:** Rural staffing shortages.
   - **Solution**: Developed internal workforce pipeline and expanded telehealth access.

2. **Challenge:** Clients not showing up for scheduled care.
   - **Solution**: Realized the need for 24/7/365 access - we must be ready when they are.

GRAND Lessons Learned

3. **Challenge:** Payer complexity and service authorization delays
   - **Solution**: Added Utilization Review roles and improved payer communication
4. **Challenge:** Community distrust and trauma
   - **Solution**: Embedded peer support and prioritized trauma-informed care

Lesson Learned:

Engagement happens on the client's terms.
Unbridled access means immediate, flexible care.

GRAND Mental Health

Facility Merge

GRAND CCBHC + Residential Facility Merge

Recent integration of CCBHC with SUD residential treatment

- Shared systems (EHR, staffing, billing)
- Reduced care drop-off between levels of care
- Improved continuity and outcomes

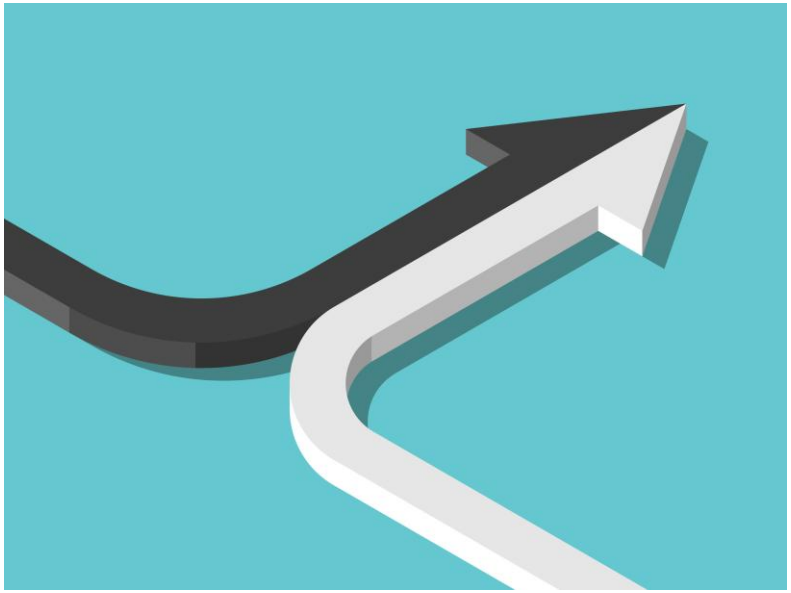


Image source: PowerPoint, 2024

Our own Crisis Recovery Center with SUD Focus

Structure of crisis center

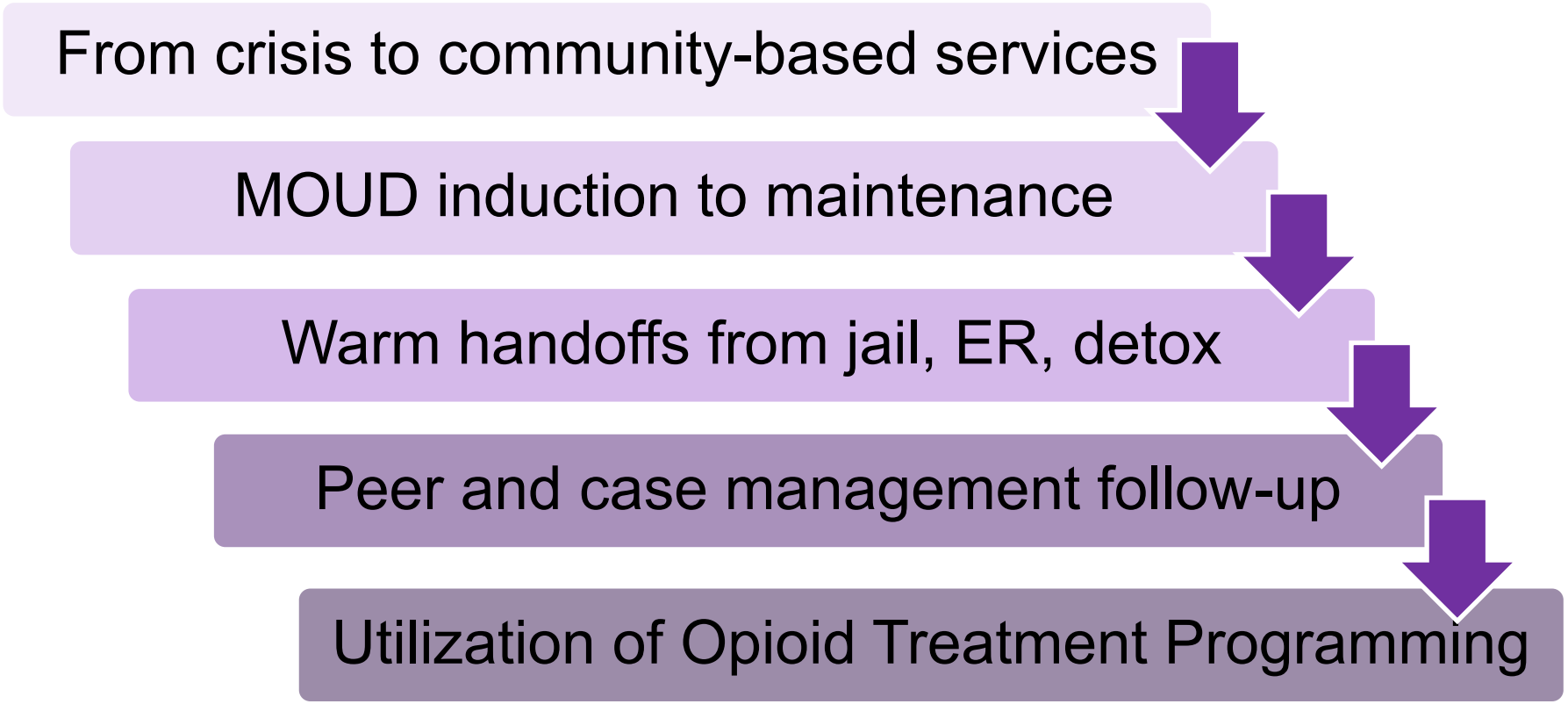
Staffing with SUD-competent professionals

Withdrawal management protocols

Immediate linkage to outpatient or residential care

Images source: PowerPoint, 2024

Transitions of Care: Keeping People Engaged is Key



GRAND Patient Case Example

Patient Information

- **Demographic Information:** 35-year-old, white, female, recently homeless, unemployed, recent legal issues/jail
- Substance use since 15 with no significant periods of sobriety, which has interfered with family relationships and job stability
- **Patient History:**
  - **SUD History:** long history of opioid, cocaine, sedative-hypnotic and alcohol use disorders
  - **Mental Health History:** severe anxiety (early adolescence, prior to substance use), intermittent depressed mood, and chronic insomnia

Detailed Substance Use History

- Began regularly using alcohol and cigarettes at age 12
- Received a prescription for benzodiazepines for anxiety, which "improved her high" from heroin; began using heroin at age 18
- Often combined heroin (smoking and injecting) with cocaine to "get a better rush"
- Self-reported intermittent cannabis use, which made anxiety worse
- Experimented with hallucinogens but never tried inhalants
- **Last Substance Use:**
  - **Opioids:** heroin – 6 months ago
  - **Stimulants:** cocaine – 48 hours ago
  - **Benzodiazepines:** klonopin (2mg) – 72 hours ago
  - 1 pack of **cigarettes** per day

Withdrawal and Treatment History

- **Withdrawal Symptoms:** sweats, chills, tremor, headache, nausea, vomiting, irritability, restlessness, GI cramping and diarrhea
- **Treatment History:**
  - **Methadone maintenance**: regular opioid treatment program (OTP) attendance for methadone for 6 months with increased cravings for benzodiazepines and cocaine
  - **Inpatient Treatment**: completed 2 inpatient substance programs, abstinent for ~2 weeks post-discharge
  - **Mutual Support:** previously attended AA & NA, fears criticism from others at meetings
- **Current Medications:** Methadone, 120mg/day (via OTP)

Initial Patient Care Plan and Treatment Pathway

- Recommend inpatient detoxification for benzodiazepines
- Begin benzodiazepine taper protocols
- Continuation of methadone medication with discussions about other options available for OUD
- Admission to co-occurring disorders/dual diagnosis clinic while inpatient
- Admission to residential inpatient treatment unit with recommendations for sober living upon discharge
- Case work initiation for long term support and aftercare

Replicating the Model:
Advice for New Programs

First Steps to Replicating the Model

- **Start small**: pick high-impact entry points (e.g., MOUD in crisis)
- **Build local partnerships** (hospitals, jails, courts, OTPs)
- **Focus on workforce cross-training**
- **Be flexible**, perfect is the enemy of progress

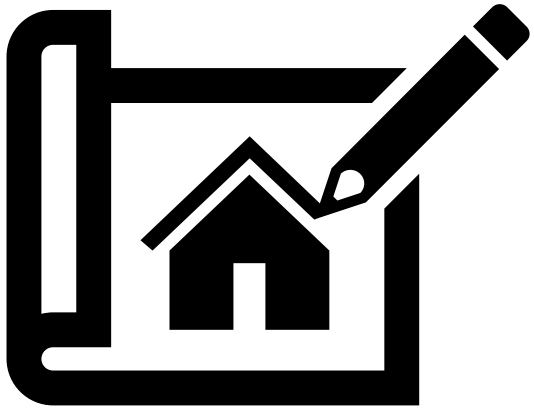


Image source: PowerPoint, 2024

Psychiatric Buy-In: Shifting the Culture

Engagement Strategies:

- Education on MOUD and co-occurring treatment
- Show data on outcomes
- Build co-treatment teams (Behavioral health and medical)

Involve psychiatrists in leadership discussions

Poll

How confident are you that your organization could implement or expand MOUD through a CCBHC model?

- **Very confident** – we're already doing some of this
- **Somewhat confident** – we have pieces in place
- **Not sure** – we need help getting started
- **Not confident** – we're missing key resources or buy-in
- **Not applicable** – this doesn't align with our mission

Image source: PowerPoint, 2024

Questions?

Thank You!!!

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Kim Hill-Crowell:
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PCSS-MOUD Mentoring Program

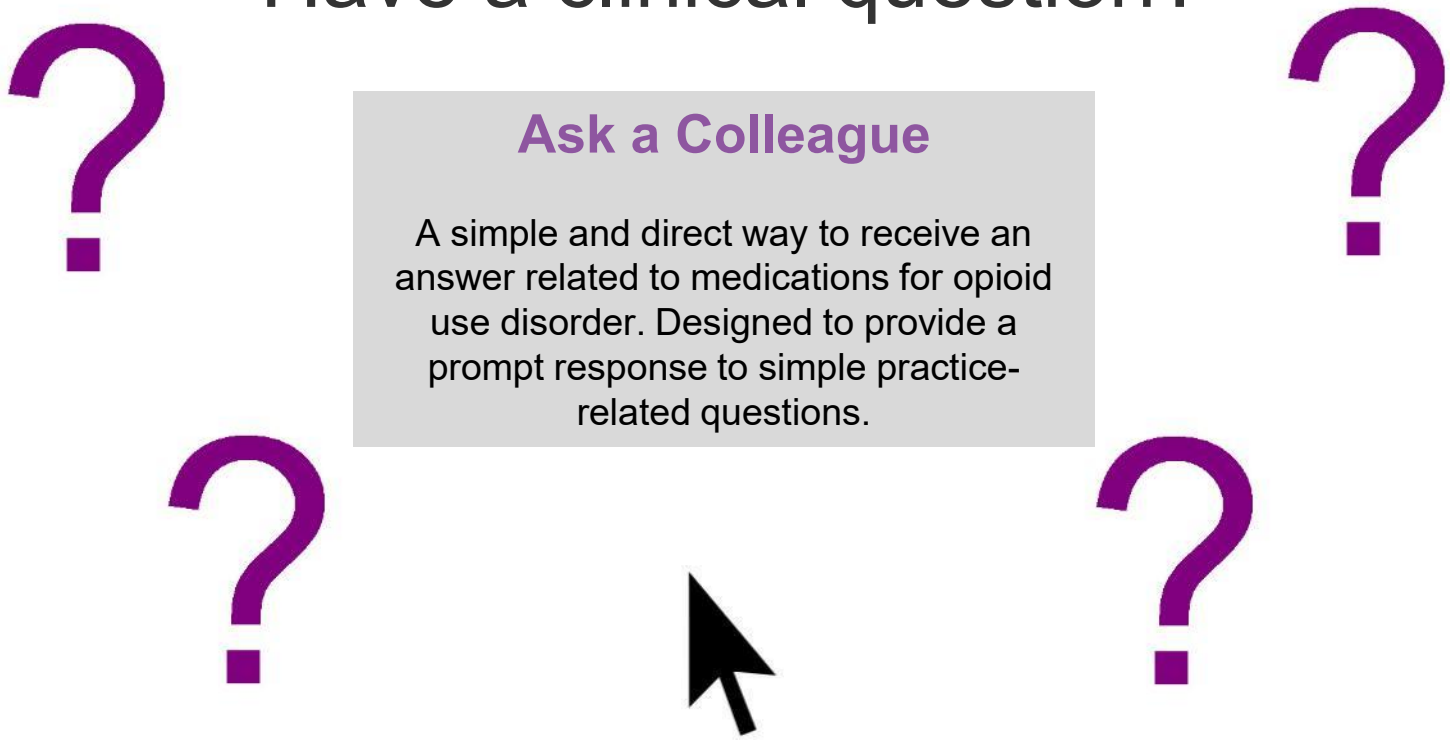
- PCSS-MOUD Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS-MOUD Mentors are a national network of providers with expertise in **addictions, pain, and evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

https://pcssNOW.org/mentoring/

PCSS-MOUD Discussion Forum

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

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PCSS-MOUD is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Policy Forum	American College of Emergency Physicians*
Addiction Technology Transfer Center*	American College of Medical Toxicology
African American Behavioral Health Center of Excellence	American Dental Association
All Rise	American Medical Association*
American Academy of Child and Adolescent Psychiatry	American Orthopedic Association
American Academy of Family Physicians	American Osteopathic Academy of Addiction Medicine*
American Academy of Neurology	American Psychiatric Association*
American Academy of Pain Medicine	American Psychiatric Nurses Association*
American Academy of Pediatrics*	American Society for Pain Management Nursing
American Association for the Treatment of Opioid Dependence	American Society of Addiction Medicine*
American Association of Nurse Practitioners	Association for Multidisciplinary Education and Research in Substance Use and Addiction*
American Association of Psychiatric Pharmacists	Black Faces Black Voices
American Chronic Pain Association	Coalition of Physician Education

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Columbia University, Department of Psychiatry*	Northwest Portland Area Indian Health Board
Council on Social Work Education*	Partnership to End Addiction
Faces and Voices of Recovery	Physician Assistant Education Association
Mobilize Recovery	Project Lazarus
NAADAC Association for Addiction Professionals*	Public Health Foundation (TRAIN Learning Network)
National Alliance for HIV Education and Workforce Development	Sickle Cell Adult Provider Network
National Association of Community Health Centers	Society for Academic Emergency Medicine*
National Association of Social Workers*	Society of General Internal Medicine
National Council for Mental Wellbeing*	The National Judicial College
National Council of State Boards of Nursing	Veterans Health Administration

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