IMPLEMENTATION FINDINGS FROM THE NATIONAL EVALUATION OF THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION

September 2020

Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the U.S. Department of Health and Human Services (HHS) on policy development in health, disability, human services, data, and science; and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

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The Office of Behavioral Health, Disability, and Aging Policy (BHDAP) focuses on policies and programs that support the independence, productivity, health and well-being, and long-term care needs of people with disabilities, older adults, and people with mental and substance use disorders.

NOTE: BHDAP was previously known as the Office of Disability, Aging, and Long-Term Care Policy (DALTCP). Only our office name has changed, not our mission, portfolio, or policy focus.

This report was prepared under contract #HHSP233201600017I between HHS's ASPE/BHDAP and Mathematica Policy Research to conduct the national evaluation of the demonstration. For additional information about this subject, you can visit the BHDAP home page at https://aspe.hhs.gov/bhdap or contact the ASPE Project Officer, Judith Dey, at HHS/ASPE/BHDAP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Judith.Dey@hhs.gov.

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ACT	Assertive Community Treatment
AOT	Assisted Outpatient Treatment
ASAM	American Society of Addiction Medicine
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
CBT	Cognitive Behavioral Therapy
CCBHC	Certified Community Behavioral Health Clinic
CMHC	Community Mental Health Center
CMS	HHS Centers for Medicare & Medicaid Services
DBT	Dialectical Behavior Therapy
DCO	Designated Collaborating
DY	Demonstration Year
DY1	First Demonstration Year
DY2	First Demonstration Year
EBP	Evidence-Based Practice
ED	Emergency Department
EHR	Electronic Health Record
FHQC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HIT	Health Information Technology
IOP	Intensive Outpatient
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer (or questioning)
MAT	Medication-Assisted Treatment
MH	Mental Health
PAMA	Protecting Access to Medicare Act
PPS	Prospective Payment System
PPS-1	PPS First Model/Methodology
PPS-2	PPS Second Model/Methodology
QBP	Quality Bonus Payment
RN	Registered Nurse

SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TCM	Targeted Case Management
VA	U.S. Department of Veterans Affairs

EXECUTIVE SUMMARY

Section 223 of the Protecting Access to Medicare Act (PAMA), enacted in April 2014, authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test new strategies for delivering and reimbursing services provided in community mental health centers (CMHCs). The CCBHC demonstration aims to improve the availability, quality, and outcomes of ambulatory services provided in CMHCs and other providers by establishing a standard definition and criteria for CCBHCs and developing a new payment system that accounts for the total cost of providing comprehensive services to all individuals who seek care. The demonstration also aims to provide coordinated care that addresses both behavioral and physical health conditions.

In October 2015, the U.S. Department of Health and Human Services (HHS) awarded planning grants to 24 states to begin certifying providers to become CCBHCs, develop new prospective payment systems (PPS), and plan for the demonstration's implementation. To support the demonstration's first phase, HHS, as required by PAMA, developed criteria for use in certifying CCBHCs in six important areas: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and reporting; and (6) organizational authority.[1] The criteria established a minimum threshold for the structures and processes that CCBHCs should have in place to provide high-quality care, although states may exercise some discretion in implementing the criteria to reflect their particular needs.

States used the planning grants to develop infrastructure to support the CCBHC demonstration, and to select a PPS model and develop PPS rates. States chose between two broad PPS models developed by the HHS Centers for Medicare & Medicaid Services (CMS) (although they may exercise some flexibility in operationalizing the models). The first model (PPS-1) is similar to the PPS model used by federally qualified health centers--it reimburses costs by using a fixed daily rate for all services rendered to a Medicaid beneficiary. If a state elected the PPS-1 model, CMS reimburses participating CCBHCs at a fixed daily rate for all services provided to a Medicaid beneficiary. The PPS-1 model also includes a state option to provide quality bonus payments (QBPs) to CCBHCs that meet defined quality metrics. The second model (PPS-2) reimburses costs by using a standard monthly rate per person served, with separate monthly rates that vary with beneficiaries' clinical conditions. Under the PPS-2 model, CMS reimburses participating CCBHCs at a fixed monthly rate for all services provided to a Medicaid beneficiary. The PPS-2 also includes outlier payments for costs above and beyond a specific threshold (that is, payment adjustments for extremely costly Medicaid beneficiaries). The PPS-2 model also requires bonus payments for clinics that meet defined quality metrics. Both PPS models aim to enhance Medicaid reimbursement by ensuring that reimbursement rates more closely reflect the cost of providing an enhanced scope of services. While clinics cannot reject or limit services on the basis of a client's ability to pay, CCBHCs can, however, only bill Medicaid

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[1] HHS Substance Abuse and Mental Health Services Administration (SAMHSA). "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics." Rockville, MD: SAMHSA, 2016.

for services provided to Medicaid beneficiaries. In addition, states must establish and publish a sliding fee discount schedule for consumers.

TABLE ES.1. Number of CCBHCs, Demonstration Start Date, and PPS			
State	**Number of CCBHCs**	**Demonstration Start Date**	**PPS**
Minnesota	6	July 1, 2017	PPS-1*
Missouri	15	July 1, 2017	PPS-1*
Nevada	3[a]	July 1, 2017	PPS-1*
New Jersey	7	July 1, 2017	PPS-2
New York	13	July 1, 2017	PPS-1*
Oklahoma	3	April 1, 2017	PPS-2
Oregon	12	April 1, 2017	PPS-1
Pennsylvania	7	July 1, 2017	PPS-1*
SOURCE: Mathematica/RAND review of CCBHC demonstration applications and telephone consultations with state officials.			
NOTES:			
a. Nevada initially certified 4 clinics; however, 1 is no longer participating in the demonstration. In March 2018, that CCBHC withdrew from the demonstration after Nevada revoked its certification. The total in the table reflects the number of participating CCBHCs in May 2019.			
* = PPS-1 with QBPs.			

In December 2016, HHS selected eight states from among the 24 that received planning grants to implement their PPS models and provide services that align with the CCBHC certification criteria. Consistent with PAMA requirements, HHS selected Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania based on the completeness of the scope of services that their CCBHCs will offer; the CCBHCs' ability to improve the availability of, access to, and engagement with a range of services (including assisted outpatient treatment); and their potential to expand mental health services without increasing federal spending. CCBHCs participating in the demonstration must also provide coordinated care and make available a comprehensive range of nine types of services[2] to all who seek help, including but not limited to those with serious mental illness, serious emotional disturbance, and substance use disorder (SUD). Services must be person-centered and family- centered, trauma-informed, and recovery-oriented, and the integration of physical and behavioral health care must serve the "whole person." To ensure the availability of the full scope of CCBHC services, service delivery could involve the participation of Designated Collaborating Organizations (DCO), which are entities not under the direct supervision of a CCBHC but that are engaged in a formal, contractual relationship with a CCBHC to provide selected services. CCBHCs that engage DCOs maintain clinical and financial responsibility for services provided by a DCO to CCBHC consumers, and DCOs provide services under the same requirements as CCBHCs and are reimbursed for these services directly by the CCBHC. In addition, CCBHCs and participating states must be able to

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[2] The nine types of services are: (1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization; (2) screening, assessment, and diagnosis, including risk assessment; (3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; (4) outpatient mental health and substance use services; (5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; (6) targeted case management; (7) psychiatric rehabilitation services; (8) peer support and counselor services and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans. CCBHCs must provide the first four services directly; the other service types may be provided by a DCO. In addition, crisis behavioral health services may be provided by a DCO if the DCO is an existing state-sanctioned, certified, or licensed system or network. DCOs may also provide ambulatory and medical detoxification in American Society of Addiction Medicine categories 3.2-WM and 3.7-WM.

collect, track, and report on a wide range of encounter, outcome, cost, and quality data. As summarized in Table ES.1, 66 CCBHCs are participating across eight states; only two states elected the PPS-2 model. As of August 2019, the demonstration will end on September 13, 2019.

In September 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Mathematica and its subcontractor, the RAND Corporation, to conduct a comprehensive national evaluation of the demonstration. ASPE is overseeing the evaluation in collaboration with CMS.

Working with these federal partners, Mathematica and RAND designed a mixed-methods evaluation to examine the implementation and outcomes of the demonstration and to provide information for HHS to include in its reports to Congress. Specifically, Section 223 of PAMA mandates that HHS's reports to Congress must include: (1) an assessment of access to community-based mental health services under Medicaid in the area or areas of a state targeted by a demonstration program as compared to other areas of the state; (2) an assessment of the quality and scope of services provided by CCBHCs as compared to community-based mental health services provided in states not participating in a demonstration program and in areas of a demonstration state not participating in the demonstration; and (3) an assessment of the impact of the demonstration on the federal and state costs of a full range of mental health services (including inpatient, emergency, and ambulatory services). To date, the evaluation has focused on providing critical information to Congress and the larger behavioral health community about the strategies that CCBHCs employ to improve care. As more data become available, the evaluation will describe the effects of the demonstration on consumer outcomes and costs.

In June 2018, Mathematica and RAND submitted to ASPE a report titled "Interim Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration," which described--through April 2018--the progress that states and CCBHCs made in implementing the demonstration and their successes and challenges. The current report provides updated information on implementation of the demonstration through April 2019 (approximately the first 22 months of the demonstration for six states and 24 months for the remaining two states). The findings in this report draw on data collected from interviews with state Medicaid and behavioral health agency officials and progress reports submitted by all participating CCBHCs (hereafter referred to as clinics). Unless otherwise noted, the 2018 and 2019 findings in this report are based on the number of clinics participating in the demonstration at the time of data collection each year (67 CCBHCs in 2018, and 66 CCBHCs in 2019 respectively).[3]

The clinic profiles in the report are based on site visits to CCBHCs in four states. In future reports, we will examine the impact of the demonstration on health care utilization, quality, and costs, using claims data and information submitted by CCBHCs and states. In August 2019, we will submit a separate report that summarizes states' and clinics' experiences with the required

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[3] Nevada initially certified four clinics; however, one is no longer participating in the demonstration. In March 2018, that CCBHC withdrew from the demonstration after Nevada revoked its certification.

quality measures (based on interview and site visit data) and costs (using data from the CCBHC cost-reporting template).[4]

Implementation Findings

During the demonstration, states and CCBHCs have focused on increasing access to care, maintaining the staffing and scope of services requirements in the certification criteria, and ensuring coordinated care for CCBHC clients. Although some CCBHCs experienced early implementation challenges related to staffing or the implementation of new services, state officials reported that the CCBHCs addressed these challenges and appear to be adhering to the certification criteria in the second demonstration year.

Most CCBHCs hired additional staff as part of the certification process. As shown in Figure ES.1 and detailed in Appendix Table A.1, most CCBHCs already employed licensed clinical social workers (LCSWs), SUD specialists, nurses, a medical director, bachelor's degree-level counselors, case managers, adult psychiatrists, and peer specialists/recovery coaches before they received certification. The CCBHCs most often hired case managers, peer specialists/recovery coaches, and family support workers, perhaps reflecting the criteria's focus on enhancing care coordination and person-centered and family-centered care. In addition, CCBHCs often hired various types of nurses and child/adolescent psychiatrists to provide the full scope of required services. Although states had the latitude to determine the specific types of staff their CCBHCs must employ, as of March 2018 (Demonstration Year 1 [DY1]), nearly all CCBHCs employed the types of staff mentioned in the CCBHC certification criteria.

CCBHCs' ability to maintain the required types of staff throughout the demonstration varied by staff type. For example, as shown in Figure ES.1, there was no substantial difference between DY1 and second Demonstration Year (DY2) in the proportion of clinics that employed the following staff types: LCSWs, nurses, associate's degree-level or non-degree counselors, case management staff, peer specialists/recovery coaches, licensed psychologists, other clinician types, mental health professionals, family support staff, and community health workers. However, the proportion of clinics that employed psychiatrists declined from DY1 to DY2. Seventy-six percent of clinics employed child psychiatrists in DY1 versus 64 percent in DY2. Likewise, 91 percent of clinics employed adult psychiatrists in DY1 versus 82 percent in DY2. There was also a 13 point decline from DY1 to DY2 in the percentage of clinics that employed interpreters or linguistic counselors. Such changes in staffing may suggest clinics' efforts to experiment and identifying ways to use staff and resources more efficiently. CCBHCs and states reported that clinics faced several ongoing challenges associated with hiring and retaining staff, including, for example, uncertainty around the future of the demonstration, retaining enough of each staff type to meet increased demand for services, and increases in caseloads and responsibilities leading to staff burnout. However, officials generally perceived that clinics effectively used strategies such as increased salaries and benefits to overcome challenges.

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[4] CCBHCs submit cost reports within nine months following each demonstration year. CMS provided CCBHCs with a cost-reporting template. This report does not contain findings based on data from these cost reports, but, where noted, some of the definitions and terminology used in this report align with definitions and terms from the CMS cost-reporting template.

FIGURE ES.1. Proportion of CCBHCs that Employed Specific Types of Staff Before Certification and in March 2018 (DY1) and March 2019 (DY2)

Staff type	Before CCBHC certification	March 2018 (DY1)	March 2019 (DY2)
CCBHC medical director	82	99	91
Adult psychiatrists	70	91	82
Child/adolescent psychiatrists	58	76	64
Other psychiatrists	43	60	47
Licensed clinical social workers	94	99	100
Licensed marriage and family therapists	60	63	61
Licensed psychologists	45	52	44
Other clinician types	43	55	58
Mental health professionals	40	45	47
SUD specialists	91	100	92
Nurses	85	100	98
Bachelor's degree-level counselors	73	75	77
Case management staff	72	97	97
Peer specialists/recovery coaches	69	99	100
Interns	61	70	73
Medical/nursing assistants	42	55	58
Associate's degree-level or non-degree counselors	40	45	48
Family support staff	37	67	68
Interpreters or linguistic counselors	36	43	30
Community health workers	27	40	35
Occupational therapists	16	25	17
Pharmacy staff	12	15	17

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: Denominator is 67 CCBHCs for "Proportion of CCBHCs that employed staff type before certification" and March 2018 findings, and 66 CCBHCs for March 2019 findings.

See Appendix Table A.1 for detailed findings and number of clinics corresponding to the percentages.

See Appendix Table A.2 for state-level findings. These findings were generally consistent across states, with the exception of Minnesota and Pennsylvania, where the proportion of clinics employing each type of staff did not decrease from 2018 to 2019.

Consistent with the CCBHC cost-reporting template, the mental health professional category includes only providers trained and credentialed for psychological testing.

"Other clinician types" is a write-in category.

In the second year of the demonstration, officials in all but one state cited uncertainty around the future of the demonstration as the most significant staffing challenge for clinics. State officials reported that the uncertainty has adversely affected clinics' ability to retain staff and maintain workforce morale as the demonstration draws to a close, noting that clinics have been reluctant to add new positions or fill vacancies for fear of not being able to sustain those staff positions after the demonstration ends.

CCBHCs have worked throughout the demonstration to make services more convenient and tailored to the needs of specific populations. As reported by states, the most common strategy used by CCBHCs to increase access to care was to introduce open-access scheduling. In addition, as shown in Figure ES.2, CCBHCs provided services in locations outside of the clinic, such as consumers' homes and community service agencies like Social Security offices and community centers, in both demonstration years. Clinics also have continued to make broad use of telehealth to extend the reach of CCBHC services. Clinics have used a variety of other strategies to improve accessibility, such as conducting outreach to new and underserved populations, and remodeling the physical space of clinics to accommodate the delivery of new

services (such as detoxification and physical health screening and monitoring) Stakeholder organizations representing consumers and their family members reported that the strategies CCBHCs have employed, such as open-access and expanded hours of service provision, have significantly improved access to care for CCBHC clients in their states.

FIGURE ES.2. Proportion of CCBHCs that Provided Services Outside of Physical Clinic Space in the Past 12 Months

Consumers' homes	78%
Schools	47%
Courts, police offices, and other justice-related facilities	33%
Hospitals and EDs	30%
Community service agencies and nonprofit organizations	20%
Homeless shelters	11%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTES: The denominator is the number of CCBHCs that reported offering services outside of the CCBHC physical buildings in the past 12 months as of March 2019 (n = 64).
See Appendix Table A.6 for 2018 findings.
See Appendix Table A.7 for state-level findings. The majority of clinics in all 8 demonstration states offered services outside of the CCBHC as of 2018, increasing to 100% of all CCBHCs as of 2019 in all states except New Jersey.

Most CCBHCs expanded their scope of services to meet the certification requirements. Clinics most often added services within the categories of outpatient mental health and/or SUD services, psychiatric rehabilitation services, crisis services, peer support, services for members of the armed forces and veterans, and primary care screening and monitoring (Figure ES.3). The extent to which the CCBHCs added services to meet the certification requirements varied widely across the states depending on the service infrastructure that existed before the demonstration.

FIGURE ES.3. Proportion of CCBHCs that Added Each Type of Service as a Result of Certification (as of March 2018)

Service	Percentage
Outpatient mental health and/or SUD services	63%
Psychiatric rehabilitation services	55%
Crisis behavioral health services	51%
Peer support services	49%
Intensive community-based mental health services for members of the armed forces and veterans	45%
Primary care screening and monitoring	42%
Targeted case management	40%
Screening, assessment, and diagnosis	22%
Person- and family-centered treatment planning services	18%
Other required CCBHC services	16%

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 data collected by Mathematica and the RAND Corporation, March 2018.

NOTES: Denominator is 67 CCBHCs.

See Appendix Table A.11 for detailed findings on individual services.

CCBHCs may have provided services within each of the service categories illustrated in the figure before CCBHC certification. For example, all clinics provided some type of outpatient mental health and/or SUD treatment before certification. However, 63% of clinics added some type of outpatient mental health and/or SUD treatment as a result of certification. The service categories illustrated in this figure correspond to the service categories described in the CCBHC certification criteria.

Officials in all states perceived that clinics were able to sustain delivery of the nine core CCBHC services throughout the demonstration, a finding confirmed by clinics in the progress report. As shown in Figure ES.4, nearly all CCBHCs in both DY1 and DY2 reported that they provided the required services, with the exception of intensive community-based mental health services for members of the armed forces and veterans, which were provided by about 70 percent of clinics in both years. State officials speculated that the armed forces/veterans populations did not comprise a large percentage of CCBHC clients and that CCBHCs may have struggled to engage these populations and to develop strong referral relationships and care coordination agreements with the U.S. Department of Veterans Affairs providers. Though not required by the demonstration, about half of clinics provided on-site primary care in each demonstration year.

FIGURE ES.4. Proportion of CCBHCs that Provided Each Type of Service Either Directly or Through a DCO
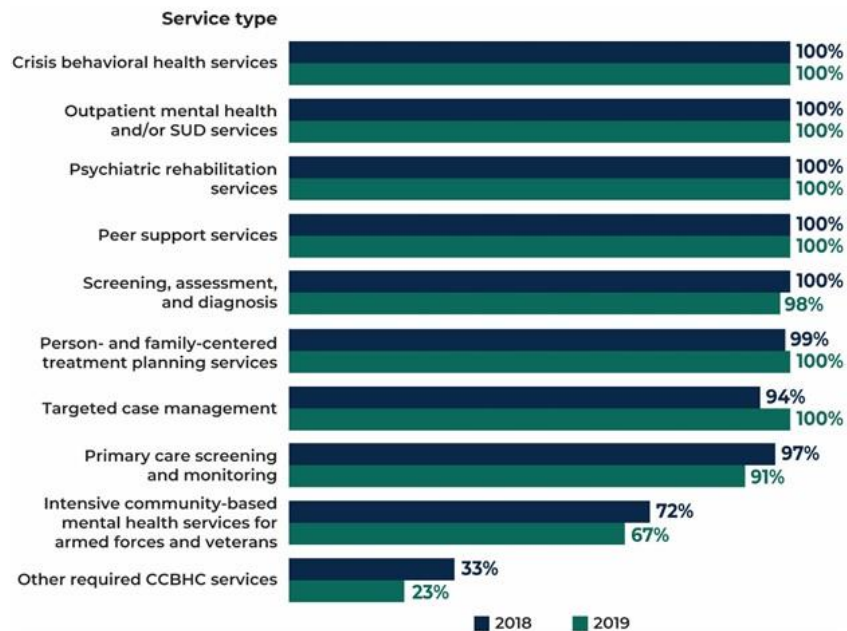
SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTE: Denominator is 67 CCBHCs in 2018 (DY1) and 66 CCBHCs in 2019 (DY2).
The "other required CCBHC services" category denotes additional services that do not fall within the 9 service types defined in federal criteria but that may be required by individual states.
See Appendix Table A.12 for detailed findings and the number of clinics corresponding to the percentages.
See Appendix Table A.13 for state-level findings.

CCBHCs were able to add and sustain a range of evidence-based practices (EBPs) across demonstration years. In the first year of the demonstration, CCBHCs offered a wide range of EBPs and psychiatric rehabilitation and other services either directly or through DCOs. As shown in Figure ES.5, most clinics were able to sustain or provide more of these services in the second year of the demonstration. For example, 46 percent (n = 31) of clinics added medication-assisted treatment (MAT) for alcohol or opioid use as a result of certification, and 92 percent of clinics (n = 61) offered MAT in DY2 compared to 84 percent (n = 56) in DY1. Even though, early in the demonstration, CCBHCs generally addressed challenges to maintaining EBPs and providing the full scope of CCBHC services, officials continued to explore ways to support clinics in offering the full range of services, such as by providing CCBHCs with increased flexibility to better tailor EBPs and other services to reflect the needs and preferences of their client populations.

CCBHCs have used a variety of strategies to improve care coordination, including adding various provider types to treatment teams and expanding targeted care coordination strategies to different populations and service lines. In the early stages of the demonstration, improvements to electronic health records (EHR) and health information technology aided clinics in their care coordination efforts, in some cases permitting CCBHCs to integrate care plans more fully, connect with external providers, and receive alerts about clients' care

transitions. As the demonstration progressed, clinics implemented additional strategies, and initiated collaboration with various external organizations to facilitate coordinated care. For example, some clinics partnered with first responders and law enforcement officials on strategies to intervene in crisis situations and divert those in crisis from the criminal justice system.

CCBHCs, for the most part, elected to offer the full scope of CCBHCs services directly, instead of engaging separate organizations to deliver required services. While the certification criteria allowed for some services to be provided by DCOs, officials suggested that CCBHCs preferred to provide services directly because they wished to embrace the model fully and were reluctant to assume oversight responsibility for another provider's services. CCBHCs did, however, continue to provide and expand services in collateral agencies such as schools and shelters and to build and sustain close formal and informal relationships with a range of external providers.
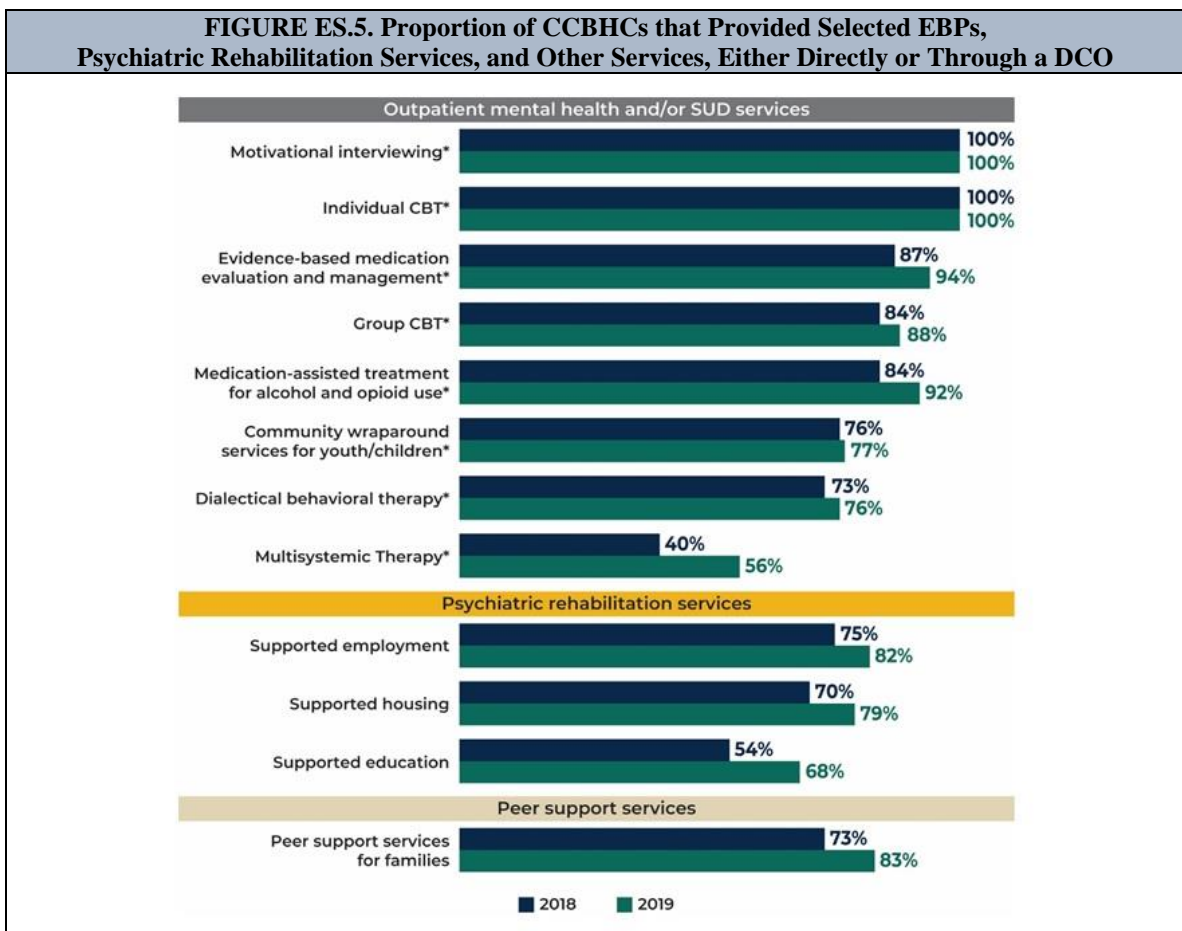
FIGURE ES.5. Proportion of CCBHCs that Provided Selected EBPs, Psychiatric Rehabilitation Services, and Other Services, Either Directly or Through a DCO

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: Denominator is 67 CCBHCs in 2018 and 66 CCBHCs in 2019.
See Appendix Table A.12 for detailed findings and the number of clinics corresponding to the percentages.
See Appendix Table A.11 for the number and percentage of clinics that added each type of service as a result of CCBHC certification.
See Appendix Table A.13 for state-level findings.
* = EBP listed in CCBHC criteria.

Future Evaluation Activities

In August 2019, we will submit a report summarizing information from the first year of CCBHC cost reports. The report will also draw on information from interviews and site visits to describe clinics' experience with the PPS and the progress that CCBHCs and states are making toward submission of the required quality measures. We will update the report in August 2020 to include information from the second year of CCBHC cost reports and will summarize the quality of care provided to CCBHC consumers by using data from the CCBHC-reported and state-reported quality measures.

We are in the process of obtaining Medicaid claims and encounter data from states to examine changes in service utilization and costs. We plan to examine the impacts of CCBHC services on: (1) hospitalization rates; (2) emergency department service utilization; and (3) ambulatory care relative to within-state comparison groups (Medicaid beneficiaries with similar diagnostic and demographic characteristics who did not receive care from CCBHCs). Depending on the availability of data within each state, we expect that the impact analyses will use approximately four years of Medicaid claims/encounter data (up to a two-year pre-demonstration period and a two-year post-implementation period). We will report these findings in our final report in May 2021, along with updated findings that draw on both years of CCBHC cost reports and quality measures.

1. BACKGROUND

A. Description of the CCBHC Demonstration

In April 2014, Section 223 of the Protecting Access to Medicare Act (PAMA) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test new strategies for delivering and reimbursing services provided in community mental health centers (CMHCs). The CCBHC demonstration aims to improve the availability, quality, and outcomes of ambulatory services provided in CMHCs by establishing a standard definition and criteria for CCBHCs and developing a new payment system that accounts for the total cost of providing comprehensive services to all individuals who seek care. The demonstration also aims to provide coordinated care that addresses both behavioral and physical health conditions.

In October 2015, the U.S. Department of Health and Human Services (HHS) awarded planning grants to 24 states to begin certifying CMHCs to become CCBHCs, develop new prospective payment systems (PPS), and plan for the demonstration's implementation. To support the demonstration's first phase, HHS, as required by PAMA, developed criteria for use in certifying CCBHCs in six important areas: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and reporting; and (6) organizational authority.[5] The criteria established a minimum threshold for the structures and processes that CCBHCs should have in place to provide high-quality care, although states may exercise some discretion in implementing the criteria to reflect their particular needs.

States used the planning grants to develop infrastructure to support the CCBHC demonstration, and to select a PPS model and develop PPS rates. States chose between two broad PPS models developed by the HHS Centers for Medicare & Medicaid Services (CMS) (although they may exercise some flexibility in operationalizing the models). The first model (PPS-1) is similar to the PPS model used by federally qualified health centers (FHQCs)--it reimburses costs by using a fixed daily rate for all services rendered to a Medicaid beneficiary. If a state elected the PPS-1 model, CMS reimburses participating CCBHCs at a fixed daily rate for all services provided to a Medicaid beneficiary. The PPS-1 model also includes a state option to provide quality bonus payments (QBPs) to CCBHCs that meet defined quality metrics. The second model (PPS-2) reimburses costs by using a standard monthly rate per person served, with separate monthly rates that vary with beneficiaries' clinical conditions. Under the PPS-2 model, CMS reimburses participating CCBHCs at a fixed monthly rate for all services provided to a Medicaid beneficiary. The PPS-2 also includes outlier payments for costs above and beyond a specific threshold (that is, payment adjustments for extremely costly Medicaid beneficiaries). The PPS-2 model also requires bonus payments for clinics that meet defined quality metrics. Both PPS models aim to enhance Medicaid reimbursement by ensuring that reimbursement rates more closely reflect the cost of providing an enhanced scope of services. The use of a PPS provides a unique opportunity for states and CCBHCs to develop rates based on the expected cost of care

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[5] HHS Substance Abuse and Mental Health Services Administration (SAMHSA). "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics." Rockville, MD: SAMHSA, 2016.

that accounted for total costs associated with delivering the nine required services to Medicaid beneficiaries. This included the ability to use a mix of staffing models, as well as pay for services that were allowed under the demonstration, but might not have been traditionally covered under Medicaid, such as those that do not involve face-to-face contact with the consumer. These PPS reflect HHS's broader strategy of encouraging the development of a health care system that results in better care, smarter spending, and healthier people. While clinics cannot reject or limit services on the basis of a client's ability to pay, CCBHCs can, however, only bill Medicaid for services provided to Medicaid beneficiaries. In addition, states must establish and publish a sliding fee discount schedule for clients.

In December 2016, HHS selected eight states from among the 24 that received planning grants to implement their PPS models and provide services that align with the CCBHC certification criteria. Consistent with PAMA requirements, HHS selected Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania based on the completeness of the scope of services their CCBHCs will offer; the CCBHCs' ability to improve the availability of, access to, and engagement with a range of services (including assisted outpatient treatment [AOT]); and their potential to expand mental health services without increasing federal spending. CCBHCs participating in the demonstration must also provide coordinated care and make available a comprehensive range of nine types of services[6] to all who seek help, including but not limited to those with serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). Services must be person-centered and family-centered, trauma-informed, and recovery-oriented, and the integration of physical and behavioral health care must serve the "whole person." To ensure the availability of the full scope of CCBHC services, service delivery could involve the participation of other Designated Collaborating Organizations (DCO), which are entities not under the direct supervision of a CCBHC but that are engaged in a formal relationship with a CCBHC to provide selected services. DCOs provide services under the same requirements as CCBHCs. CCBHCs that engage DCOs maintain clinical and financial responsibility for services provided by a DCO to CCBHC consumers, and directly reimburse DCOs for provided services. CCBHCs and participating states must be able to collect, track, and report on a wide range of encounter, outcome, cost, and quality data. As summarized in Table I.1, 66 CCBHCs are participating across eight states; only two states elected the PPS-2 model. As of August 2019, the demonstration will end on September 13, 2019.

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[6] The nine types of services are: (1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization; (2) screening, assessment, and diagnosis, including risk assessment; (3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; (4) outpatient mental health and substance use services; (5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; (6) targeted case management (TCM); (7) psychiatric rehabilitation services; (8) peer support and counselor services and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans. CCBHCs must provide the first four service types directly; a DCO may provide the other service types. In addition, crisis behavioral health services may be provided by a DCO if the DCO is an existing state-sanctioned, certified, or licensed system or network. DCOs may also provide ambulatory and medical detoxification in American Society of Addiction Medicine (ASAM) categories 3.2-WM and 3.7-WM.

TABLE I.1. Number of CCBHCs, Demonstration Start Date, and PPS			
State	**Number of CCBHCs**	**Demonstration Start Date**	**PPS**
Minnesota	6	July 1, 2017	PPS-1*
Missouri	15	July 1, 2017	PPS-1*
Nevada	3[a]	July 1, 2017	PPS-1*
New Jersey	7	July 1, 2017	PPS-2
New York	13	July 1, 2017	PPS-1*
Oklahoma	3	April 1, 2017	PPS-2
Oregon	12	April 1, 2017	PPS-1
Pennsylvania	7	July 1, 2017	PPS-1*
SOURCE: Mathematica/RAND review of CCBHC demonstration applications and telephone consultations with state officials.			
NOTES:			
a. Nevada initially certified 4 clinics; however, 1 is no longer participating in the demonstration. In March 2018, this CCBHC withdrew from the demonstration after Nevada revoked its certification. The total in the table reflects the number of participating CCBHCs in May 2019.			
* = PPS-1 with QBPs.			

1. Goals of the National Evaluation

In September 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Mathematica and its subcontractor, the RAND Corporation, to conduct a comprehensive national evaluation of the demonstration. ASPE is overseeing the evaluation in collaboration with CMS.

Working with these federal partners, Mathematica and RAND designed a mixed-methods evaluation to examine the implementation and outcomes of the demonstration and to provide information for HHS to include in its reports to Congress. Specifically, Section 223 of PAMA mandates HHS's reports to Congress to include: (1) an assessment of access to community-based mental health services under Medicaid in the area or areas of a state targeted by a demonstration program as compared to other areas of the state; (2) an assessment of the quality and scope of services provided by CCBHCs as compared to community-based mental health services provided in states not participating in a demonstration program and in areas of a demonstration state not participating in the demonstration; and (3) an assessment of the impact of the demonstration on the federal and state costs of a full range of mental health services (including inpatient, emergency, and ambulatory services). To date, the evaluation has focused on providing critical information to Congress and the larger behavioral health community about the strategies that CCBHCs employ to improve care. As more data become available, the evaluation will describe the effects of the demonstration on consumer outcomes and costs.

2. Purpose of Report

In June 2018, Mathematica and RAND submitted to ASPE a report titled "Interim Implementation Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration," which described--through April 2018--the progress that states and CCBHCs made in implementing the demonstration and their successes and challenges. The current report provides updated information on the implementation of the demonstration through April 2019 (approximately the first 22 months of the demonstration for six states and 24 months

for the remaining two states). The findings in this report draw on data collected from interviews with state Medicaid and behavioral health agency officials and progress reports submitted by all participating CCBHCs (hereafter referred to as clinics). The clinic profiles in the report are based on site visits to CCBHCs in four states. Chapter II of the report describes the data collection and analytic methods. Chapter III provides updated findings on implementation progress, successes, and challenges with respect to CCBHCs' staffing (Chapter III.A), access to care (Chapter III.B), scope of services (Chapter III.C), and care coordination (Chapter III.D). The final chapter summarizes overarching themes that emerged from our analysis and briefly describes next steps for the evaluation. In future reports, we will examine the impact of the demonstration on health care utilization, quality, and costs, using claims data and information submitted by CCBHCs and states. In August 2019, we will submit a separate report that summarizes states' and clinics' experiences with the required quality measures (based on interview and site visit data) and costs (using data from the CCBHC cost-reporting template).[7]

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[7] CCBHCs submit cost reports within nine months following each demonstration year. CMS provided CCBHCs with a cost-reporting template. This report does not contain findings based on data from these cost reports, but, where noted, some of the definitions and terminology used in this report align with definitions and terms from the CMS cost-reporting template.

II. METHODS

The findings in this report are based on: (1) responses to progress reports each clinic completed in spring 2018 and 2019; (2) three rounds of interviews with state Medicaid and behavioral health officials; and (3) site visits to clinics in four demonstration states.

CCBHC progress reports. In spring 2018 (Demonstration Year 1 [DY1]), clinics submitted an online progress report that included information about their staffing, training, accessibility of services, scope of services, electronic health record (EHR)/health information technology (HIT) capabilities, care coordination activities, and relationships with other providers. Clinics submitted a second progress report in spring 2019 to report on Demonstration Year 2 (DY2) activities (the 2018 and 2019 progress report templates appears in Appendix B). Questions in the DY2 progress report were almost identical to those in the DY1 progress report, with a few minor changes to streamline data collection for clinics and update the timeframes referenced by the questions. In collaboration with the CCBHC demonstration program leadership in each state, we conducted extensive outreach to clinic leaders via telephone and email before and during collection of the progress reports to encourage clinics' participation and answer any questions. In 2018, all 67 participating clinics completed the progress report. In 2019, the remaining 66 clinics completed the report. At both time points, all participating CCBHCs completed the progress reports--a 100 percent response rate.[8] Unless otherwise noted, the 2018 and 2019 findings in this report are based on the number of clinics participating in the demonstration at the time of data collection each year (67 CCBHCs in 2018, and 66 CCBHCs in 2019 respectively).

We computed descriptive statistics (for example, means, percentages) by using Excel and SAS to analyze the clinic progress report data. We summarize findings across all clinics and within each state. However, readers should interpret state-level variation in the findings cautiously, given that some states such as Nevada and Oklahoma account for a small number of clinics participating in the demonstration (n = 3 each), whereas others, such as New York and Missouri, have over a dozen clinics. In addition, the service systems and policy context in which clinics operate vary considerably across states, posing a challenge to direct cross-state comparisons. Finally, although we compare across the first and second demonstration years across similar items, we focus in this report on the status of implementation as of March 2019 (three months prior to the end of DY2), when the clinics submitted their second progress reports to us. CCBHCs have also continued to make changes and implement new programs and procedures since completion of the progress reports as they approach the end of the demonstration period; thus, the progress report findings reported here do not capture the most recent developments.

Telephone interviews. We conducted three rounds of telephone interviews with state behavioral health and Medicaid officials involved in leading implementation of the CCBHC demonstration in each state. We conducted the first round of interviews early in DY1--September and October 2017. We conducted the second round from February to March 2018 and the third

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[8] Nevada initially certified four clinics; however, one is no longer participating in the demonstration. In March 2018, shortly after we collected the first round of progress reports, this CCBHC withdrew from the demonstration after Nevada revoked its certification.

round from February to April 2019. The first round of interview questions gathered information about early implementation, decisions made during the demonstration planning phase, early successes and challenges in fulfilling the certification requirements and following the data collection and monitoring procedures, and projected challenges or barriers to successful implementation. The second round of interviews gathered information on interim successes and challenges since the initial interview; successes in implementing demonstration cost-reporting procedures and quality measures; and early experiences with the PPS systems. The third round of interviews collected information on implementation successes and challenges in the second demonstration year. The interview guides for each round appear in Appendix C.

We conducted 29 state official interviews (ten interviews during the first two rounds and nine during the third). In seven states, the behavioral health and Medicaid officials asked to participate in the interviews together to reduce scheduling burden and provide comprehensive answers.[9] Each state interview required approximately 90 minutes. In the third round, we also conducted interviews with consumer and family representative organizations in four states in order to gather the perspective of consumers and families on the demonstration.

Two researchers conducted each interview, with one leading the interview and one taking notes. We asked interviewees' permission to audio record the discussions for purposes of confirming the accuracy and completeness of interview notes. Following the interviews, to expedite analysis, we organized the interview information into categories defined by the CCBHC certification criteria. We summarized interviewees' responses about implementation experiences within each domain of the certification criteria covered by this report (that is, staffing; access to care; scope of services; care coordination) separately for each state and then identified cross-state themes in the findings.

Site visits. We conducted site visits to two clinics in each of four demonstration states in February and March 2018. In collaboration with ASPE, we selected the four states to visit: Missouri, Oklahoma, Oregon, and Pennsylvania.[10] Using information from clinic responses to the progress report and interview transcripts, we selected two clinics within each state to visit that varied in terms of the following characteristics: urban-rural designation, location and proximity to other CCBHCs, size and number of CCBHC service locations, implementation of intensive team-based supports, Assertive Community Treatment (ACT), medication-assisted treatment (MAT), and any innovative engagement strategies or mobile/community-based supports that clinics' reported in their progress reports or that we learned about during interviews with state officials. During the site visits, we conducted in-depth discussions with clinic administrators and frontline clinical staff about how care has changed following implementation of the demonstration. Interview topics included successes and barriers related to CCBHC staffing, steps clinics have taken to improve access to care and expand their scope of services,

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[9] In one state, we conducted separate interviews for each group of state officials--one with behavioral health officials and one with Medicaid officials per the state's preference.

[10] We selected these states based on their geographic diversity, use of different PPS options (i.e., PPS-1, PPS-1 with QBPs, and PPS-2), and because we are including these states in the evaluation's claims analysis.

CCBHCs' experience with payments and the PPS, and quality reporting practices. The interview guides for each staff type appear in Appendix D. We asked interviewees' permission to audio record the discussions to facilitate our analysis. Following the interviews, we organized the interview information into categories defined by the CCBHC certification criteria to facilitate analysis and to develop the clinic profiles in Chapter III.

III. IMPLEMENTATION FINDINGS

This chapter updates interim findings on the implementation of the demonstration presented in our June 2018 report to incorporate data gathered through April 2019. The chapter presents findings on implementation progress, successes, and challenges with respect to CCBHC staffing (Chapter III.A), access to care (Chapter III.B), scope of required services (Chapter III.C), and care coordination (Chapter III.D).

A. Staffing

The certification criteria require CCBHCs to maintain staff appropriate to providing comprehensive behavioral health care. The criteria include some specific staffing requirements; for example, clinics are required to have a psychiatrist serving in the role of medical director[11] as well as the following staff: a medically trained behavioral health care provider who can prescribe and manage medications independently under state law; credentialed SUD specialists; and individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with SED and adults with SMI and/or SUD. However, the certification criteria allow states flexibility to develop more detailed plans for appropriately staffing CCBHCs according to their existing systems of licensure and accreditation and based on the needs of the populations served by the states' CCBHCs. The criteria provides examples of CCBHC staff types states could require, including the following: (1) psychiatrists (including child, adolescent, and geriatric psychiatrists); (2) nurses trained to work with consumers across the lifespan; (3) licensed independent clinical social workers; (4) licensed mental health counselors; (5) licensed psychologists; (6) licensed marriage and family therapists; (7) licensed occupational therapists; (8) staff trained to provide case management; (9) peer specialists/recovery coaches; (10) licensed addiction counselors; (11) staff trained to provide family support; (12) medical assistants; and (13) community health workers.[12] The certification criteria also require CCBHCs to provide staff training in a variety of topics, including provision of culturally competent care, patient-centered care, risk assessment, suicide prevention, and suicide response.

This section of the report summarizes: (1) the types of staff that clinics hired; (2) the challenges that clinics encountered in maintaining the required staff during the demonstration; and (3) the types of training that CCBHC staff received since the demonstration's outset.

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[11] In cases in which a CCBHC is unable to employ a psychiatrist as medical director (e.g., because of a documented behavioral health professional shortage in its vicinity), the criteria specify that "a medically trained behavioral health care provider with appropriate education and licensure with prescriptive authority in psychopharmacology who can prescribe and manage medications independently pursuant to state law" may serve as a CCBHC medical director.

[12] HHS Substance Abuse and Mental Health Services Administration (SAMHSA). "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics." Rockville, MD: SAMHSA, 2016.

1. What Types of Staff did CCBHCs Hire as a Result of Certification?

CCBHCs employed a wide variety of clinical staff before the demonstration. As shown in Figure III.1, before CCBHC certification, most clinics employed licensed clinical social workers (LCSWs), SUD specialists, nurses, a medical director, bachelor's degree-level counselors, case managers, adult psychiatrists, peer specialists/recovery coaches, and child/adolescent psychiatrists. However, before CCBHC certification, fewer clinics employed family support staff, community health workers, interpreters or linguistic counselors, occupational therapists, and mental health professionals trained and credentialed to provide psychological testing.

Interviews with state officials suggested that variation across clinics in the types of staff that they employed before the demonstration was related in part to the types of services the clinic historically provided. For example, before the demonstration, the CCBHCs in Nevada focused primarily on the delivery of treatment for SUD, whereas the CCBHCs in New York primarily provided services for mental health disorders. Consequently, Nevada's CCBHCs had relatively few mental health providers on staff before the demonstration, whereas New York's CCBHCs employed a broad range of mental health providers but fewer substance use treatment providers.

Officials across all states reported that clinics were able to ramp up quickly and begin hiring staff as the demonstration began; they succeeded in filling the required staff positions in the first demonstration year. Officials in one state, for example, noted that its clinics created and filled 167 new staff positions during the demonstration's first year. **Accordingly, as of March 2018 (DY1 Progress Report), the majority of clinics reported employing staff to fulfill the following positions, which are required or recommended in the certification criteria**:

- Ninety-nine percent of clinics (n = 66) reported employing a CCBHC medical director compared to 82 percent (n = 55) before certification (Figure III.1). Ninety-one percent of clinics (n = 61) reported employing a psychiatrist as medical director (not shown in Figure III.1). In the few clinics that did not have psychiatrists as medical directors, clinics hired psychiatric nurse practitioners to fulfill the role of director, as permitted by the CCBHC criteria when psychiatrists are unavailable because of workforce shortages.

- Ninety-one percent of clinics (n = 61) employed adult psychiatrists compared to 70 percent (n = 47) before certification.

- Seventy-six percent of clinics (n = 51) employed child/adolescent psychiatrists compared to 58 percent (n = 39) before certification.

- All clinics employed SUD specialists compared to 91 percent (n = 61) before certification.

After the certification process, a substantially larger proportion of CCBHCs employed case managers, peer specialists/recovery coaches, child/adolescent psychiatrists, and family support workers in DY1 than before certification. For example, 69 percent of clinics (n = 46) employed peer specialists/recovery coaches before certification; by DY1, however, almost all did so (n = 66; 99 percent) (Figure III.1). Likewise, only 37 percent (n = 25) of clinics employed family

support staff before certification, but 67 percent (n = 45) did so in DY1. In contrast, the proportion of clinics that employed LCSWs, bachelor's degree-level counselors, and mental health professionals trained and credentialed for psychological testing before the demonstration did not change substantially as a result of certification. These findings varied somewhat across states, given differences in the treatment focus of CCBHCs before the demonstration (state-level findings appear in Appendix Table A.2).

In several open-ended questions in the progress report, clinics reported that they hired specific types of nurses and other clinical staff as part of the certification process (not shown in Figure III.1). For example, in DY1:

- Fifty-eight percent of clinics (n = 38) hired registered nurses (RNs), especially RNs with psychiatric experience (n = 11; 16 percent of CCBHCs).

- Thirteen percent of clinics (n = 9) hired nurses with SUD experience (one clinic reported hiring a nurse with experience in providing MAT for SUD).

- Fifty-five percent of clinics (n = 37) reported hiring "other clinician types." The most common of these other staff types were licensed professional counselors (n = 10; 15 percent of clinics), qualified mental health professionals or licensed mental health counselors (n = 7; 10 percent of clinics),[13] and licensed master social workers (n = 5; 8 percent of clinics).

In interviews, officials in several states suggested that the enhanced payment rates provided as part of the PPS may have played an important role in helping CCBHCs build their provider workforce by allowing CCBHCs to offer higher salaries and hire different types or greater numbers of staff than they previously had the capacity to employ. Officials in three states reported that the enhanced payment rates under the PPS were especially helpful in hiring and retaining psychiatrists. The rates allowed clinics to offer higher salaries and better benefits than those offered by other potential employers.

State officials suggested that experiences in hiring and maintaining required staff may also have varied somewhat by geographic designation (i.e., urban versus rural areas), noting that hiring in rural communities proved more challenging, but that clinics have developed creative solutions to rural hiring challenges. For example, officials in Nevada commented that the flexibility to employ interns and cultivate a preprofessional student workforce has been helpful to CCBHCs operating in the state's rural areas. According to state officials, these rural clinics have been able to provide training, supervision, and experience to social work students and then retain those students in their workforces after graduation.

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[13] To align with the terminology included in the CCBHC cost-reporting template, the mental health professional category in the progress report included only those trained and credentialed for psychological testing.

CCBHC Spotlight: Nurses as Key Players to Address Medical Issues in CCBHCs

A rural CCBHC provides outpatient behavioral health services to a large number of homeless and uninsured individuals. In addition to providing the required CCBHC services, the clinic's behavioral health staff collaborate with an on-site FQHC--in a non-DCO relationship--to provide clients with access to physical health care.

Before the demonstration, the clinic had one nurse on staff who served a subset of the clinic's clients. When the clinic became a CCBHC, it hired four RNs and one licensed practical nurse, and restructured and expand the nurse role to provide primary care screening and monitoring (CCBHC Requirement 4.a.1), on-site primary care services, and to coordinate physical health care with external providers. A primary focus of the nurse role under the demonstration also is to provide education to behavioral health staff on physical health topics. Clinic leadership reported that the PPS reimbursement model allowed the clinic to hire additional nursing staff, and remarked that adding nurses to the care team was "one of the biggest successes of the CCBHC demonstration."

> *"Some people are low functioning, [and] they cannot engage with primary care. Someone who has schizophrenia or bipolar disorder, or who is having substance abuse issues, and we just can't get them to come in to see [FQHC]. The nurses will work them into the schedule to initiate care. The nurse does a visit, and they do an assessment on them."*
> *--Psychiatrist*

Under the demonstration, each nurse partners with a psychiatrist in the clinic to collect labs and complete nursing assessments to collect clients' vitals and history when clients attend psychiatric appointments. Clinic leadership explained that the nurse is strategically placed with the psychiatrist as a way to encourage clients to address their physical health. The nurse introduces primary care services to clients and helps then overcome any fear or mistrust of primary care providers. Behavioral health providers and clinic leadership value the nurses in that they provide access to physical health services for clients who otherwise might not have considered engaging in physical health care.

Nurses at this CCBHC also provide care coordination services for clients who receive physical health services outside of the clinic. For these clients, the nurse obtains permission from the client and calls the external provider's office to discuss plans for behavioral and physical health care and to review labs. Nurses also refer clients to medical specialists and follow up with clients to ensure that they completed the referral. If a client visits an emergency department or is hospitalized, the clinic's transition team notifies the nurse, who calls the client to review discharge instructions and medication changes, and to schedule a follow-up appointment.

> *"When the nursing staff started having didactic engagement with us that made a big difference. When they came and made themselves accessible to everyone, you started seeing care navigators do things differently."*
> *--MH provider*

The nursing staff also provides training to behavioral health providers at the CCBHC. The clinic implemented a "nurse college," a 16-week program that educates behavioral health staff on common chronic physical illnesses in the client population. One nurse explained the goal of the one-hour sessions as follows: "To introduce the clinical staff to the physical side of the clients and explaining the disease process, like diabetes and upper respiratory diseases." Behavioral health staff and clinic leadership believe that the nurse college complemented and enhanced the program's existing training opportunities and encouraged behavioral health staff to consider their clients' physical health issues and address them with their clients.

CCBHC behavioral health staff also view the nurse as a valuable resource for consultation on clients' medical needs. According to behavioral health providers, the presence of nurses on-site provided staff with access to physical health expertise and reduced the burden of having to address all of the clients' concerns alone. As one provider noted, "I don't need to know everything about diabetes, I have a team I can connect you to. I can walk to a nurse and tell them I am worried about this person. Doesn't have to be my scope of practice, I just know what path to go to." One therapist echoed the sentiment, remarking that "We don't feel like we have to [address physical health needs] on our own...I can utilize the nurses. That's the great change from me being here before CCBHC."

2. *Have CCBHCs Maintained Required Staffing?*

Officials across all demonstration states indicated that CCBHCs generally succeeded in meeting and maintaining the required types of staff throughout the demonstration, noting few instances of clinics struggling to sustain at least the minimum staffing requirements. **Consistent with state officials' perceptions, there was no substantial difference between DY1 and DY2 in the proportion of clinics that employed the following staff types**: LCSWs, nurses, associate's degree-level or non-degree counselors, case management staff, peer specialists/recovery coaches, licensed psychologists, other clinician types, mental health professionals, family support staff, and community health workers (Figure III.1).

However, fewer clinics employed the following types of staff in DY2 compared with DY1:

- SUD specialists (92 percent of clinics in DY2 versus 100 percent in DY1).

- CCBHC medical directors (91 percent in DY2 versus 99 percent in DY1).

- Adult psychiatrists (82 percent in DY2 versus 91 percent in DY1), child/adolescent psychiatrists (64 percent in DY2 versus 76 percent in DY1), and other psychiatrists (47 percent in DY2 versus 60 percent in DY1).

- Licensed psychologists (44 percent in DY2 versus 52 percent in DY1).

- Interpreters or linguistic counselors (30 percent in DY2 versus 43 percent in DY1) and community health workers (35 percent in DY2 versus 40 percent in DY1).

- Occupational therapists (17 percent in DY2 versus 25 percent in DY1).

CCBHCs continued to report a few ongoing challenges related to hiring and retaining staff. In DY2, 76 percent (n = 50) of clinics reported that at least one position in the required staff categories was vacant for at least 2 months during the past 12 months, a small increase of 4 percentage points from DY1. This finding was generally consistent across states (state-level findings appear in Appendix Table A.3). Clinics most frequently reported vacancies for the following positions: adult and child/adolescent psychiatrists, peer support staff/recovery coaches, SUD specialists such as licensed alcohol and drug abuse counselors, and LCSWs. (These findings were similar to findings from the DY1 progress reports.) However, in 2019, clinics reported several additional staff types as being difficult to fill, especially nursing staff and licensed professional counselors.

State officials universally echoed the responses to the clinic progress report, noting that psychiatrists were the most challenging to recruit and retain; officials also noted difficulties in hiring and maintaining the following staff types: licensed psychologists and clinical social workers, licensed alcohol and drug counselors, and peers. Officials shared that the licensure requirements and credentialing processes associated with these types of licensed staff often made it more difficult to find and onboard qualified providers than other non-licensed or credentialed

staff types. Officials suggested that these staffing challenges may be related to the relative scarcity of these types of providers across the states, with the challenges particularly acute in rural and frontier communities. In addition, officials in all demonstration states remarked that, even though clinics generally were able to hire and maintain staff in the required positions, they often struggled to hire and retain *enough* of each staff type to meet the increased demand for clinics' services created by the demonstration. One state official in Minnesota noted that clinics "all had staffing plans in place based on their needs assessments, but there were some clinics that had increased demand beyond what their expectations were and then they needed to start hiring more staff."

FIGURE III.1. Proportion of CCBHCs that Employed Specific Types of Staff before Certification and in March 2018 (DY1) and March 2019 (DY2)			
Staff type	Before CCBHC certification	March 2018 (DY1)	March 2019 (DY2)
CCBHC medical director	82	99	91
Adult psychiatrists	70	91	82
Child/adolescent psychiatrists	58	76	64
Other psychiatrists	43	60	47
Licensed clinical social workers	94	99	100
Licensed marriage and family therapists	60	63	61
Licensed psychologists	45	52	44
Other clinician types	43	55	58
Mental health professionals	40	45	47
SUD specialists	91	100	92
Nurses	85	100	98
Bachelor's degree-level counselors	73	75	77
Case management staff	72	97	97
Peer specialists/recovery coaches	69	99	100
Interns	61	70	73
Medical/nursing assistants	42	55	58
Associate's degree-level or non-degree counselors	40	45	48
Family support staff	37	67	68
Interpreters or linguistic counselors	36	43	30
Community health workers	27	40	35
Occupational therapists	16	25	17
Pharmacy staff	12	15	17

SOURCES: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: Denominator is 67 CCBHCs for "Proportion of CCBHCs that employed staff type before certification" and March 2018 findings, and 66 CCBHCs for March 2019 findings.
See Appendix Table A.1 for detailed findings and number of clinics corresponding to the percentages.
See Appendix Table A.2 for state-level findings. These findings were generally consistent across states, with the exception of Minnesota and Pennsylvania, where the proportion of clinics employing each type of staff did not decrease from 2018 to 2019.
Consistent with the CCBHC cost-reporting template, the mental health professional category includes only providers trained and credentialed for psychological testing.
"Other clinician types" is a write-in category.

In both the DY1 and DY2 progress reports, clinics described a variety of reasons for experiencing difficulty in hiring and/or retaining staff. The most common included: (1) rural or remote CCBHC locations; (2) the inability to meet salary expectations; (3) regional and state workforce shortages, especially in behavioral health; and (4) competition with other health care facilities such as hospitals and non-profit and for-profit health systems (not reported in the DY1 progress reports). Officials in three states echoed the issue of competition. For example, one official commented that "we still have some clinics that have competition with other health care

systems or industries in the area and have trouble filling positions. One area in particular has hospitals, prisons, and other social service entities which are all very hard to compete with."

In the second year of the demonstration, officials in all but one state cited uncertainty around the future of the demonstration as the most significant staffing challenge for clinics. Drawing on feedback from the clinics, officials reported that the uncertainty has adversely affected their ability to retain staff and maintain workforce morale as the demonstration draws to a close. Concerns about the effects of uncertainty on staff appeared most acute in states that have not developed a plan to sustain components of the demonstration, although state officials nearly unanimously voiced the same concern. Officials in two states that are working to continue parts of the demonstration mentioned that, even though clinics have maintained the required staffing, clinic leaders have been reluctant to add new positions or fill vacancies occasioned by turnover for fear of not being able to sustain those staff positions after the demonstration concludes.

Staffing challenges cited by state officials differed somewhat in DY2 from those in DY1, and across states. In the earlier year, officials cited long-standing workforce issues, such as staff turnover and low compensation for public sector mental health positions, as the primary challenges to maintaining CCBHC staffing requirements. These officials viewed turnover not only as a barrier to CCBHC implementation but also as a more general and pervasive issue across states' behavioral health systems. During the demonstration's second year, state officials cited some specific factors associated with the CCBHC model that may have positively or negatively affected staff turnover. Two state officials perceived that increases in caseloads as a result of the expansion of services and client outreach were unmanageable and led to staff burnout. Officials also noted that the more comprehensive and collaborative nature of the CCBHC model required shifts in staff responsibilities and culture that may have led some staff to seek employment elsewhere. In contrast, officials in other states suggested that the CCBHC model had significantly reduced turnover by allowing clinics to offer improved benefits and salaries.

State officials outlined several strategies adopted by clinics to address ongoing staffing challenges. For example, officials in four states reported that a primary strategy employed by clinics throughout the demonstration was to offer enhanced salaries, noting that the offer was possible only because of increased funding under the demonstration's PPS. One official noted that "one of the CCBHCs had been able to be more successful because they finally realized that they had to pay more. And once that clinic did, they all started paying more. The CCBHCs were stuck in the [pre-demonstration] mentality that 'we can't afford to pay it' but realized that, in order to staff up as quickly as necessary and stay staffed up, we're going to have to increase salaries. And because of the PPS, they did." Officials highlighted several other strategies that clinics have used to combat staffing challenges in the second demonstration year, including the following:

- Relying on telehealth to fill gaps and extend staff reach while seeking additional staff (in progress reports, three clinics mentioned the addition of telehealth positions to their staff in order to address staffing challenges, especially telepsychiatry).

- Engaging recruiters to advertise to and hire professionals from out of state.

- Engaging the state's credentialing board to share job announcements with all credentialed providers in the state.

3. *What Training have CCBHC Staff Received?*

All clinics reported that, in the past 12 months, they provided at least one of the types of staff training required by the CCBHC criteria. In DY2, all clinics (n = 66) had provided training in the past 12 months in risk assessment, suicide prevention, and suicide response, and nearly all had provided training in evidence-based and trauma-informed care (95 percent, n = 63) and cultural competency (91 percent, n = 60) (Table III.1). For most of the training types listed in Table III.1, the proportion of CCBHCs that reported providing the training in the DY2 progress report was similar to that in DY1, except for risk assessment, suicide prevention, suicide response, and person-centered and family-centered care, all of which increased by more than a few percentage points.

TABLE III.1. CCBHC Staff Training in Required and Other Topics				
Topic of Training	**CCBHCs that Provided Training in Past 12 Months, March 2018 (DY1)**		**CCBHCs that Provided Training in Past 12 Months, March 2019 (DY2)**	
	N	**%**	**N**	**%**
Required by CCBHC certification criteria				
Risk assessment, suicide prevention, and suicide response	62	93	66	100
Evidence-based and trauma-informed care	61	91	63	95
Cultural competency training to address diversity within the organization's service population	59	88	60	91
The role of family and peers in the delivery of care	52	78	51	77
Person and family-centered care	51	76	56	85
Recovery-oriented care	51	76	51	77
Primary and behavioral health care integration	51	76	52	79
Other training (not required by CCBHC certification criteria)				
Other (see Table III.2)	40	60	38	58
Any training listed above[a]	66	99	66	100
No training	1	1	0	0
Total CCBHCs	67	100	66	100

SOURCES: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: See Appendix Table A.4 for state-level findings. The proportion of clinics that provided each type of training varied across states to some extent, but the proportion within each state was relatively consistent from March 2018 to March 2019, except for in New Jersey, where it appeared that a larger proportion of clinics delivered various types of training in 2019 compared with 2018.

a. "Any training" was calculated by combining responses across all progress report response options from each year to examine the number and proportion of clinics that provided at least 1 of the training types listed in the table or "other" trainings the clinics reported in response to an open-ended question.

Clinics reported that they provided a diverse range of non-required "other" trainings. In DY2, the most commonly reported non-required trainings included (Table III.2) motivational interviewing (an evidence-based practice [EBP] included in the CCBHC criteria) (18 percent of CCBHCs, n = 12); training focused on serving veterans and "military culture" (14 percent, n = 9); and training in two other EBPs, cognitive behavioral therapy (CBT) (9 percent, n = 6) and MAT (8 percent, n = 5). Clinics delivered training in these most commonly delivered non-

required topics in the previous year, though at lower rates except for training in serving veterans and "military culture," which 22 percent of clinics (n = 15) provided as of DY1, a decrease of 8 percentage points from DY1 to DY2. Finally, 5 percent of clinics (n = 3) offered training in disaster preparedness and response in DY1 while no clinics reported offering such training in DY2.

TABLE III.2. CCBHC Staff Training in Non-Required "Other" Topics				
Topic of "Other" Training	CCBHCs that Provided "Other" Training, March 2018 (DY1)		CCBHCs that Provided "Other" Training, March 2019 (DY2)	
	N	%	N	%
Motivational interviewing[a]	7	10	12	18
Serving veterans and "military culture"	15	22	9	14
CBT[a]	6	9	6	9
MAT[a]	3	5	5	8
Ethics	2	3	5	8
DBT[a]	2	3	5	8
Trauma-informed care	4	6	4	6
Serving LGBTQ individuals	1	2	3	5
Eye movement desensitization and reprocessing	3	5	2	3
Disaster preparedness and response training	3	5	0	0
Total CCBHCs	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTE:
a. EBP included in the CCBHC certification criteria.

States provided ongoing support for CCBHC staff training as the demonstration was implemented. In preparation for and throughout the demonstration's implementation, all states developed structured networks for regular communication with their CCBHCs to identify gaps in knowledge and provide formal and informal training and support activities. State officials viewed such efforts as essential in identifying and responding to emerging training needs.

In the demonstration's first year, officials from all states reported that they held regular meetings with CCBHCs during the early stages of implementation to identify and address CCBHC training and technical assistance needs. As one official stated, "Training topics have covered the entirety of the CCBHC project." Officials described state-led trainings for CCBHC clinical and administrative staff in the following topics:

- CCBHC certification requirements.

- Best practices such as trauma-informed care and motivational interviewing.

- Serving special populations such as children, high school students, or veterans.

- Regulations regarding licensing for clinicians, including peer specialists.

- PPS.

- Billing, quality measure reporting, cost-reporting (for example, Pennsylvania required CCBHCs to complete a test run of their cost reports six months into the first demonstration year to ensure that clinic administrative staff would be able to complete the forms for the official deadline at the end of 12 months).

In the second demonstration year, officials reported that much of the training offered by states and clinics took place during the initial stages of the demonstration, noting that, by the second year, states exhibited less focus on formalized training. One state official mentioned feedback from clinics as a primary impetus for tapering training, remarking that "clinics have been giving the state a lot of feedback that they are 'trained out' when the state asks if they want more. They had to do an enormous amount of staff training in the first year to satisfy the criteria and now they're burned out on training. Because of that feedback, we ourselves as a state have been focusing on exploring what it takes to change practice and what could we be implementing rather than continuing to throw required training at [the CCBHCs]." Officials in two other states commented that, even though their states had reduced the number of training opportunities offered to CCBHCs and clinic staff, state demonstration leadership have continued to identify and alert clinic leadership to external training opportunities for their staff.

B. Access to Care

The certification criteria specify that CCBHCs must provide accessible care, including 24-hour crisis management services; engage consumers quickly through prompt intake services; and treat all consumers, regardless of their ability to pay. This section summarizes states' projections for the number of individuals to be served by the demonstration and describes the activities that states and CCBHCs have undertaken to expand access to care.

1. How many Medicaid (including dually eligible) Beneficiaries did CCBHCs Expect to Serve in the First Demonstration Year, and How Many were Served?

In DY1, officials in all but two of the demonstration states expected that, during the demonstration's first year, CCBHCs would serve the number of consumers as originally projected. State officials in New Jersey and Oregon reported in DY1 that, based on the lower-than-expected number of consumers that CCBHCs served in the first two quarters of the demonstration, the number of consumers served during the demonstration's first year would likely be lower than originally envisioned. Table III.3 summarizes states' projections at the beginning of the demonstration, the projected changes at the demonstration's mid-point (2018), and, drawing on interviews with state officials in 2019, actual beneficiaries served in the first demonstration year. While states generally reported that clinics were on track to serve expected or fewer than expected numbers of consumers, in interviews some states reported that certain clinics experienced higher than anticipated volume which stretched resources and staff.

TABLE III.3. Projected and Actual CCBHC DY1 Enrollment					
State	State Population (in millions)	Number of CCBHCs	DY1--Total Projected CCBHC Consumers to Receive CCBHC Services (all pay sources)	DY1--Projected CCBHC Consumers Who Were Medicaid Beneficiaries[a]	Actual Number of Consumers Served in DY1
Minnesota	5.52	6	17,600	15,000	20,000[b] (15,000 Medicaid)
Missouri	6.09	15	127,083	87,284	86,002 (55,362 Medicaid)
Nevada	2.94	3[c]	7,305	5,844[c]	2,312 Medicaid[d]
New Jersey	8.94	7	79,782	50,882	79,800 (9,500 Medicaid)[e]
New York	19.75	13	40,000	32,000	49,301[f]
Oklahoma	3.92	3	23,076	11,077	16,836[f]
Oregon	4.09	12	61,700	50,000	52,911 (32,859 Medicaid)
Pennsylvania	12.80	7	24,800	17,800	19,190[f]

SOURCE: Table 5 in *Certified Community Behavioral Health Clinics Demonstration Program, Report to Congress, 2017*. Mathematica/RAND obtained information for the "Changes to Projected Total CCBHC Consumers" during interviews with state officials in March 2018 and for actual Medicaid beneficiaries during interviews with state officials in March 2019.

NOTES:
a. These estimates may include dual Medicare-Medicaid beneficiaries.
b. The state reported that the number of non-Medicaid clients was difficult to validate because of an inability to duplicate non-Medicaid clients served in more than 1 CCBHC; however, the state estimates from other sources (e.g., payer mix reports) that 25% of CCBHC clients are non-Medicaid.
c. Nevada initially certified 4 clinics; however, 1 CCBHC withdrew from the demonstration on March 14, 2018. The data in this column of the table reflect the information gathered before this change.
d. Total reflects the number of beneficiaries billed under the demonstration. Nevada officials were able to report only the number of Medicaid beneficiaries.
e. The original number of projected Medicaid beneficiaries was based on the clinics' expected Medicaid population as a percentage to total based on clinics' projections of total consumers clinics expected to serve. The actual number provided was based on actual adjudicated claim volume.
f. Total reflects both Medicaid and non-Medicaid. These states did not provide a Medicaid versus non-Medicaid breakdown.

2. What Steps have the CCBHCs and DCOs Taken to Increase Access to Care?

CCBHCs have worked to make services more convenient and tailored to the needs of specific populations. According to state officials, one of the most common ways clinics have enhanced access to care is to institute open-access scheduling, or same-day scheduling, which is a scheduling method that allows all clients to receive an appointment on the day they request one. Officials in five states mentioned that most or all CCBHCs in their state have now adopted open-access scheduling. One state official in Nevada noted that CCBHCs instituted open-access scheduling because "the clinics acknowledge that it is important to meet the client in a moment of need and be able to start to establish services so that the client doesn't leave and never come back." State officials pointed to several other positive effects of open-access scheduling, such as the elimination of wait lists and a reduction in the burden on other external community resources. As one official in Missouri remarked, "People are able to have same-day access in areas where that has never before been possible, and in turn the access reduces the burden on hospitals, emergency departments, and law enforcement. People getting into CCBHC services quickly is a big deal."

CCBHC Spotlight: Availability and Accessibility of Services: "Meet the Client Where They're At"

This CCBHC is a rural behavioral health center that provides outpatient behavioral health services and includes medical nursing staff on its care teams. The clinic serves a primarily Medicaid-covered or Medicaid-eligible population that experiences challenges such as homelessness and transportation barriers in addition to mental and substance use disorders.

The clinic created an open-access scheduling policy to enhance the availability and accessibility of services as required under the demonstration. Specifically, the clinic modified its scheduling system to accommodate open-access times between scheduled appointment slots. To support the effort, the clinic made at least one therapist available each day to conduct intake assessments and created same-day appointment slots for services. This arrangement allowed potential and existing clients to walk in or call when they were ready to seek help. Clinic leadership credited the PPS with facilitating these changes.

Under the demonstration, the clinic developed a systematic process that streamlines client enrollment into services. Potential clients who walk into the clinic meet with a referral coordinator who conducts a preliminary screening and then connects the client to a therapist to complete the intake assessment. For clients who contact the clinic by telephone, a referral coordinator screens such clients and then schedules an intake within one week of the initial contact; the clinic reported that intake often takes place within 1-2 days. A therapist then meets with the client for a full intake session, including a drug and alcohol assessment, evaluation of case management needs, and a review of physical health conditions.

> *"[We see clients] in their homes, in the community, in their friend's homes, sometimes we will track them down looking for them in the community. And the homeless, I had a client that I had to climb a very big hill to get to because his tent [was up there]. That's the greatest part of our services is that we can get to them where others can't."*
>
> *--Case manager*

Once a client is enrolled in services, the clinic fosters access and ongoing engagement by providing services in a variety of locations. For example, case managers and peer specialists meet with clients in their homes or at community locations. In addition, clinic therapists provide services to youth in schools with three groups per week at no cost to those receiving services. Care management staff explained that they occasionally provided community-based services before the clinic became a CCBHC, but, under the demonstration, they increased their efforts to "meet the client where they're at." Staff stressed that service provision in the community allowed them to establish more trusting relationships with clients while providing opportunities for better understanding clients' family and living environments, which staff would not have fully appreciated if they saw clients only in the clinic. As part of the demonstration, the clinic also made group therapy sessions available during evenings and weekends. Before the demonstration, the clinic opened Monday through Friday during business hours. Clinic leaders reported that the change in business hours have been positive, but not without some challenges. Clinic leadership reported that the availability of services beyond business hours required a cultural adjustment among staff members, who were reluctant to provide services on evenings and weekends. Likewise, clinic leaders reported that clients perceived that attending treatment outside normal business hours "took up their weekend." Staff expressed concern when clients did not use the available services. According to one staff member, "Very few have come even though we have expressed the availability of the services. It has felt like we are begging people to come on Saturdays because we're trying to build that piece out."

> *"I couldn't imagine doing it any other way. A lot of times clients are more comfortable in their home than they would be in the clinic...and being on the ground you see the benefits. We're lucky because we personally see the benefits of what's going on outside."*
> *--Peer specialist*

Overall, clinic staff and leadership acknowledged the benefits of enhancing service accessibility and availability. Clinic leadership explained that clients are more likely to engage in treatment if they can begin receiving services when they seek help. Clinic leadership and staff perceived that becoming a CCBHC helped optimize client readiness by initiating enrollment immediately rather than scheduling it several weeks out, thereby allowing staff to provide more services in the community.

In addition to same-day appointments, officials in three states suggested that the demonstration's requirements for extended service hours have significantly enhanced access for CCBHC clients in their states, noting that CCBHCs further tailored their extended hours and after-hours availability according to the needs expressed by clients and the client service use patterns in the demonstration's second year. Some respondents suggested that clients at some clinics did not take advantage of required extended service hours to the extent they expected, and clinics made changes to their availability to meet clients' needs while fulfilling the requirement. For example, an official in Minnesota said that "maybe they realized [in DY1] that having evening or Saturday hours, that wasn't working, so they moved to just have it on an on-call basis…the program intent was being met, but it wasn't necessarily that they have set [extended] hours."

Similarly, officials in two states mentioned that, as a key strategy for increasing the CCBHC population's access, clinics now schedule more frequent and shorter appointments for high-need consumer populations. For example, officials in Missouri reported that, since the demonstration's launch, community support specialists or intensive case managers at CCBHCs schedule frequent (e.g., several times per week) 30-minute sessions with consumers with SMI and youth with SED in order to target specific problems. Officials reported that CCBHCs expect that these frequent, brief visits will reduce crises as well as the use of emergency services among these populations. Officials in two states also indicated that the demonstration has had a major effect on access by streamlining the initial assessment processes and reducing intake and wait-times for the initial evaluation. An official in Minnesota, for instance, reported that initial evaluations occurring within ten days as required by the demonstration are simply "earth-shattering in the mental health world" and facilitate consumer engagement from the outset.

To meet the certification criteria, most clinics made changes to their physical space as a result of the demonstration (in the DY1 progress report) and/or in the past 12 months (in the DY2 progress report). The certification criteria require CCBHCs to provide a safe, functional, clean, and welcoming environment conducive to service provision. Changes to the physical structure of the clinic may facilitate access to care for certain populations, such as those with physical disabilities. **Clinics in all states reported that they undertook some type of renovations to their physical space in DY1 and DY2**. As summarized in Table III.4, the most common changes to their physical space included the following:

- Forty-eight percent of clinics (n = 32) in DY2 and 49 percent (n = 33) in DY1 reported expanding the CCBHC building space.

- Sixty-four percent (n = 42) in DY2 and 67 percent (n = 45) in DY1 reported renovating existing facilities.

- Fifty-two percent (n = 34) in DY2 and 40 percent (n = 27) in DY1 reported making improvements to facility safety features, such as installing defibrillators and accessible bathrooms.

Almost one-fourth of clinics (n = 15 in each year) reported making "other changes" to their physical space in DY1 or DY2. The most commonly cited "other changes" in DY1 were: (1)

improving the physical space to accommodate new CCBHC care features, such as adding physical health examination rooms, improving the space for child and adolescent consumers, and expanding office space for new staff such as peers and case managers (33 percent of the 15 clinics; n = 5); and (2) creating dedicated space for ambulatory detoxification services (13 percent of the 15 clinics; n = 2) (not shown in table). In the DY2 progress report, CCBHCs also reported the reasons for making these "other changes," including: (1) moving to new locations or new buildings in existing locations (40 percent of the 15 clinics; n = 6); (2) making improvements to the aesthetic look and feel of CCBHC facilities to improve the client experience (20 percent of the 15 clinics; n = 3); and (3) making improvements to staff workspaces (13 percent of the 15 clinics; n = 2). In the DY2 progress report, one CCBHC also reported undertaking construction for an FQHC in order to open a primary care clinic on-site.

All CCBHCs reported that they provided translation services in DY2, representing an increase from DY1 when nearly all clinics (96 percent, n = 64) reported providing translation services. As in DY1, almost all clinics reported that they offered translation services through an external interpreter contract in DY2--usually telephonic interpreting services. One clinic provided translation services through DCO contracts in DY2, a change from DY1, when no translation services were provided through DCOs. State-level findings appear in Appendix Table A.5. These findings are consistent with changes in staffing from DY1 to DY2. As noted in Chapter III.A, fewer clinics directly employed interpreters or linguistic counselors in the second demonstration year, which may suggest that some clinics determined that external contracts for such services were more appropriate and feasible.

TABLE III.4. Changes to CCBHCs' Physical Space				
Change to Physical Space and Accessibility	**Number and Proportion of CCBHCs that Made Changes, 2018**		**Number and Proportion of CCBHCs that Made Changes, 2019**	
	N	**%**	**N**	**%**
Expansions or additions to the CCBHC building space	33	49	32	48
Renovations to existing CCBHC facilities	45	67	42	64
Improvements to facility safety features	27	40	34	52
Other changes to CCBHC physical space	15	22	15	23
Total CCBHCs	67	100	66	100
SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019. **NOTE**: See Appendix Table A.5 for state-level findings.				

Almost all CCBHCs provided transportation services or transportation vouchers in DY1 and DY2 (n = 60), representing about 90 percent of clinics in each year. Clinics in both years reported that they provided transportation through bus or cab vouchers, via care manager or peer support, directly in CCBHC-owned vehicles, and by helping consumers obtain the Medicaid transportation benefit (if the consumer was eligible and the benefit was available in the given state).[14] Five percent of the clinics providing transportation services in DY2 (n = 3) reported that they used Uber services, a new finding for DY2. State-level findings appear in Appendix Table A.5.

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[14] The CCBHC PPS does not cover transportation services; rather, clinics may have worked to assist clients with obtaining and using the separate Medicaid transportation benefit if it was offered by the state and the client was eligible.

Almost all CCBHCs provided services in locations outside of their physical building(s). As of The DY1 progress report, 93 percent of clinics (n = 62) reported that they offered services outside of CCBHCs' physical buildings, including in consumers' homes, schools, or other community-based settings such as libraries, community centers, or coffee shops; 85 percent of these clinics (n = 53) were already providing off-site services before the demonstration (Appendix Table A.6). As of the DY2 progress report, 97 percent of clinics (n = 64) reported that they offered services outside CCBHCs' physical buildings, in similar locations as reported the previous year. Figure III.2 shows the most common locations where clinics have provided services outside of CCBHCs' physical buildings, which include locations such as consumers' homes, and community service agencies such as Social Security offices, food pantries, Department of Human Services offices, and community centers. Officials in four states cited CCBHCs' focus on the provision of services outside of the clinic location as a primary success of the demonstration. For example, an official in Minnesota mentioned that, in a particularly helpful strategy, one CCBHC has embedded staff at the local library in order to engage people experiencing homelessness who frequently use library services.

FIGURE III.2. Proportion of CCBHCs that Provided Services Outside of Physical Clinic Space in the Past 12 Months

Location	Percent
Consumers' homes	78%
Schools	47%
Courts, police offices, and other justice-related facilities	33%
Hospitals and EDs	30%
Community service agencies and nonprofit organizations	20%
Homeless shelters	11%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTES: The denominator is the number of CCBHCs that reported offering services outside the CCBHC physical buildings in the past 12 months as of March 2019 (n = 64).
See Appendix Table A.6 for 2018 findings.
See Appendix Table A.7 for state-level findings. The majority of clinics in all 8 demonstration states offered services outside of CCBHCs as of 2018, increasing to 100% of all CCBHCs as of 2019 in all states except New Jersey.

Other, less common locations where CCBHCs provided services included primary care offices and FQHCs, in public spaces, or even on the street (not included in Figure III.2); these locations were similar in DY1 and DY2. State officials highlighted some of these efforts; for example, officials in Oklahoma and Minnesota reported on clinics deploying clinical staff such as LCSWs in tandem with emergency responders, such as police or emergency medical service teams, to provide care wherever it is required. Officials in Oregon highlighted one clinic's efforts to

provide services in rural and frontier communities by specially outfitting and delivering care in a mobile van. Officials in three states noted that the demonstration requirements for outreach and engagement were particularly helpful for assisting first responders and intervening during crisis situations.
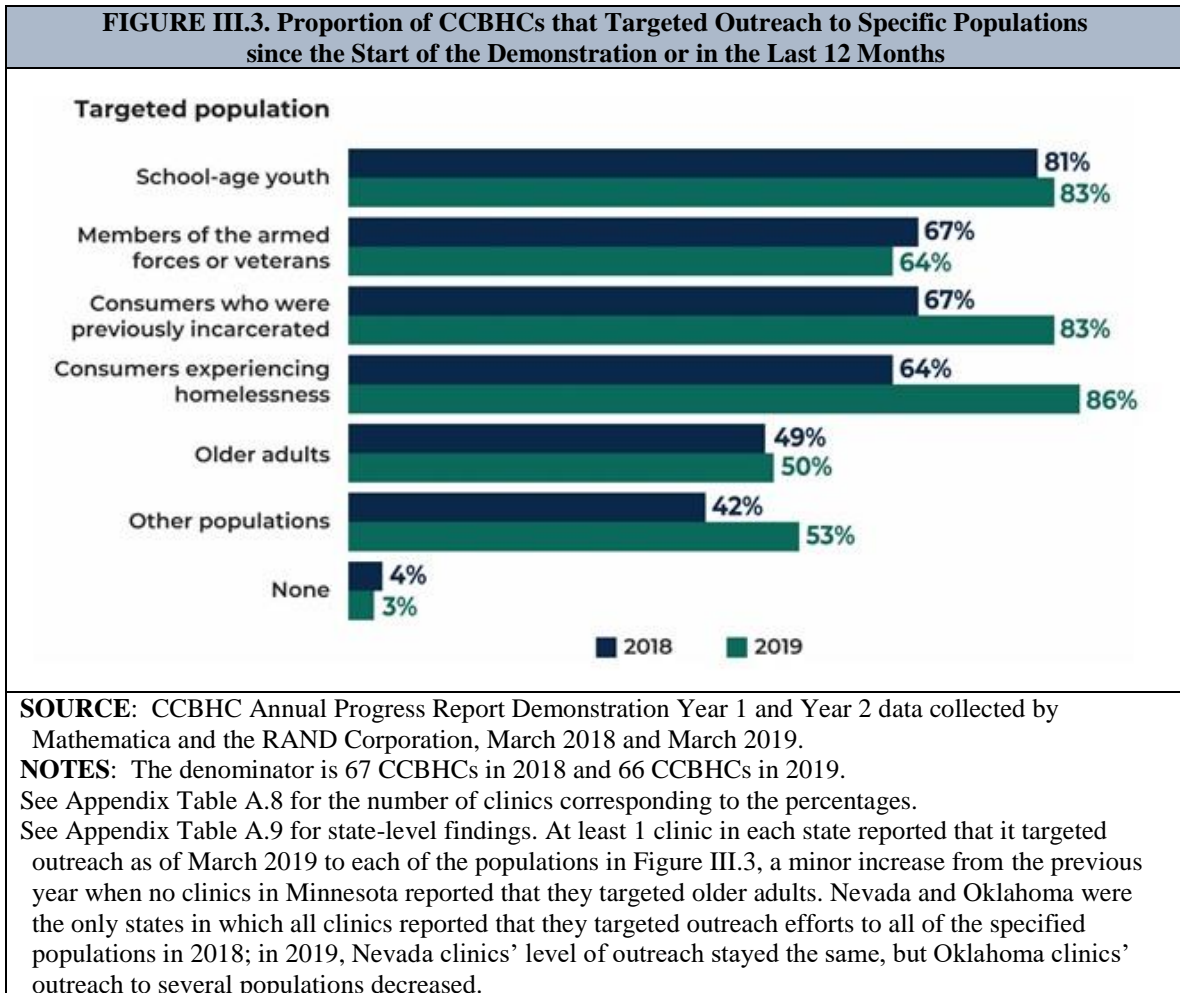
Most CCBHCs reported that they targeted outreach and engagement efforts to new populations and continued or expanded outreach into the second demonstration year. In both DY1 and DY2, the populations of interest most frequently included school-age youth, veterans, previously incarcerated individuals, and people experiencing homelessness (Figure III.3). From DY1 to DY2, outreach to consumers experiencing homelessness increased by 22 percentage points, and outreach to consumers who were previously incarcerated increased by 16 percentage points; outreach to the other main targeted populations stayed approximately the same.

Fifty-three percent of clinics (n = 35) reported targeting "other populations" with outreach in DY2 compared to 42 percent (n = 28) in DY1 (Figure III.3). These other populations included the following:

- People with SUD: 37 percent (n = 13) of these clinics in DY2 and 36 percent (n = 10) in DY1.

- People with frequent emergency department and inpatient use: 17 percent (n = 6) of these clinics in DY2 and 21 percent (n = 6) in DY1.

- People with mental health diagnoses: 11 percent (n = 4) of these clinics in DY2 and 18 percent (n = 5) in DY1.

- People with psychiatric diagnoses and comorbid chronic physical health conditions: 9 percent (n = 3) of these clinics in DY2 and 18 percent (n = 5) in DY1.

- People who identify as sexual or gender minorities, especially youth: 14 percent (n = 5) of these clinics in DY2 and 14 percent (n = 4) in DY1.

- People with law enforcement/corrections contact, which was a new finding for 2019: 20 percent of these clinics (n = 7) reported targeting outreach to this population as of the DY2 progress report, whereas only 4 percent of these clinics (n = 1) did so of the DY1 progress report.

To increase outreach to special populations, officials in two states mentioned the importance of population-specific strategies. For example, an official in Minnesota noted one clinic's efforts to develop care coordination teams to address the unique needs of specific groups by, for example, deploying a corrections care coordinator and an American Indian population coordinator, both of whom provide services in locations where they come into contact with these target populations, as a key strategy for engaging clients.

CCBHCs in some states implemented processes to improve client engagement and retention in services by, for example, monitoring the frequency of telephone follow-ups and increasing reminder calls for consumers before appointments. In Oregon, for instance, one CCBHC set forth the goal of three interactions or "touches" following closely after the initial engagement with each new consumer. Similarly, after examining preliminary data indicating low client retention, Pennsylvania decided to focus on improving follow-up with consumers after initial telephone contact with a CCBHC. Pennsylvania officials provided feedback and support to CCBHCs with respect to clinics' plans for improving their follow-up rates, and the state plans to review CCBHCs' progress toward improving follow-up rates over time.

FIGURE III.3. Proportion of CCBHCs that Targeted Outreach to Specific Populations since the Start of the Demonstration or in the Last 12 Months

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: The denominator is 67 CCBHCs in 2018 and 66 CCBHCs in 2019.
See Appendix Table A.8 for the number of clinics corresponding to the percentages.
See Appendix Table A.9 for state-level findings. At least 1 clinic in each state reported that it targeted outreach as of March 2019 to each of the populations in Figure III.3, a minor increase from the previous year when no clinics in Minnesota reported that they targeted older adults. Nevada and Oklahoma were the only states in which all clinics reported that they targeted outreach efforts to all of the specified populations in 2018; in 2019, Nevada clinics' level of outreach stayed the same, but Oklahoma clinics' outreach to several populations decreased.

3. Do Consumer and/or Family Organizations Perceive Improvements in the Accessibility of Care?

Stakeholder organizations representing consumers and families overwhelmingly reported that the CCBHC model has improved access to care for CCBHC clients in their states. Respondents from groups in three states reported that the move to open-access scheduling and expanded hours of service in particular have significantly improved consumer engagement and the availability of care. One consumer representative noted, for example, that "the wait-times in

CCBHCs are down. We get calls from people dissatisfied with services or that they have three to five months for waits. For the CCBHCs, there are no [lengthy] waits in any of the clinics." Another consumer representative commented that consumers experience much faster access, noting that the relevant organization has heard that some consumers are surprised by the short lead time for an appointment. Consumer group representatives in another state noted that they observed quicker access among CCBHC consumers for certain services, including medication and therapy.

Consumer and family representatives noted that the comprehensive, one-stop-shop nature of the demonstration has engendered greater access to a full range of services. One representative remarked, for example, that "the advantage of the CCBHC is the wraparound services, the full spectrum of services, integrated mental health and SUD or getting peer support and therapy and having it all available there. In some places, especially in rural areas, the advantage of multiple providers in one location [is significant]." Other representatives commented that bringing services for both adults and children, including mental health and SUD services, under one roof and has facilitated greater access to comprehensive services for whole families, noting that CCBHCs have become "family-oriented" environments that offer care to children and their parents alike. In addition, a representative from another state reported that state officials shared information on CCBHC quality measures with stakeholders through the state's quality "dashboard" system, which displays data on quality measure performance aggregated at the clinic-level. The respondent appreciated the clarity of information presented in this tool and emphasized its utility in tracking the availability and use of EBPs across CCBHCs in the state.

Consumer and family organization representatives also cited the PPS as a major facilitator of access by allowing clinics to hire the types and number of staff, including peers, required for fully addressing consumers' mental health and SUD service needs. The use of a PPS provides a unique opportunity for states and CCBHCs to develop rates based on the expected cost of care that accounted for total costs associated with delivering the nine required services to Medicaid beneficiaries. This included the ability to use a mix of staffing models, as well as pay for services that were allowed under the demonstration, but might not have been traditionally covered under Medicaid. In particular, representatives noted that the ability to hire and retain peers has substantially increased consumer engagement. In one state, for example, a representative reported that several CCBHCs have partnered with hospitals and other organizations to embed peers in order to engage consumers in times of crisis, noting "the peers bring a lot to the table to help individuals and families navigate the systems with a lived experience perspective." Representatives from organizations in the other states noted that CCBHCs have continued to create and fill peer specialist and recovery coach positions throughout the demonstration, further confirming peers' importance to the model. One representative reported an increase of 10-15 percent in the hiring of peer support and recovery support specialists, with room to grow.

Consumer and family representatives generally credited the demonstration with increasing access to care, yet representatives also identified several ways CCBHCs could further improve access. For example, one representative described ongoing challenges with transportation in rural and frontier communities and pointed to the need to intensify current CCBHC efforts to address transportation issues. In addition, although consumer and family representatives applauded

efforts and strides to incorporate peers into the CCBHC workforce, representatives in three states believed that even greater access to peers would be helpful to CCBHC clients. One representative noted, for example, that it would be ideal if anyone entering treatment could have access to a certified peer specialist or family support professional if so desired. Another representative conveyed their organization's belief that CCBHCs need to hire at least several peers so that they "can support one another and change the culture in the clinic and change the attitudes towards [sic] positive regarding mental illness and wellness."

4. Are CCBHCs in the State Providing Care through the Internet, Telehealth, and Other Technologies?

Most CCBHCs provided telehealth services in DY1 and DY2, but most did not indicate that they added these services as a result of certification. Sixty-seven percent of clinics (n = 45) reported that they offered telehealth services as of the DY1 progress report, 80 percent of which (n = 36) already did so before the demonstration (Figure III.4). State officials confirmed in March 2018 (DY1) that most clinics initiated telehealth services (specifically, telepsychiatry) to help expand access to services. Use of telehealth services varied somewhat among CCBHCs before the demonstration's launch; some clinics had robust and long-standing telehealth programs, whereas others were in the early stages of developing telehealth platforms. The Medicaid program in Missouri approved telehealth SUD services in 2015 and made telehealth billable via billing code modifiers in 2017; however, state officials were unsure of the extent to which CCBHCs in the state were using telehealth.
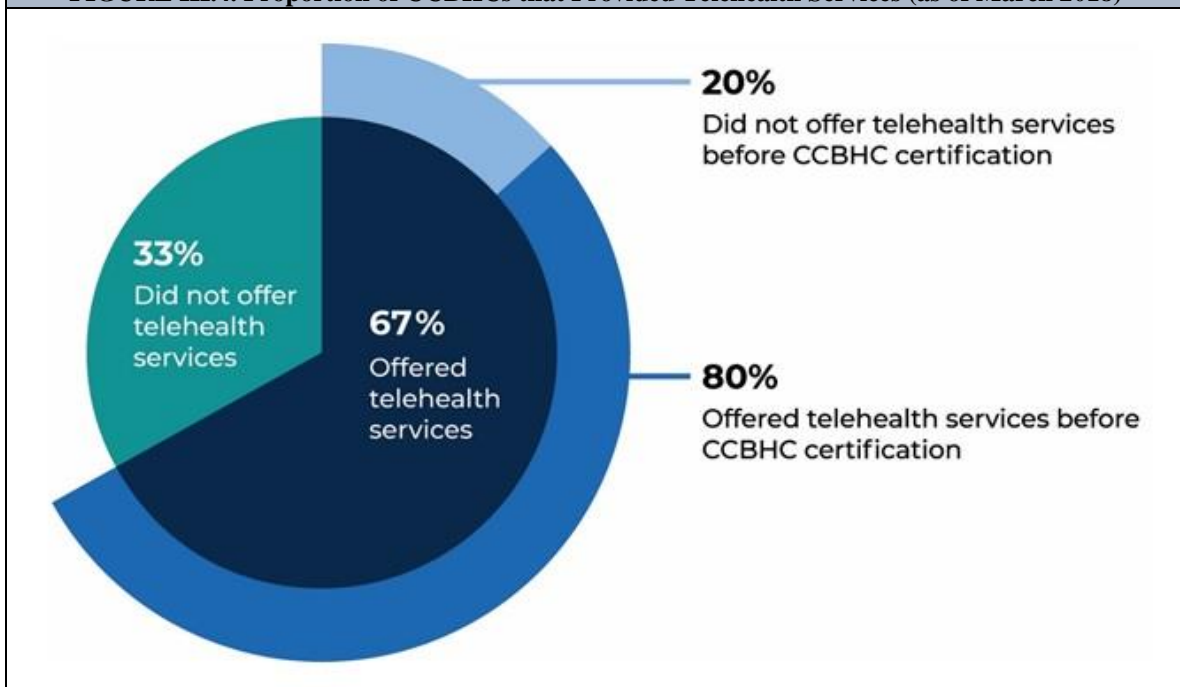
As of the DY2 progress report, 70 percent of clinics (n = 46) reported that they offered telehealth services, at an increase of 3 percentage points from the previous year (not shown in Figure III.4; detailed findings appear in Appendix Table A.6). Of the 70 percent of clinics offering telehealth services in DY2, the most common services were the following:

- Telepsychiatry, offered by 67 percent of clinics (n = 31) compared to 64 percent of clinics (n = 29) in DY1.

- Therapy or counseling, offered by 39 percent of clinics (n = 18) compared to 24 percent (n = 11) in DY1.

- Medication management, offered by 30 percent of clinics (n = 14) compared to 20 percent (n = 9) in DY1.

As in DY1, most CCBHCs in DY2 reported that they provided telehealth for all consumers who needed it, with a few focusing on children and youth and incarcerated individuals.[15] In addition, as we described in Section A, three clinics reported the addition of telehealth positions to their staff in order to address common staffing challenges such as rural locations, unrealistic salary expectations, workforce shortages, and competition with other health care facilities.

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[15] States are unable to bill Medicaid for incarcerated or justice involved individuals, and services delivered to incarcerated individuals were not approved under this demonstration. However, clinics may have elected to provide telehealth services to incarcerated individuals without billing Medicaid.

FIGURE III.4. Proportion of CCBHCs that Provided Telehealth Services (as of March 2018)

33%
Did not offer telehealth services

67%
Offered telehealth services

20%
Did not offer telehealth services before CCBHC certification

80%
Offered telehealth services before CCBHC certification

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 data collected by Mathematica and the RAND Corporation, March 2018.

NOTES: See Appendix Table A.6 for the number of clinics corresponding to the percentages and for 2019 findings.

See Appendix Table A.7 for state-level findings. There was no meaningful change at the state level in the proportion of CCBHCs that offered telehealth services.

State officials in most states described telehealth services provided by clinics as a particularly valuable tool for increasing access to CCBHC services in rural or frontier areas. In Nevada, for example, rural and frontier CCBHCs use telehealth tools, as needed, to deliver MAT services, specialty medical care, and child psychiatry. In particular, the frontier clinics reportedly have a long-standing history of using telehealth to overcome consumer transportation barriers. States varied, however, in their support for and adoption of technological strategies to expand access to care. For example, even though officials in Nevada recognized the value of telehealth in certain situations, officials cautioned against the *widespread* use of telehealth, noting that the state wanted clinics "to focus on implementation, and be able to fulfill the demand for services in person." Nevada officials also remarked that "importantly, a client of the CCBHC should have access to all CCBHC core services, and telehealth is not clinically appropriate for some core services. Therefore, a client cannot have some services via telehealth and we wanted to be cautious and provide services medically necessary and clinically appropriate." Officials in other states noted that while some CCBHCs use telehealth, it does not account for a large share of service provision.

Officials in states that reported broader use of telehealth saw the technology as serving two purposes: (1) to assist with filling gaps occasioned by staff shortages; and (2) to expand the reach of CCBHCs into consumers' homes and communities. For example, in Oklahoma, CCBHCs rely on various technology provided to consumers, law enforcement officers, and emergency departments to help link consumers to needed services with the intention of reducing

hospitalizations. One CCBHC in Oklahoma has distributed more than 1,000 tablet computers (iPads) with built-in communication systems to consumers for use in their homes, to on-call psychiatrists, to sheriffs and police departments in several counties surrounding the CCBHC, and to emergency departments, with the goal of overcoming traditional transportation barriers to accessing care in rural communities. Via the tablets, individuals can communicate with staff at intensive outpatient (IOP) centers, which are open and available via telehealth 24 hours a day, seven days a week. In addition to gaining access to crisis services, consumers can access other CCBHC services remotely through their tablets, including individual therapy/counseling, psychiatric rehabilitation, and treatment planning and assessment services. Officials reported that, in the second demonstration year, the other two CCBHCs in Oklahoma also began using iPads to expand access to services. Similarly, officials in Minnesota noted that one clinic decided that traditional in-office telehealth did not go far enough and wanted clients to be able to receive services in their home. "So [the clinic] purchased a bunch of tablets and provided them to their clients so they could have them at home, and people were able to receive their services and be at home and have their therapy sessions…truly how I've always envisioned telehealth. One client had been coming to the clinic for quite a while, and had been really engaged in services, and was pregnant and put on bed rest. And she was still able to be engaged in her services until her baby was born. Another was a client who was in a lot of crises, and got caught in a traffic jam, and realized that she wasn't going to make her appointment, and pulled off the highway and had her session right then."

5. What has been the Role of CCBHCs in Delivering Services to Individuals in AOT?

Almost all clinics reported that, in DY2, they accepted referrals from courts or consumers with AOT orders. Ninety-eight percent of clinics (n = 65) accepted referrals from courts for individuals with involuntary treatment or AOT orders as of the DY2 progress report, an increase from 91 percent of clinics (n = 61) in DY1. As of the DY2 progress report, all clinics in all states except New York accepted AOT orders (state-level findings appear in Appendix Table A.10). In interviews, Pennsylvania was the only state reporting potential changes to the way its CCBHCs may have supported AOT in the second demonstration year but these potential changes were not the result of the demonstration. In Pennsylvania a law was passed during the 2018-2019 winter legislative session that established standards for AOT in the state, with implementation required on April 22, 2019. Officials in the state speculated that the law could encourage some CCBHCs to begin participating in AOT but they also noted that the law was not specific to CCBHCs.

C. Services

CCBHCs are required to provide a broad set of services that include but are not limited to the following nine service types listed in the authorizing legislation:

- Twenty-four-hour crisis services.

- Screening, assessment, and diagnosis.

- Patient-centered treatment planning.

- Outpatient mental health and substance use treatment.

- Screening and monitoring of key health indicators.

- TCM.

- Psychiatric rehabilitation services.

- Peer and family support and counselor services.

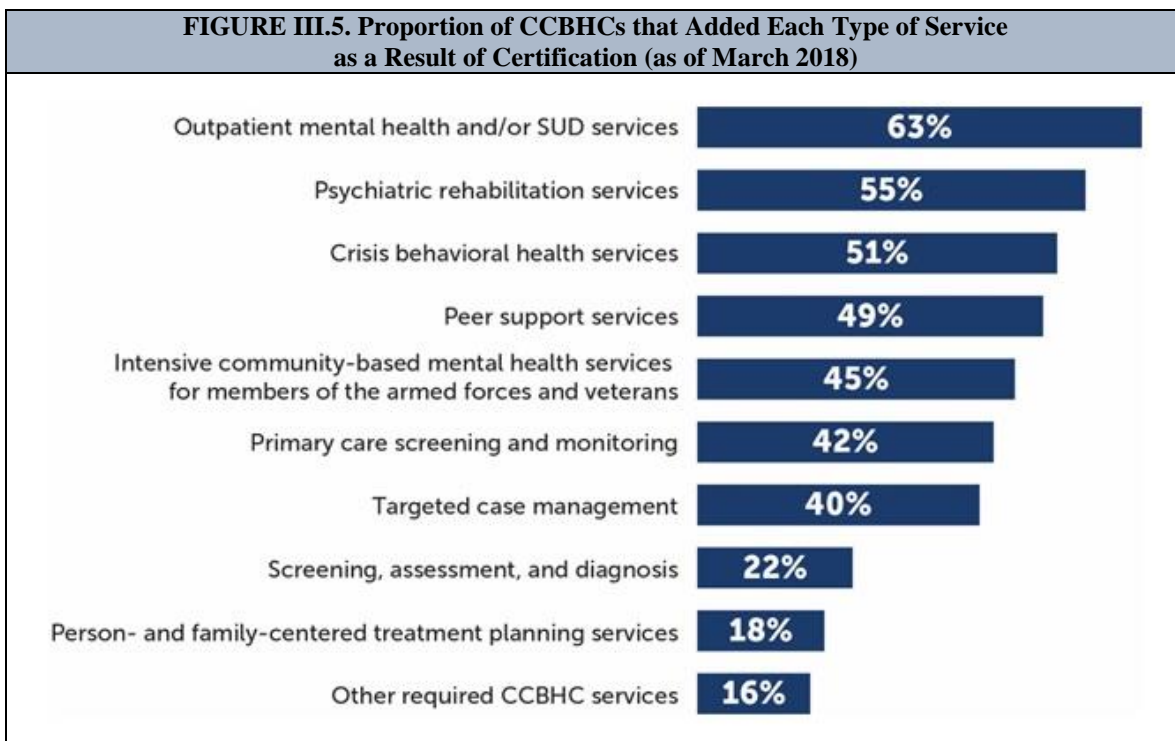- Intensive, community-based mental health care for members of the armed forces and veterans.

PAMA lists the minimum scope of service requirements for CCBHCs but also affords states flexibility in establishing those requirements, thereby ensuring alignment of the scope of services with states' respective Medicaid State Plans and other state regulations and goals. For example, in addition to federal requirements for screening and monitoring of health indicators, Oregon required its clinics to provide 20 hours of on-site primary care services per week in the second demonstration year. Given that that providing the full scope of services might challenge many CMHCs, the demonstration allows CCBHCs to provide directly the first four services listed above and to provide the remaining services either directly or through a relationship with an external provider known under the demonstration as a DCO--an entity engaged in a formal financial relationship with CCBHCs to deliver some of the nine required services under the same requirements.[16] This section summarizes: (1) the types of services that CCBHCs added or expanded as a result of the certification process; (2) CCBHCs' experience with sustaining the full scope of services into the second demonstration year and any barriers encountered in providing those services; and (3) the EBPs that CCBHCs provided as a result of the demonstration.

1. What Types of Health and Behavioral Health Services did CCBHCs and DCOs Offer in the First Demonstration Year?

In the first demonstration year, most clinics reported that they expanded their scope of services to meet CCBHC certification criteria. Eighty-four percent (n = 56) reported that they made changes to the range of services they provided to consumers. They most often added services to meet certification requirements in the areas of outpatient mental health and/or SUD services, psychiatric rehabilitation services, and crisis behavioral health services (Figure III.5). Other services commonly added services as a result of certification included peer support services, intensive community-based mental health services for members of the armed forces and

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[16] CCBHCs may engage DCOs to provide primary care screening and monitoring; TCM; psychiatric rehabilitation services; peer support services and family support services; and services for members of the armed services and veterans. In addition, a DCO may provide crisis behavioral health services if the DCO is an existing state-sanctioned, certified, or licensed system or network. DCOs may also provide ambulatory and medical detoxification in ASAM categories 3.2-WM and 3.7-WM.

veterans, primary care screening and monitoring, and TCM. Fewer clinics reported the addition of other types of screening and assessment services or person-centered and family-centered treatment planning.

FIGURE III.5. Proportion of CCBHCs that Added Each Type of Service as a Result of Certification (as of March 2018)

Service	Percentage
Outpatient mental health and/or SUD services	63%
Psychiatric rehabilitation services	55%
Crisis behavioral health services	51%
Peer support services	49%
Intensive community-based mental health services for members of the armed forces and veterans	45%
Primary care screening and monitoring	42%
Targeted case management	40%
Screening, assessment, and diagnosis	22%
Person- and family-centered treatment planning services	18%
Other required CCBHC services	16%

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 data collected by Mathematica and the RAND Corporation, March 2018.
NOTES: Denominator is 67 CCBHCs.
See Appendix Table A.11 for detailed findings on individual services.
CCBHCs may have provided services within each of the service categories illustrated in the figure before CCBHC certification. For example, all clinics provided some type of outpatient MH and/or SUD treatment before certification. However, 63% of clinics added some type of outpatient MH and/or SUD treatment as a result of certification. The service categories illustrated in this figure correspond to the service categories described in the CCBHC certification criteria.

During the first demonstration year, CCBHCs provided crisis behavioral health services both directly and through DCOs. In the DY1 progress report, at least three-quarters of clinics reported that they provided crisis behavioral health services directly (these individual services appear in Appendix Table A.12), and at least one-third reported that they added such services as a result of certification (these individual services appear in Appendix Table A.11). The criteria require CCBHCs to provide crisis behavioral services directly unless an existing state-sanctioned, certified, or licensed system or network is functioning as a DCO. The relatively high proportion of clinics that also rely on DCOs to provide crisis behavioral services suggests that CCBHCs may contract with DCOs to supplement their own services or perhaps to provide services that are more targeted than they can offer directly. Interviews with state officials echoed this finding; for example, in Minnesota and Missouri, the DCOs provided crisis services only for the clinics that do not directly provide such services.

As of the DY1 progress report, 33 percent of clinics (n = 22) reported in a write-in progress question that they provided some "other" CCBHC services. Of these, 41 percent (n = 9, all in Missouri) provided emergency room enhancement services (three added this service as a result of certification); 41 percent (n = 9) provided community mental health liaisons[17] (none added this service as a result of certification); and 14 percent (n = 3) offered withdrawal management services (all added as a result of certification). None of these services were provided through DCO partnerships. See Appendix Table A.12 for detailed findings on the availability of each type of service provided by CCBHCs and DCOs, and Appendix Table A.11 for the frequency with which the service was added as a result of certification. State-level findings appear in Appendix Table A.13.

Nearly all CCBHCs provided primary care screening and monitoring, but only 55 percent also provided on-site primary care services during the first demonstration year. In the DY1 progress report, 97 percent of clinics (n = 65) reported that they provided primary care "screening and monitoring" (as required by the certification criteria) either on-site or through DCOs (Appendix Table A.12). Fifty-five percent of clinics (n = 37) also provided on-site primary care services in the first year (provision of these services is not required by the certification criteria) (Appendix Table A.14). Among CCBHCs that provided on-site primary care, 84 percent (n = 31) provided these services before certification; the remaining 16 percent (n = 6) added on-site primary care during or after the certification process. Some clinics in all states provided on-site primary care in the first demonstration year, ranging from 75 percent in Nevada (n = 3) and Oregon (n = 9) to 29 percent in Pennsylvania (n = 2). In addition, 8 percent of clinics (n = 5) reported that they were FQHCs as of the DY1 progress report.

State officials noted that changes to the scope of services to meet certification requirements varied across states, depending on the existing service array offered by the clinics before the demonstration. According to officials in Pennsylvania, New York, and Missouri, the clinics that became CCBHCs provided--before certification--the full scope of services through a mix of *in-house* (i.e., services provided on-site by CCBHC staff) and externally contracted services. CCBHCs commonly brought some of those previously contracted services *in-house* during the certification process. These services were new to the clinics, but not necessarily new to the care network. As one official in Missouri said, "Clinics were doing many aspects of the required services already, so to fulfill the requirements it was a matter of bringing the aspects together under one roof, adding staff, some training, serving more people and covering costs for the full complement of services." In other states, certification required the dramatic expansion of clinics' scope of services. For instance, in Nevada, the clinics that became CCBHCs were previously SUD treatment clinics. To meet certification criteria, the clinics had to add the full range of specialty mental health services, including psychiatric rehabilitation and child/adolescent services.

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[17] Community mental health liaisons, who are employed by clinics (including CCBHCs), work closely with the criminal justice system (including courts, police) to help direct consumers into behavioral health care.

> **CCBHC Spotlight: Scope of Services: Expansion of Therapeutic Group Services**
>
> This CCBHC is a non-profit behavioral health center located in an urban setting. The organization operates two locations for the delivery of behavioral health services (one for adults and one for children and families), as well as operates several additional locations for residential addiction recovery services.
>
> As part of the demonstration, the CCBHC focused on enhancing its scope of services and creating a person-centered and family-centered atmosphere. To this end, the clinic expanded the breadth of group services that it offered. Since the demonstration's outset, the clinic introduced several new group services, including art therapy, health and wellness, yoga, meditation, teen discussion, family change transition, mindfulness, and anger management.
>
> The CCBHC took steps to promote client participation in the new services. For example, each week the clinic posted a schedule of group activities in the common areas of the clinic and encouraged staff to distribute copies of the schedule to clients during routine encounters. Staff reported that they introduced existing clients to the groups through internal referrals; any staff member could suggest a group to a client who might benefit or be interested. Further, clinicians advertised the group services during intake sessions in order to make new clients aware of the clinic's offerings.
>
> > *"We are not seeing as many extreme psychoses because they are participating in the groups. [The group] services that emphasize coping skills potentially has a protective effect."*
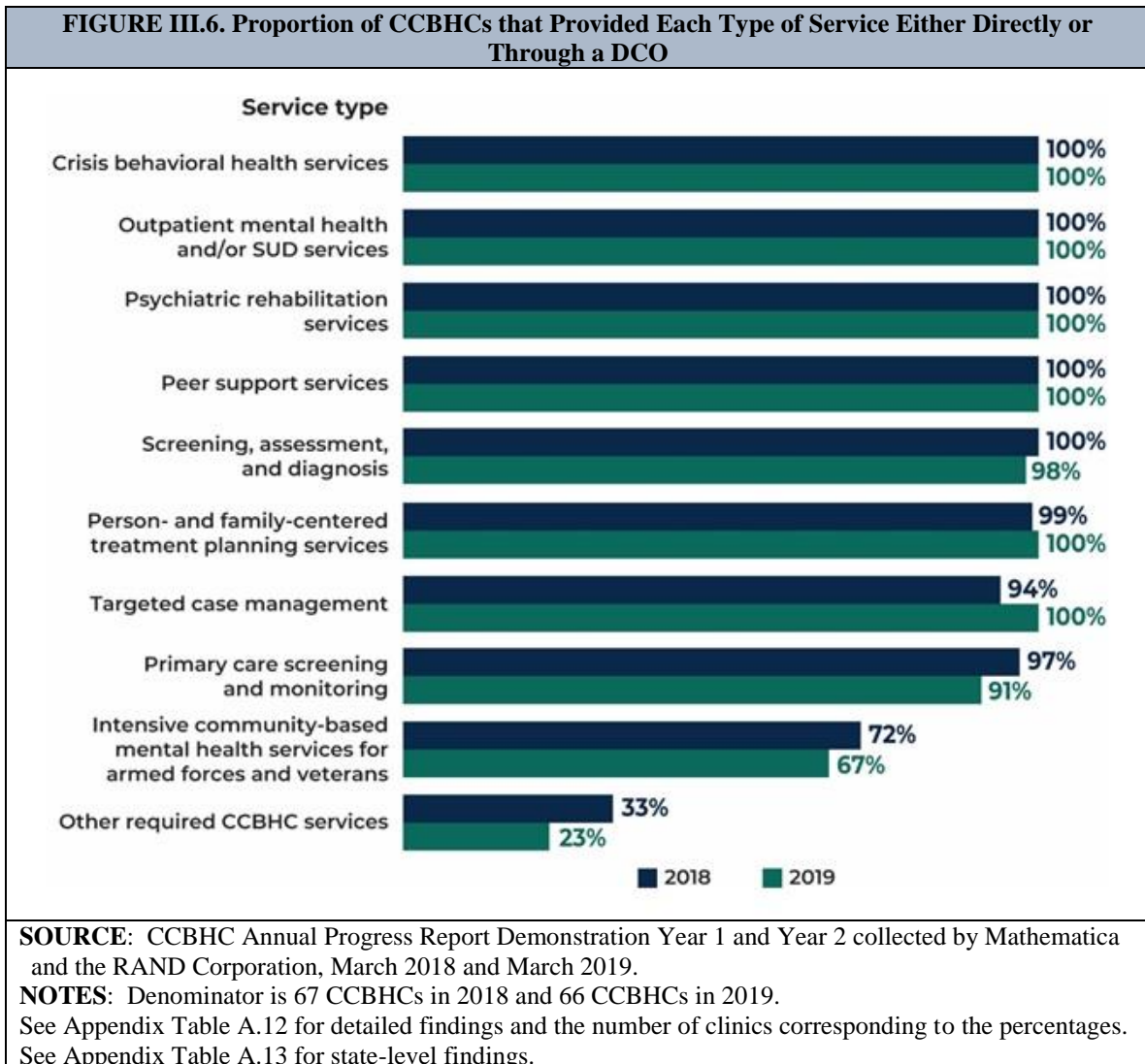> > *--Clinic leader*
>
> CCBHC staff and leaders highlighted the benefits of the new group services, noting that the groups promote positive self-care and coping strategies to help clients manage their symptoms. In addition, staff commented that the groups help keep high-need clients engaged in services. One therapist remarked on the difficulty of keeping clients who are less verbal engaged in services, stating, "Because we provide groups…We can see more clients' experiences and we can keep them engaged." Overall, clinic staff and leadership echoed that the expansion of groups was pivotal in fostering a client-centered environment, promoting resiliency, and creating community. As one psychiatrist said, "The clients love the groups because they don't feel alone, and they enjoy it, and we see that the groups have made a positive change in the clients."
>
> Although the clinic perceived that the groups were successful, the clinic faced some challenges in expanding its group services. Clinic staff and leadership voiced concern that the small physical setting made it difficult to secure meeting spaces suitable for larger groups. In addition, interviewees focused on the costs of offering more groups. While some services, such as art therapy and music therapy, are billable under the state's Medicaid program, others are not. For example, when reflecting on the PPS, the clinic director stated, "The rate sounds fair at face value, but from a programmatic standpoint [the rate] is not enough in order to meet the steady increase of clients that continues to grow. The [service provision] trend is holistic, but some of those things are not billable, for example, the yoga group therapy is not billable." The clinic valued the additional group services for its given client population and therefore planned to continue searching for solutions that will maximize physical space and fund non-billable services.

2. Have CCBHCs and DCOs Sustained the Delivery of Required Services in the Second Year of the Demonstration?

During interviews in the second year of the demonstration, officials in all states indicated that clinics were able to sustain delivery of the nine core CCBHC services throughout the demonstration. As one official in New York noted, "The first year [of the demonstration] was building the full scope of services. The clinics have been able to address all of the core services more effectively moving into Year 2. Now, we are looking to effectively maximize the core services based on client needs…[and]…to help clinics see the shift to multiple services in the same visit."

CCBHCs reported maintaining most of the required services in the second demonstration year. All or nearly all clinics in both DY1 and DY2 reported that they provided crisis behavioral health services; screening, assessment, and diagnosis services; person-centered and family-centered treatment planning services; outpatient mental health and/or SUD services; psychiatric rehabilitation services; peer support services; and TCM either directly or through DCOs (Figure III.6).

FIGURE III.6. Proportion of CCBHCs that Provided Each Type of Service Either Directly or Through a DCO

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: Denominator is 67 CCBHCs in 2018 and 66 CCBHCs in 2019.
See Appendix Table A.12 for detailed findings and the number of clinics corresponding to the percentages.
See Appendix Table A.13 for state-level findings.

Unlike the previous services that were provided by practically all CCBHCs, only 72 percent of clinics (n = 48) reported that, in DY1, they provided intensive community-based mental health services for members of the armed forces and veterans either directly or through a DCO, and only 67 percent (n = 44) reported that they provided such services in DY2 (Figure III.6). State officials offered some explanations for why these services were not offered more frequently. Some state officials perceived that CCBHCs were not located in communities in which a large number of members of the armed forces or veterans sought services from CMHCs. However, they also reported that some CCBHCs struggled to engage these populations and to develop

referral relationships with agencies that serve veterans and military members. In New Jersey, for example, officials indicated that the clinics that provided a greater number of services to larger numbers of members of the armed forces and veterans either hired peer-veterans to conduct outreach or had been providing services to veterans before the demonstration and thus had existing relationships with other community providers.

Ninety-one percent of CCBHCs (n = 60) provided primary care screening and monitoring in the second year of the demonstration compared to 97 percent (n = 65) in DY1 (Figure III.6). The following findings from the progress reports suggest that some CCBHCs shifted responsibility for primary care screening and monitoring to DCOs in the second year of the demonstration (Appendix Table A.12):

- In DY1, only 4 percent of clinics (n = 3) provided primary care screening and monitoring through a DCO relationship, but the proportion increased to 14 percent of clinics (n = 9) in DY2 (a difference of six clinics).

- Of the six clinics that reported newly partnering with DCOs to provide primary care screening and monitoring in DY2, five reported that they provided the service directly in DY1; the other clinic did not provide this service at all in DY1.

The reasons for the shift to DCOs for primary care screening and monitoring are unclear from the progress report data alone, but it is possible that CCBHCs found the service difficult to provide directly.

All CCBHCs provided crisis behavioral health services in both years of the demonstration (Figure III.6). There were some shifts over time in the proportion of clinics that provided individual crisis behavioral health services directly versus through a DCO relationship (Appendix Table A.12):

- Ninety-five percent (n = 63) of clinics directly provided emergency crisis intervention services in DY2 compared with 88 percent (n = 59) in DY1.

- At the same time, 27 percent of clinics (n = 18) provided crisis stabilization through a DCO relationship in DY2 compared with 21 percent (n = 14) in DY1.

- Eighty percent (n = 53) of clinics directly provided 24-hour mobile crisis teams in DY2 compared with 73 percent (n = 49) in DY1. DCO provision of 24-hour mobile crisis teams (one of the most commonly provided DCO services) decreased correspondingly from 34 percent of clinics (n = 23) in DY1 to 29 percent (n = 19) in DY2.

Fifty-five percent of CCBHCs (n = 36) provided on-site primary care during the second year of the demonstration (Figure III.7), the same proportion of CCBHCs that reported provision of this service in DY1 (Appendix Table A.14). All clinics in Nevada and Oregon reported that they provided on-site primary care services, whereas only some clinics in other states reported the provision of these services. Officials in Oregon reported a new state requirement for CCBHCs in the second demonstration year that mandated the provision of 20

hours per week of on-site primary care. When discussing the addition of primary care, one official commented that "the federal [CCBHC] requirements set us up, so really trying to meet the federal requirements in year one allowed us to ramp up in year two." Only in New York did on-site primary care services decrease, from 54 percent of clinics (n = 7) in DY1 to 15 percent (n = 2) in DY2. New York clinics reported several DCO relationships with FQHCs in DY2, perhaps helping to explain the decrease in direct service provision (more information appears in Section III.D).

Provision of "other" services decreased by the second year of the demonstration. In a write-in question in the DY2 progress report, 23 percent of clinics (n = 15) reported that they provided some "other" CCBHC services, a decrease from the 33 percent (n = 22) that reported the same in DY1. More specifically, among these clinics, they wrote in similar "other" services as in the previous year, but at lower rates: 20 percent (n = 3) provided emergency room enhancement services (compared to 41 percent [n = 9] in DY1); 13 percent (n = 2) provided withdrawal management services (compared to 14 percent [n = 3] in DY1); and 7 percent (n = 1) provided community mental health liaisons (compared to 41 percent (n = 9) in DY1). None of these services was provided through DCO partnerships in either year.

FIGURE III.7. Proportion of CCBHCs that Provided On-Site Primary Care in DY2 and Before CCBHC Certification

16%
Did not provide on-site primary care services before CCBHC certification

45%
Did not provide on-site primary care services

55%
Provided on-site primary care services (in addition to primary care screening and monitoring)

84%
Provided on-site primary care services (in addition to primary care screening and monitoring) before CCBHC certification

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: See Appendix Table A.14 for detailed findings and the number of clinics corresponding to the percentages.
See Appendix Table A.15 for state-level findings.

3. What EBPs did CCBHCs Adopt as a Result of Certification? Were CCBHCs able to Sustain These Practices?

In the first year of the demonstration, CCBHCs offered a wide range of EBPs and psychiatric rehabilitation and other services either directly or through DCOs. Most clinics were able to sustain or provide more of these services in the second year of the demonstration (Figure III.8).

- All or almost all CCBHCs provided many EBPs in both DY1 and DY2, including motivational interviewing, individual and group CBT, dialectical behavior therapy (DBT), evidence-based medication evaluation and management, and community wraparound services for youth/children.

- Ninety-two percent of clinics (n = 61) offered MAT in DY2 compared to 84 percent (n = 56) in DY1.

- Fifty-six percent of clinics (n = 37) offered Multisystemic Therapy services in DY2 compared to 40 percent (n = 27) in DY1.

Some CCBHCs shifted the delivery of certain EBPs and psychiatric rehabilitation services to DCOs in the second year of the demonstration (Appendix Table A.12).

- Five percent of CCBHCs (n = 3) delivered individual or group CBT through DCOs in DY2 compared to no CCBHCs in DY1.

- Three percent of clinics (n = 2) delivered Multisystemic Therapy through DCOs in DY2 compared to no clinics in DY1.

- Three percent of clinics (n = 2) delivered evidence-based medication evaluation and management through DCOs in DY2 compared to no clinics in DY1.

CCBHCs adopted several of the following services as a result of certification, as reported in the DY1 progress report (Appendix Table A.11).

- Forty-six percent (n = 31) added MAT for alcohol or opioid use as a result of certification.

- Forty percent (n = 27) added TCM.

- Thirty-one percent (n = 21) added Illness Management and Recovery.

- Fifteen percent (n = 10) added community wraparound services for youth/children.

At the state level, New York saw the most change in delivering EBPs from DY1 to DY2, with many more CCBHCs reporting that they provided these services either directly or through DCOs in the demonstration's second year (state-level findings appear in Appendix Table A.13).

CCBHCs in Minnesota and Oregon substantially increased their provision of MAT from DY1 to DY2.

FIGURE III.8. Proportion of CCBHCs that Provide Selected EBPs, Psychiatric Rehabilitation Services, or Other Services, Either Directly or Through a DCO

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: Denominator is 67 CCBHCs in 2018 and 66 CCBHCs in 2019.
See Appendix Table A.12 for detailed findings and the number of clinics corresponding to the percentages.
See Appendix Table A.11 for the number and percentage of clinics that added each type of service as a result of CCBHC certification.
See Appendix Table A.13 for state-level findings.
* = EBP listed in CCBHC criteria.

Provision of several key psychiatric rehabilitation and other services increased in the second demonstration year (Figure III.8) as noted below.

- Eighty-two percent of clinics (n = 54) offered supported employment in DY2 compared to 75 percent (n = 50) in DY1.

- Eighty-three percent of clinics (n = 55) offered peer support services for families in DY2 compared to 73 percent (n = 49) in DY1.

- Seventy-nine percent of clinics (n = 52) offered supported housing in DY2 compared to 70 percent (n = 47) in DY1.

- Sixty-eight percent of clinics (n = 45) offered supported education in DY2 compared to 54 percent (n = 36) in DY1.

CCBHCs used several best practices to facilitate crisis planning, with little change from DY1 to DY2. A similar proportion of clinics in both years reported the use of wellness recovery action plans, psychiatric advance directives, and safety or crisis plans (Table III.5). Nevada was the only state in which CCBHCs did not use all of the strategies: zero percent of clinics in either year reported the use of safety/crisis plans.

Fifty-five percent of clinics (n = 37) reported reliance on some "other" strategy to facilitate crisis planning in DY1, increasing to 64 percent (n = 42) in DY2 (Table III.5). In a write-in question in the progress report, clinics listed a range of such strategies that were similar in DY1 and DY2, including suicide assessments (for example, the Columbia Scale), relapse prevention and planning, critical/crisis intervention planning, and working with external partners and stakeholders to provide patient-centered services in the area of crisis planning.

TABLE III.5. Strategies Used by CCBHCs to Facilitate Crisis Planning				
Strategy	**Number and Proportion of CCBHCs that Used Strategy, 2018**		**Number and Proportion of CCBHCs that Used Strategy, 2019**	
	N	**%**	**N**	**%**
Wellness recovery action plan	49	73	49	74
Psychiatric advance directives	46	69	49	74
Develop a safety or crisis plan	29	43	27	41
Other	37	55	42	64
Total CCBHCs	67	100	66	100
SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019.				
NOTE: See Appendix Table A.16 for state-level findings.				

Officials in most states indicated that, even though individual CCBHCs may have added a few new practices, clinics, in general, have consistently implemented the EBPs required by states across demonstration years. One state official remarked, for example, that the "CCBHC model in the state was a launching point for clinics to embed EBPs into their clinic models and all clinics have grown their trainings and monitoring processes for EBPs in the second year." To support CCBHCs' efforts to enhance the provision of EBPs, officials in two states mentioned the

initiation of learning collaboratives to help clinics work toward adopting and using different EBPs.

Officials in two states noted that, even though EBPs have been an important component of the CCBHC service array, **states have found it necessary to grant CCBHCs some flexibility to adjust their offerings to ensure that their services reflected the needs of their client populations** as those needs came into focus during the first demonstration year. In Nevada, for example, state officials mentioned that they initially asked CCBHCs to provide specific EBPs; however, the state later recognized that requiring clinics to expend significant resources to provide a service used by only a small percentage of consumers was not a judicious use of funds for CCBHCs, particularly when other less resource-intensive services were available to meet the same need. Nevada, therefore, was planning to provide CCBHCs with more flexibility to meet what it perceived as the underlying intent of the EBP requirement. For example, the state initially expected CCBHCs to provide a specific EBP, namely, Trauma-Focused CBT, to ensure that clients received trauma-focused care; however, the state has broadened the requirement to allow CCBHCs to establish a trauma-specific framework for interventions without limiting them to delivery of the provider-intensive and resource-intensive specific Trauma-Focused CBT EBP. An official in the state reported that the state "received feedback over the 18 months and [is] evaluating how we can stay true to the intent of EBPs but give flexibility to the clinic that is appropriate to meet the need of their clients and not completely dictated by the state."

Some states reported that the demonstration is dovetailing with other efforts underway to expand EBPs across the demonstration states. For example, in the second demonstration year, Minnesota decided that, given the nationwide focus on the ongoing opioid crisis, the state needed a clear policy document about MAT, what it is and why it works, and how to integrate it into a behavioral health clinic. The state also mentioned that, as part of its Opioid State Targeted Response grant, it developed three opioid-specific hub-and-spoke networks by adopting the ECHO model.[18] Minnesota noted that CCBHCs have been closely involved with these efforts and "were oriented before everyone else and invited to participate. And we've heard fantastic feedback from the physicians and psychiatrists in the clinics who have attended and said the ECHO model has done a lot to help them prescribe buprenorphine when they were quite uncomfortable with it before. This mainly is a psychiatry population that has been in CMHCs and mental health clinics and they haven't been thinking about MAT, so this was a big push for them to feel comfortable, and the ECHO model has helped a lot."

4. What Barriers have CCBHCs Encountered in Providing the Full Scope of Services?

State officials identified some services as initially challenging for some CCBHCs to implement but indicated that the states generally addressed these challenges early in the demonstration. At the beginning of the demonstration, state officials most commonly reported that outpatient SUD treatment and peer support services were the most challenging for CCBHCs to provide. However, at the time of the second round of interviews, officials in most states noted that

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[18] The ECHO model is a hub-and-spoke model that links expert specialist teams at a "hub" with providers and clinicians in local communities--the "spokes" of the model.

CCBHCs and states had resolved most challenges. State officials described overcoming several barriers to the implementation of the full scope of services, including the following:

- **Inexperience in providing specific services to certain populations**. As described above, CCBHCs in some states were required to add new service lines or types of services to fulfill the demonstration criteria. For example, Nevada's CCBHCs provided primarily SUD services before the demonstration and thus had to add outpatient mental health services. Some CCBHCs in other states had to expand certain services to new populations. In Minnesota, for example, before the demonstration, CCBHCs provided some services only to adults and others only to children.

- **State credentialing and licensure requirements**. Officials in some states described challenges either in obtaining licensure to provide certain required services or hiring staff with the credentials needed to provide such services. For example, stringent state requirements for licensure for ambulatory withdrawal management in New Jersey initially posed a challenge for the state in certifying its CCBHCs. The state worked closely with its CCBHCs and state licensure office to help the former meet the licensure requirements. Similarly, some CCBHCs initially faced challenges in delivering peer support services because of state regulations governing the credentialing of peer support staff.

- **Workforce shortages**. As described earlier, some states initially experienced challenges in recruiting and hiring certain types of staff. Officials in several states, including Minnesota, New Jersey, and New York, noted particular challenges in hiring peer support staff in rural areas.

In the second year of the demonstration, **officials confirmed that states and clinics no longer encountered major barriers to providing the full scope of services**. As the demonstration winds down and states reflect on how to improve the model in the future, officials noted several lessons learned regarding the implementation of services. Officials in New Jersey, for instance, indicated that a more prescriptive approach to certain services at the beginning of the demonstration could perhaps have engendered the more widespread availability and use of those services. For example, the state reported that it hoped that clinics would provide more and better-integrated peer services than ultimately were available and suggested that: (1) the lack of a state definition or credentialing process for peers; and (2) the need for more guidance from state demonstration leadership on how to provide peer services may have contributed. Even though peer services were available, clinics struggled to incorporate such services into all facets of CCBHC service provision and care coordination as was envisioned by the state. A New Jersey official noted that "when we started doing our site visits we asked them…where are your peers, where are they involved…and we started to see this that peers were not an active component. They were available, but they weren't a big part of the program. That's one of the areas where we would have been more prescriptive."

Officials in most states also suggested that **the comprehensive and collaborative nature of service provision represented a paradigm shift for their states, clinics, and consumers alike**,

and two states reported surprise at the way CCBHC clients responded to the availability of certain services.

- Officials in Oklahoma, for example, noted that, even though clinics have been able to incorporate the components needed to deliver an IOP level of services for SUD, including MAT and recovery-focused services, persuading clients to make use of such services posed a challenge. As one official noted, "For many years all there was [for SUD treatment] were residential and 12-step programs. So that's still embedded in our culture, so it's convincing people that 'yes you can get better by going to MAT, and we have these IOP services you can get and not have to wait until you go off to a residential bed.' But I think that shift in culture is a process, I think once people realize how much easier it is not to have to put lives on hold, give up jobs, and leave families in order to go somewhere and get treatment, we'll see people using the services more."

- Similarly, Minnesota officials voiced surprise over consumer reactions to the demonstration's requirements for an initial assessment to be completed within ten days and a much more comprehensive assessment within 60 days. The state expected CCBHC clients to favor this approach, which would allow time for providers and clients to build rapport before delving into sensitive topics. Instead, officials noted that clients expressed a clear preference for the completion of all assessments at one time because "trying to convince clients to come into the clinic for evaluation twice or more was a hard sell, particularly for clinics in remote areas where clients live far from their clinic. The clients wanted to come in for 2-3 hours and get it all done at once. This was a surprise because the thought was that clients felt that it was frontloaded and here's this stranger asking personal questions at the beginning…but it didn't work that way." The state has since created a work group to explore ways to improve the assessment process that will better meet client preferences and needs.

D. Care Coordination

The CCBHC certification criteria describe care coordination as the "linchpin" of the CCBHC model. The criteria require CCBHCs to provide integrated and coordinated care that is person-centered and family-centered and addresses all aspects of a person's health. The authorizing statute requires CCBHCs to coordinate care across settings and providers, and to establish partnerships and formal relationships with a range of other providers. CCBHCs must ensure adequate communication and collaboration between and among them, including formal relationships with DCOs. This section summarizes: (1) the types of care coordination services offered by CCBHCs; (2) changes that CCBHCs implemented in their treatment teams to support care coordination; and (3) the extent to which CCBHCs expanded the network of care providers participating in the treatment of their clients, including DCOs.

1. What Processes have CCBHCs and DCOs Implemented to Share Information across Providers and Coordinate Care?

Officials in most states acknowledged that CCBHCs and other behavioral health providers generally engage in care coordination across their respective states by relying on a variety of specific care management programs or care models. Officials described some of the specific ways in which CCBHCs have leveraged or expanded these models under the demonstration, including the following:

- Several state officials pointed to the importance of TCM for CCBHC consumers. In particular, officials in New Jersey and Pennsylvania mentioned plans for expanding TCM to populations served by CCBHCs. In New Jersey, outside of the demonstration, providers primarily offer TCM to people released from state psychiatric hospitals who have serious and persistent mental illness and/or are considered "high acuity."[19] New Jersey officials commented that the state's goal is to expand and make structured care coordination and case management available to all populations served by CCBHCs, including those with SUD or a lower level of need for whom TCM is not traditionally available. Pennsylvania CCBHCs are providing TCM for all CCBHC consumers and using two other models of care coordination: (1) a nurse navigator model in rural areas that focuses on improving medication adherence for both physical and behavioral conditions; and (2) a case management model in urban and rural areas that focuses on SUD treatment for individuals receiving MAT.

- Officials in Oklahoma characterized care coordination before the demonstration as generally "one size fits all," noting that the state's CCBHCs are becoming much more sophisticated in providing care coordination. For example, one CCBHC has started to use a one-page CCBHC consumer "report card," accessible to staff, that shows laboratory results, medication compliance, the number of services received, and screenings for a given consumer. The report cards assign a grade to the agency on how well the services provided to each CCBHC consumer are coordinated, with those results also available to all staff involved in the individual's care.

- Officials in Oregon noted that "the main difference [between what CCBHCs and other behavioral health providers are providing] is the standards that go along with CCBHC care coordination. We had care coordination before, but now we have the care coordination agreements with the various entities that are required, so it's really an increase in *intensity* of care coordination."

- Officials in Missouri reported that CCBHCs leveraged existing care coordination efforts in the state, commenting that "the state already had initiatives for Health Home and care management that all CCBHCs leveraged to fulfill and expand care coordination--related services for CCBHC consumers." Similarly, officials in Minnesota and New Jersey mentioned that care coordination, now available to all CCBHC clients, had previously been available only to certain populations or service lines.

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[19] High acuity typically refers to consumers with acute (active) disorders that require substantial amounts of care.

Most CCBHCs made changes to the composition of their treatment teams as a result of the certification process and then continued to refine the membership of the teams during the demonstration's second year. In DY1, 76 percent of clinics (n = 51) reported a change in the membership of their treatment teams as a result of the certification process; in DY2, 58 percent (n = 38) reported that members of their treatment teams changed in the last 12 months. However, as noted below, clinics reported few substantial differences from DY1 to DY2 in the proportion of clinics that reported the participation of specific types of providers in their treatment teams (Table III.6).[20]

CCBHC Spotlight: Risk-Stratification for Tailoring Scope of Services and Care Coordination

Snapshot of CCBHC. This CCBHC is a non-profit behavioral health center within a larger health system network. It is located in an urban area and is considered the largest behavioral health provider in its region.

As part of the demonstration, the CCBHC developed an algorithm to classify clients into four levels of risk based on a client's biopsychosocial factors. The risk score is documented in the client's health records and then used to identify clients in need of more intensive services and/or care coordination. The CCBHC reassesses the risk level every six months or when the client experiences a change in health status. Before the demonstration, the clinic did not have a strategy for risk-stratifying clients.

Program staff and leadership reported on the several benefits of the risk-stratification process. For example, the clinic developed care teams charged with specializing in and treating specific conditions and addressing specific needs such as SMI, SUD, and medical complexities. The risk-stratification process allows the clinic to assign clients to the care team that best meets their particular care needs, and guides the teams' care decisions related to each client. Stratification also allows staff to enhance services to meet the needs of high-risk clients and proactively identify moderate-risk clients. Staff reported that the risk scores proved helpful with intervening and reducing the likelihood that clients would transition to the higher-risk categories, noting that "it is not just the squeaky wheel that gets our attention. Sometimes it is the consumer who is not engaged who might not be the highest risk and needs our attention."

> *"The risk-stratification categories have really improved communication among the provider team and afforded a higher level of care for all consumers. The categories and meeting time give us the structure and forum to discuss consumers' needs and the teams that is engaging with consumers."*
>
> *--Supervisor*

Staff also used the risk categories to tailor care coordination to clients' needs. For example, clients considered "high-risk" receive high priority in treatment team discussions, leading to enhanced care management for those clients. In addition, to enhance care coordination across the service landscape, CCBHC staff members collaborate with internal and external providers who serve the same clients. One provider said, "The meetings to discuss the groups of consumers, especially the high-risk group, bring together providers from the multiple locations--and consumers may get services from the multiple service locations--so that helps us provide person-centered care."

The proportion of CCBHCs that changed their treatment teams as a result of certification in DY1 was generally consistent across states; the exception was Missouri, where only about one-third of clinics reported that they made changes. However, state officials in Missouri described well-established care coordination efforts across the state before the demonstration, perhaps

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[20] This seemingly contradictory finding may reflect the fact that the questions in the progress reports about specific treatment team members capture information only at each time point rather than fluctuations in these specific team members over the past 12 months.

explaining in part the low percentage of changes to treatment teams in their state as a result of certification. The state-level proportion of clinics reporting in DY2 that members of their treatment teams changed in the last 12 months was more variable.

In interviews, state officials described clinics' efforts in the demonstration's second year to enhance treatment teams by more successfully incorporating certain provider types. In Nevada, for example, officials described efforts aimed at better integrating psychiatrists into treatment planning and treatment teams as required under the demonstration. Officials noted that, before the demonstration, clinics typically contracted with psychiatrists in private practice for psychiatry services. One official commented that the demonstration has therefore "created a very different utilization of psychiatry by integrating the medical doctor into the therapeutic team. The clinic size influences how that is implemented…comprehensive team meetings once per week…has been feasible at small clinics. At the urban [larger] clinic, the clinic needed to really work hard to change the approach to psychiatry to get the medical doctors involved and have team meetings. The change took a lot of coaching from the CCBHC administration with the staff."

For most provider types, the proportion of CCBHCs that included them on treatment teams did not change substantially from DY1 to DY2 (Table III.6). A larger proportion of clinics wrote in "other" types of providers as participants in treatment teams in DY2 compared with DY1 (an explanation of these providers appears in Table III.7). However, the proportion of clinics that reported the inclusion of consumers or clients on treatment teams decreased by 10 percentage points from DY1 to DY2. We have no further information to validate or explain this finding. In Nevada, all of the CCBHCs continued to include primary care providers on treatment teams in DY2, whereas the same approach was less common in other states.

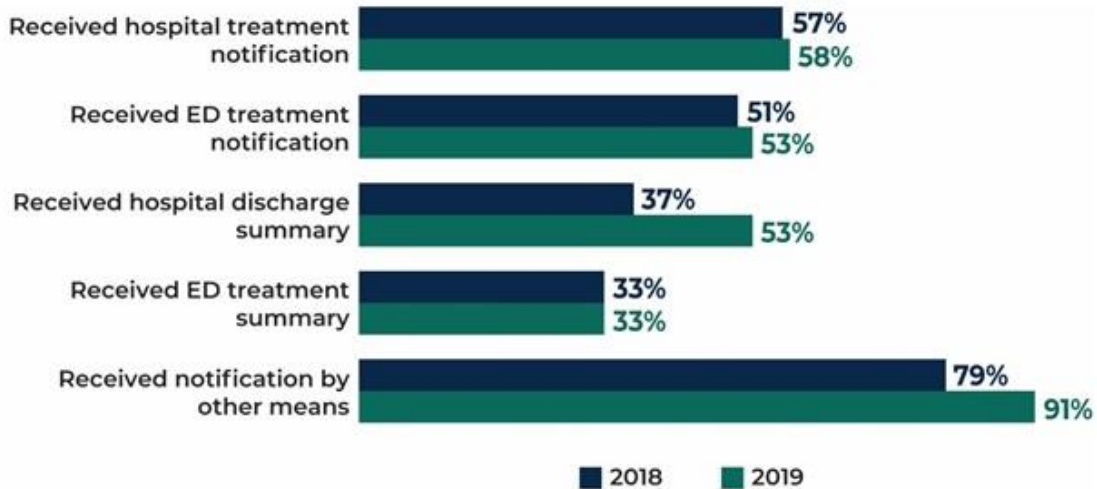| TABLE III.6. Types of Providers Participating in CCBHC Treatment Teams				
Type of Provider	**Number and Proportion of CCBHCs that Included Providers on Treatment Teams, 2018**		**Number and Proportion of CCBHCs that Included Providers on Treatment Teams, 2019**	
	N	**%**	**N**	**%**
MH clinicians	67	100	66	100
Case managers	67	100	64	97
SUD treatment providers	66	99	64	97
Psychiatrists	63	94	60	91
Consumers/clients	62	93	55	83
Community support and social service providers	56	84	51	77
Consumer/client family members	52	78	51	77
Primary care physicians	36	54	32	48
Other	31	46	36	55
Total CCBHCs	67	100	66	100
SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019. **NOTES**: See Appendix Table A.17 for state-level findings.				

CCBHCs reported that a wide range of "other" types of providers and partners participated in treatment teams in both years of the demonstration (Table III.7), as demonstrated by the following:

- Twenty-nine percent of clinics (n = 19) included peers on treatment teams in DY2 compared to 19 percent (n = 13) in DY1.

- Twenty percent of clinics (n =19) included nursing staff on treatment teams in DY2 compared to 8 percent (n = 5) in DY1.

- Five percent of clinics (n = 3) included corrections staff, such as external probation or parole officers, on treatment teams in DY2 compared to zero percent in DY1.

The findings underscore the importance of these various provider types in CCBHCs' delivery of services, which seems to have grown as the demonstration progressed. Consistent with these findings, and as noted in previous sections, officials in most states mentioned the crucial role played by peers on treatment teams.

TABLE III.7. Types of "Other" Providers or Partners that Participated in CCBHC Treatment Teams				
"Other" Provider or Partner Type	**"Other" Providers or Partners that Participated in CCBHC Treatment Teams, March 2018 (DY1)**		**"Other" Providers or Partners that Participated in CCBHC Treatment Teams, March 2019 (DY2)**	
	N	**%**	**N**	**%**
Peer support staff	13	19	19	29
Family support providers	5	8	3	5
Nursing staff	5	8	13	20
Care coordinators	3	5	3	5
Guardians	2	3	3	5
School staff	1	2	4	6
Corrections staff	0	0	3	5
Total CCBHCs	67	100	66	100
SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.				

In both years, CCBHCs more often received notifications about consumers' treatment at external facilities for behavioral health conditions than for physical health conditions (Figure III.9 and Figure III.10). However, the rate of notifications about physical health conditions increased between DY1 and DY2, whereas some notifications for behavioral health conditions declined. In DY1, 88 percent of clinics (n = 59) reported that they received notifications when hospitals treated their consumers' behavioral health conditions compared with 71 percent (n = 47) in DY2 (Figure III.9). Conversely, 37 percent of clinics (n = 25) reported that they received notification from emergency departments when they treated consumers' physical health conditions in DY1 compared with 53 percent (n = 35) in DY2 (Figure III.10).

FIGURE III.9. Proportion of CCBHCs that Received Notification about Consumers' Treatment for Behavioral Health Conditions
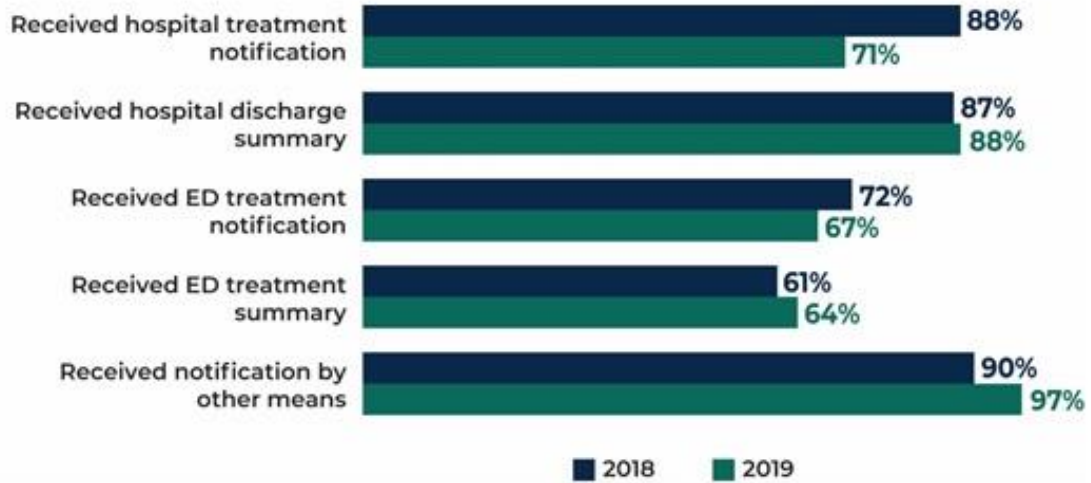
	2018	2019
Received hospital treatment notification	88%	71%
Received hospital discharge summary	87%	88%
Received ED treatment notification	72%	67%
Received ED treatment summary	61%	64%
Received notification by other means	90%	97%

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: See Appendix Table A.18 for detailed findings and the number of clinics that correspond to the percentages.
See Appendix Table A.19 for state-level findings.

FIGURE III.10. Proportion of CCBHCs that Received Notification about Consumers' Treatment for Physical Health Conditions

	2018	2019
Received hospital treatment notification	57%	58%
Received ED treatment notification	51%	53%
Received hospital discharge summary	37%	53%
Received ED treatment summary	33%	33%
Received notification by other means	79%	91%

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES: See Appendix Table A.18 for detailed findings and the number of clinics that correspond to the percentages.
See Appendix Table A.20 for state-level findings.

Over 90 percent of CCBHCs reported that they received notifications by "other means" when their consumers were treated for either behavioral health (97 percent of clinics, n = 64) or physical health conditions (91 percent, n = 60) in DY2. The figures represent an increase of 9 percentage points for behavioral health conditions and 13 percentage points for physical health conditions from DY1 (Figure III.9 and Figure III.10). A new progress report question in DY2 allowed clinics to describe these "other means" (not shown in the below figures). By far the most common were direct reports by consumers (33 percent, n = 22) and consumers' families (38 percent, n = 25). Other notification sources included consumers' PCPs and other providers (12 percent, n = 8), corrections and law enforcement officers (9 percent, n = 6), crisis centers including crisis DCOs (6 percent, n = 4), and insurance agencies (6 percent, n = 4).

Although not a widespread practice, officials in some states described statewide efforts to use HIT to alert clinics about CCBHC consumers' use of other health care services. For example, in Missouri, the state Medicaid agency provides CCBHCs with lists of Medicaid consumers who are hospitalized once Medicaid is notified via authorization. In New Jersey, CCBHCs receive Admission, Discharge, Transfer alerts electronically when a client is admitted to a hospital, transferred to another facility, or discharged from the hospital, thereby allowing clinics to follow up with clients while in the hospital or shortly after discharge.

2. Have CCBHCs Sustained Relationships with DCOs?

Although still relatively uncommon, the number and variety of DCO relationships increased from DY1 to DY2. As of the DY1 progress report, CCBHCs most frequently relied on DCOs for the provision of suicide/crisis services; otherwise, DCO relationships were not common (Table III.8). In DY2, DCOs providing suicide/crisis services were still by far the most common type of DCO; 30 percent of CCBHCs (n = 20) reported a relationship with a DCO to provide suicide/crisis hotlines or warmlines compared with 28 percent (n = 19) in DY1. Clinics in the same four of the eight demonstration states (Missouri, New Jersey, New York, and Pennsylvania) reported DCO relationships with suicide/crisis hotlines and warmlines in DY1 and DY2. Officials in these states noted that reliance on a DCO for such services made sense because the services are specialized and relatively low-volume.

Other than suicide/crisis services, the variety of facility/provider types with which CCBHCs established DCO partnerships as of the DY2 progress report increased from the previous year (Table III.8). CCBHCs reported DCO relationships with the following ten new types of providers in DY2, eight of which are not traditional health care providers:

- Post-detoxification step-down facilities (5 percent of CCBHs, n = 3).

- Schools (3 percent of CCBHs, n = 2).

- Adult criminal justice agencies/courts (3 percent of CCBHs, n = 2).

- Mental health/drug courts (3 percent of CCBHs, n = 2).

- School-based health centers (2 percent of CCBHs, n = 1).

- Homeless shelters (2 percent of CCBHs, n = 1).

- Housing agencies (2 percent of CCBHs, n = 1).

- Older adult services (2 percent of CCBHs, n = 1).

- U.S. Department of Veterans Affairs (VA) treatment facilities (2 percent of CCBHs, n = 1).

- Urgent care centers (2 percent of CCBHCs, n = 1).

In addition, the number of DCO relationships with facility/provider types with which clinics reported DCO relationships in DY1 increased in DY2, including, for example:

- MAT providers (from 3 percent of CCBHCs [n = 2] in DY1 to 9 percent [n = 6] in DY2).

- FQHCs (from 3 percent of CCBHCs [n = 2] in DY1 to 8 percent [n = 5] in DY2).

- Employment services and/or supported employment (from 3 percent of CCBHCs [n = 2] in DY1 to 8 percent [n = 5] in DY2).

In general, social and human service providers such as schools; criminal justice agencies; and employment, older adult, and peer service providers seemed to be emerging as increasingly important for DCO relationships, whereas inpatient behavioral health-related facilities were the only type of DCO to decrease in number from DY1 to DY2. However, the findings in this paragraph and in the above bullets should be interpreted with caution. Although CCBHCs reported that they established formal DCO relationships with a variety of new types of providers, it is unclear how some of these entities (e.g., criminal justice agencies/courts and mental health/drug courts) could provide CCBHC services on clinics' behalf. In addition, as indicated below, state officials maintained throughout both demonstration years that CCBHCs rarely engaged DCOs and instead preferred to provide CCBHC services directly.

At the state level, Minnesota, Missouri, and especially New York reported substantial increases in DCO relationships from DY1 to DY2. CCBHCs in New York doubled the number of DCOs, from 15 in DY1 to 30 in DY2. CCBHCs in Minnesota reported zero DCOs in DY1 but added three in DY2. With Minnesota CCBHCs establishing their first DCOs in the 12 months before the DY2 progress report, Oklahoma became the only state without a DCO as of the DY2 progress report.

TABLE III.8. Number and Proportion of CCBHCs that had DCO Relationships with Other Facilities and Providers in DY1 and DY2				
Facility/Provider Type[a]	**DCO (as of March 2018)**		**DCO (as of March 2019)**	
	N	**%**	**N**	**%**
FQHCs	2	3	5	8
Rural health clinics	0	0	0	0
Primary care providers	2	3	3	5
Inpatient psychiatric facilities	1	1	0	0
Psychiatric residential treatment facilities	1	1	0	0
SUD residential treatment facilities	3	4	3	5
Medical detoxification facilities	2	3	2	3
Ambulatory detoxification facilities	1	1	2	3
Post-detoxification step-down facilities	0	0	3	5
Residential (non-hospital) crisis settings	3	4	2	3
MAT providers for substance use	2	3	6	9
Schools	0	0	2	3
School-based health centers	0	0	1	2
Child welfare agencies	0	0	0	0
Therapeutic foster care service agencies	0	0	0	0
Juvenile justice agencies	0	0	0	0
Adult criminal justice agencies/courts	0	0	2	3
MH/drug courts	0	0	2	3
Law enforcement	0	0	0	0
Indian Health Service or other tribal programs	0	0	0	0
Indian Health Service youth regional treatment centers	0	0	0	0
Homeless shelters	0	0	1	2
Housing agencies	0	0	1	2
Suicide/crisis hotlines and warmlines	19	28	20	30
Employment services and/or supported employment	2	3	5	8
Older adult services	0	0	1	2
Other social and human service providers	2	3	4	6
Consumer-operated/peer service provider organizations	3	4	4	6
VA treatment facilities	0	0	1	2
Urgent care centers	0	0	1	2
EDs	2	3	4	6
Hospital outpatient clinics	0	0	0	0
Total CCBHCs	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: See Appendix Table A.21 for state-level findings.

a. Color shading approximately represents the 5 main care coordination groupings from the CCBHC certification criteria: red (rows 1-3) = FQHCs, rural health clinics, other primary care providers; green (rows 4-10) = inpatient and residential behavioral health treatment; blue (rows 11-28) = community or regional services, supports, and providers; orange (row 29) = VA facilities; gray (rows 30-32) = inpatient acute care hospitals. For more information about the grouping of providers/facilities, see the criteria at https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf, pp. 27-31.

In the first year of the demonstration, state officials offered several reasons for why CCBHCs strongly prefer to provide services directly rather than establish a formal financial relationship with a DCO. CCBHCs' concerns extend to the legal requirements governing and other specifications related to formal DCO agreements, the need to share sensitive information about clients with external providers, and uncertainties about payment through the PPS. Consistent with their perceptions reported during the demonstration's first year, state officials universally indicated in DY2 that DCOs have not been an important component of the CCBHC model in their states. Officials reported that most clinics preferred to build and provide the full scope of CCBHC services directly for the following three primary reasons:

- Officials in three states remarked that an overarching deterrent to widespread development of DCO relationships was clinics' reluctance to assume responsibility for the oversight of another provider's services and data. As an official in Minnesota noted, clinics "shied away from wanting to have to hold other organizations accountable for the quality standards and training and everything so chose to develop services they didn't already offer internally."

- Officials also suggested that CCBHCs wished to meet fully all the CCBHC criteria on their own and to develop comprehensive programs themselves. An official in New Jersey perceived that the state's clinics "all truly wanted to meet the requirements and wanted to be the true CCBHC and meet the model…for all the work they were going to have to do to manage the DCO relationship, it was going to be better for their models and financing models to grow their programs in house."

- Officials also cited ongoing concerns about the process for billing for services provided by DCOs. Officials in two states noted that CCBHCs were unfamiliar with and challenged by the provider-to-provider reimbursement arrangement required for DCOs. Setting up agreements and contracts and then adjusting accounting systems to allow for payments to be made to DCOs took time and required significant state oversight and monitoring to ensure compliance with billing requirements.

Officials in three states noted that crisis services were the exception to CCBHCs' reluctance to engage DCOs; in part, the exception reflects the close formal partnerships between CCBHCs and crisis providers that predated the demonstration, thus making reliance on these providers much less complicated and more familiar for clinics.

3. Are CCBHCs in the State Providing CCBHC Services in Collateral Agencies such as Schools and Shelters?

CCBHCs reported that they worked with and in a wide variety of facilities and providers to deliver services to consumers, including social and human service agencies such as schools and shelters. Fifty-five percent of clinics (n = 34) in DY1 and 45 percent (n = 30) in DY2 described delivering services in a wide range of external locations, including schools and shelters, as a way for best reaching consumers. Nine percent of clinics (n = 6) reported that they provided services in homeless shelters in DY1, increasing slightly to 11 percent (n = 7) in DY2. More information about CCBHCs' service provision in external locations appears in Section B.

As mentioned, DCO relationships with schools, school-based health centers, and homeless shelters increased from DY1 to DY2 (Table III.8). Outside of formal DCO partnerships, CCBHCs continued to work with a broad range of facilities and providers, again including schools and shelters (Table III.9), as described below:

- Other formal (non-DCO) relationships with schools stayed relatively steady at about three-quarters of clinics in both DY1 and DY2; in fact, schools were the

facilities/providers with which CCBHCs most often reported a formal (non-DCO) relationship in DY2.

- Informal relationships with schools decreased from 29 percent of clinics (n = 19) in DY1 to 18 percent (n = 12) in DY2.

- Informal relationships with school-based health centers decreased from 30 percent of clinics (n = 20) in DY1 to 18 percent (n = 12) in DY2, but formal (non-DCO) relationships with school-based health centers increased from 31 percent of clinics (n = 21) in DY1 to 42 percent (n = 28) in DY2.

- CCBHC relationships with homeless shelters stayed relatively steady over time, with approximately 43 percent of clinics reporting formal (non-DCO) relationships with shelters and approximately 48 percent reporting informal relationships in both DY1 and DY2.

In interviews, officials highlighted several specific efforts to extend the reach of CCBHCs into external organizations, such as the following:

- New York officials discussed efforts to enhance services in schools, noting that clinics "are doing a lot of school-based expansions and establishing satellites in the schools. The school districts want staff on-site, so they are supportive, and the relationships are good." Officials in Missouri also mentioned growth in school-based services throughout the demonstration.

- As noted in Section A, one Minnesota clinic was able to embed staff at a local library as a way to address mental health challenges for people experiencing homelessness who often spend time at the library. The state also reported on efforts to develop and embed care coordination staff in locations specific to particular target populations, such as those in the criminal justice system and tribal populations.

- Officials in three states commented that CCBHCs have made efforts to send a variety of staff (peers and care coordinators, for example) into hospitals and crisis centers and to work with first responders to engage clients experiencing crises. An official in Oklahoma, for example, noted that "CCBHCs are getting much more proactive about having staff that go regularly to the crisis centers or urgent care centers so that they can intervene as quickly as possible with their clients who may be going into…to get them out of crisis as quickly as possible. And to go regularly to the hospital…to ensure more smooth transitions."

4. Have CCBHCs and DCOs Sustained Relationships with Other Providers?

CCBHCs have established and maintained formal (non-DCO) and informal relationships with a wide variety of external providers, with some variation over time (Table III.9). Fifty percent of clinics reported formal (non-DCO) relationships with external facilities/providers in DY2, slightly lower than the 53 percent that reported such relationships in DY1. The most

common types of facilities/providers with which clinics reported having formal (non-DCO) relationships follow (Table III.9):

- In DY1, inpatient psychiatric facilities (78 percent of clinics; n = 52) and mental health/drug courts (78 percent of clinics; n = 52).

- In DY2, schools (79 percent of clinics; n = 52) and mental health/drug courts (76 percent of clinics; n = 50).

The least common type of facilities/providers with which CCBHCs reported formal (non-DCO) relationships in both years were HHS Indian Health Service youth regional treatment centers; only 6 percent of clinics (n = 4) had established such relationships in DY1 or DY2.

Formal (non-DCO) relationships increased with two types of facilities/providers over time: school-based health centers--from 31 percent of clinics (n = 21) in DY1 to 42 percent (n = 28) in DY2--and urgent care centers--from 31 percent of clinics (n = 21) in DY1 to 41 percent (n = 27) in DY2. However, formal (non-DCO) relationships decreased over time with a greater number of facility/provider types: primary care providers, inpatient psychiatric facilities, medical detoxification facilities, MAT providers, child welfare agencies, and suicide/crisis hotlines and warmlines (percentages and numbers appear in Table III.9).

Thirty-six percent of CCBHCs reported informal relationships with external facilities/providers in DY2, similar to the 37 percent reporting the same relationships in DY1. Hospital outpatient clinics were the facility with which the highest proportion of CCBHCs reported informal relationships in both years: 55 percent (n = 37) in DY1 and 52 percent (n = 34) in DY2 (Table III.8). Similar to formal relationships, informal relationships with Indian Health Services youth regional treatment centers were uncommon, with only 19 percent of clinics (n = 13) reporting such relationships in DY1 and 15 percent (n = 10) in DY2.

In general, informal relationships between CCBHCs and external facilities/providers were somewhat steadier over time than formal (non-DCO) relationships, with only VA treatment facilities, emergency departments, and schools and school-based health centers showing meaningful decreases over time, and only inpatient psychiatric facilities showing a meaningful increase (numbers and percentages in Table III.9). The latter may be related to the decrease in DCO and other formal (non-DCO) relationships with inpatient psychiatric facilities from DY1 to DY2. Similarly, the decrease in informal CCBHC relationships with schools and school-based health centers may be related to the increase in DCO and other formal (non-DCO) relationships with these facilities (Table III.8 and Table III.9).

TABLE III.9. Number and Proportion of CCBHCs that have Formal (non-DCO) and Informal Relationships with Other Facilities and Providers in DY1 and DY2								
Facility/Provider Type[a]	**Formal (non-DCO) Relationship (as of March 2018)**		**Formal (non-DCO) Relationship (as of March 2019)**		**Informal Relationship (as of March 2018)**		**Informal Relationship (as of March 2019)**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
FQHCs	40	60	39	59	19	28	17	26
Rural health clinics	21	31	21	32	12	18	13	20
Primary care providers	48	72	41	62	25	37	27	41
Inpatient psychiatric facilities	52	78	45	68	19	28	26	39
Psychiatric residential treatment facilities	40	60	35	53	28	42	30	45
SUD residential treatment facilities	43	64	40	61	28	42	24	36
Medical detoxification facilities	42	63	34	52	23	34	28	42
Ambulatory detoxification facilities	32	48	30	45	26	39	27	41
Post-detoxification step-down facilities	31	46	28	42	24	36	27	41
Residential (non-hospital) crisis settings	35	52	31	47	24	36	21	32
MAT providers for substance use	43	64	35	53	20	30	25	38
Schools	51	76	52	79	19	28	12	18
School-based health centers	21	31	28	42	20	30	12	18
Child welfare agencies	43	64	36	55	26	39	31	47
Therapeutic foster care service agencies	31	46	26	39	31	46	31	47
Juvenile justice agencies	38	57	34	52	26	39	29	44
Adult criminal justice agencies/courts	51	76	45	68	19	28	19	29
MH/drug courts	52	78	50	76	15	22	16	24
Law enforcement	36	54	35	53	32	48	31	47
Indian Health Service or other tribal programs	10	15	11	17	18	27	13	20
Indian Health Service youth regional treatment centers	4	6	4	6	13	19	10	15
Homeless shelters	28	42	29	44	33	49	31	47
Housing agencies	40	60	40	61	30	45	25	38
Suicide/crisis hotlines and warmlines	38	57	30	45	15	22	16	24
Employment services and/or supported employment	35	52	34	52	29	43	24	36
Older adult services	27	40	26	39	30	45	33	50
Other social and human service providers	38	57	34	52	35	52	31	47
Consumer-operated/peer service provider organizations	26	39	29	44	31	46	28	42
VA treatment facilities	37	55	33	50	32	48	26	39
Urgent care centers	21	31	27	41	29	43	24	36
EDs	45	67	48	73	26	39	20	30
Hospital outpatient clinics	29	43	28	42	37	55	34	52
Total CCBHCs	67	100	67	100	66	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: Columns are not mutually exclusive.
  See Appendix Table A.22 for state-level findings.

a. Color shading approximately represents the 5 main care coordination groupings from the CCBHC certification criteria: red (rows 1-3) = FQHCs, rural health clinics, other primary care providers; green (rows 4-10) = inpatient and residential behavioral health treatment; blue (rows 11-29) = community or regional services, supports, and providers; orange (row 30) = VA facilities; gray (rows 31-33) = inpatient acute care hospitals. For more information about the grouping of providers/facilities, see the criteria at
    https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf, pp. 27-31.

Officials in all states confirmed that CCBHCs have succeeded in building and sustaining relationships with external providers. Officials in most states suggested that clinics focused more on fostering informal rather than formal relationships because the execution of formal care coordination agreements with external organizations was burdensome and not needed to maintain effective relationships. For example, an official in Minnesota commented that "the piece that they found really challenging is that getting actual written care coordination agreements in place. It was pretty easy getting them from community providers they've been working with for years. But what was very difficult to do was getting care coordination agreements with hospitals, getting through the legal systems with hospitals. I don't know that

anyone got one. Schools were another. Places where they were already providing mental health services in schools could go with a simpler agreement. But overall they didn't find care coordination agreements helpful." Officials in three states mentioned that establishing formal partnerships with VA facilities proved particularly challenging. The challenges stemmed primarily from an inability to execute formal care coordination agreements. One official noted, for instance, that the VA requested changes to the care coordination agreement that would not align with demonstration requirements for such agreements. Despite challenges with entering into formal care coordination agreements, officials in the three states indicated that CCBHCs maintained productive informal relationships with local VA providers in order to coordinate care for veterans.

Despite the challenges associated with entering into formal care coordination agreements, officials universally agreed that CCBHCs have succeeded in cultivating informal relationships with partner community organizations, noting, for example, that "it helps that these clinics had already done a tremendous amount of work forging connections; that's just how it works with community mental health that you are building connections in the community. They've built new connections through CCBHC, and have even made very strong connections with one another." An official in New Jersey commented that, during state site visits, one clinic reported that it participated in daily telephone calls with the other entities with which it coordinates service delivery, such as hospitals and urgent care centers, to ensure that it works "the human angle with partners."

Some states have taken extra steps to help foster relationships between CCBHCs and external providers and facilitate coordinated care. Oklahoma, for example, developed a "most in need" list of consumers who account for the most crisis center and inpatient stays, distributed a clinic-specific list to each CMHC with a state contract that identified the clinic's consumers who are on the state's "most in need" list, and asked the clinics to prioritize stabilization of these individuals. The state has convened and participated in "grand staffing" conversations that bring together different types of providers and entities (e.g., CCBHCs, law enforcement, hospitals) to develop strategies for assisting those in greatest need of care coordination. The state noted that the enhanced funding that CCBHCs receive under the demonstration permits CCBHCs to think "outside the box" and develop different or more creative solutions to meeting the needs of high-need clients.

In Nevada, officials described as particularly helpful a set of demonstration requirements for outreach to and engagement with a variety of external providers, such as hospitals and law enforcement, noting that "the collaboration was profound because CCBHCs engaged law enforcement and other providers so the CCBHC became the initial point of contact for people in need of behavioral health [care] instead of civil commitment, jail, or emergency room…their presence and action have now made them a reliable resource for people in need of BH instead of civil commitment, jail, or emergency room." To assist clinics further in measuring the effect of and improving such coordination efforts, the state has developed a concise data collection tool to capture the number of individuals diverted from jail or emergency rooms.

5. *Have CCBHCs Adopted or Altered EHR or HIT Systems as a Result of the Demonstration?*

A majority of CCBHCs made changes to their EHR or HIT systems as a result of the CCBHC certification process and during the demonstration period. As of the DY1 progress report, 97 percent of clinics (n = 65) reported that they altered their EHR or HIT systems to meet CCBHC certification, and 33 percent (n = 22) adopted a new EHR or HIT system as part of the CCBHC certification process. As of the DY2 progress report, 67 percent of clinics (n = 44) reported that they modified their EHR or HIT systems in the past 12 months (state-level findings appear in Appendix Table A.23).

The CCBHCs demonstrated wide variation in the functionalities of their EHR systems, although those functionalities did not change in any meaningful way over time (Table III.10). All clinics reported that their EHRs included mental health, SUD, and case management or care coordination records in both DY1 and DY2. (For most clinics, these features were not new as a result of CCBHC certification [not shown in Table III.10].) Quality measure reporting capability, generation of electronic care plans, and electronic prescribing were also available in over 90 percent of clinics in both years. Less common EHR features in both years included the incorporation of primary care records, the ability to communicate with laboratories to request tests or receive results, and the capacity for electronic exchange of clinical information with DCOs or other external providers.

TABLE III.10. Functions of CCBHC EHR and HIT Systems				
Function	**Number and Proportion of CCBHCs that Reported Function, 2018**		**Number and Proportion of CCBHCs that Reported Function, 2019**	
	N	**%**	**N**	**%**
EHR contains MH records	67	100	66	100
EHR contains SUD records	67	100	66	100
EHR contains case management or care coordination records	67	100	66	100
EHR has quality measure reporting capabilities	63	94	61	92
EHR generates electronic care plan	62	93	61	92
EHR uses any form of electronic prescribing	61	91	63	95
EHR incorporates laboratory results into health record	55	82	53	80
EHR provides clinical decision support	52	79	54	82
EHR contains primary care records	41	61	37	56
EHR communicates with laboratory to request tests or receive results	38	57	38	58
EHR allows electronic exchange of clinical information with other external providers	31	46	30	45
EHR allows electronic exchange of clinical information with DCOs	26	39	20	30
Total CCBHCs	67	100	66	100
SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 collected by Mathematica and the RAND Corporation, March 2018 and March 2019. **NOTES**: See Appendix Table A.23 for state-level findings				

CCBHCs were at different starting points at the demonstration's outset with respect to their EHR or HIT systems, but officials in all states reported that substantial changes to EHRs were required in the early stages of the demonstration to permit clinics to improve care coordination, meet demonstration reporting requirements, and facilitate billing through the PPS. In Pennsylvania, for

example, officials mentioned that "some clinics went from paper records to a new EHR, other clinics were changing an EHR vendor, or staying with EHR but needing to modify the system to work for the CCBHC." Officials in several states cited EHRs as central facilitators of care coordination, noting, for example, that the integration of treatment plans and physical and behavioral health care records has enabled providers engage in improved communication about a client's care. In Minnesota, officials reported that clinics "retooled all of their EHRs so that they could do integrated treatment planning and assessments, and be able to have multidisciplinary teams be able to chart on a client and read material on a client across multiple service lines, and that's not generally how EHRs are designed."

Even though officials noted that most clinics resolved many EHR challenges in the first year of the demonstration, some minor challenges persisted into the second year. The challenges that stood out to officials as ongoing included the following:

- **Billing challenges**. States noted that CCBHCs had to alter their electronic billing systems and processes significantly to account for the PPS and payments to DCOs, a process that was easier for some CCBHCs and vendors than for others. Some states reported that clinics' systems were not structured properly and, in at least one case, required a clinic to resubmit claims.

- **Quality measure data collection and reporting**. States noted that CCBHCs had to make significant changes to electronic systems to build assessment tools into their EHRs, allow for the collection of data elements for the clinic-reported quality measures, and permit clinics to run reports for submission to states.

In August 2019, we will submit a report that summarizes information on clinics' experiences with billing and the cost reports and on the progress that CCBHCs and states are making toward submission of the required quality measures.

IV. CONCLUSIONS AND FUTURE EVALUATION ACTIVITIES

In the demonstration's second year, CCBHCs and states built on and further refined efforts to hire and maintain staff, increase access to care, sustain the full scope of CCBHC services, and ensure coordinated care for CCBHC clients. Although some CCBHCs experienced challenges related to staffing or the implementation of new services, state officials reported that CCBHCs generally addressed these challenges and, since then, have consistently adhered to the demonstration criteria.

With few exceptions, CCBHCs were able to hire and maintain the required types of staff throughout the demonstration. The first and second years of the demonstration saw little difference in the proportion of CCBHCs that employed most required staff types. In the categories in which fewer clinics employed staff in DY2 than in DY1, reductions in staff employment were minimal. Such changes in staffing may suggest clinics' efforts to experiment and identifying ways to use staff and resources more efficiently. CCBHCs and states reported that clinics faced several ongoing challenges associated with hiring and retaining staff, including, for example, uncertainty around the future of the demonstration, retaining enough of each staff type to meet increased demand for services, and increases in caseloads and responsibilities leading to staff burnout. However, officials generally perceived that clinics effectively used strategies such as increased salaries and benefits to overcome challenges.

In the second demonstration year, CCBHCs and states continued to focus on making services more accessible and increasing consumer engagement. States reported that the most common strategy that CCBHCs used to increase service access was the introduction of open-access scheduling. CCBHCs also have continued to provide services in locations outside of the clinic and make broad use of telehealth to extend the reach of CCBHC services. Stakeholder organizations representing consumers and families reported that the strategies adopted by CCBHCs, such as open-access scheduling and expanded hours of service provision, have significantly improved access to care for CCBHC clients in their states.

Officials in all states perceived that clinics were able to sustain delivery of the nine core CCBHC services throughout the demonstration, a finding confirmed by clinics in the progress report. Nearly all CCBHCs in both DY1 and DY2 reported that they provided the required services, with the exception of intensive community-based mental health services for members of the armed forces and veterans; about 70 percent of clinics provided those services in both years. States speculated that the armed forces/veteran populations did not comprise a large percentage of CCBHC clients and that CCBHCs may have struggled to engage members of these groups and to develop strong referral relationships and care coordination agreements with VA providers. Though not required by the demonstration, a smaller number of clinics provided on-site primary care; only about half of clinics provided this service in either demonstration year.

CCBHCs were able to add and sustain a range of EBPs across demonstration years. In addition, provision of many EBPs by DCOs increased substantially in the second demonstration

year. Early in the demonstration, CCBHCs generally addressed the challenges to maintaining EBPs and providing the full scope of CCBHC services, although officials continued to explore ways to support clinics' efforts to offer the full range of services. For example, officials granted CCBHCs increased flexibility to tailor EBPs and other services more precisely to the needs and preferences of their client populations.

CCBHCs have used a variety of strategies to improve care coordination, including the addition of various provider types to treatment teams and the expansion of targeted care coordination strategies to different populations and service lines. Improvements to EHR and HIT systems in the early stages of the demonstration aided clinics' care coordination efforts, in some cases permitting CCBHCs to better integrate care plans, create linkages with external providers, and receive alerts about clients' care transitions.

CCBHCs did not, for the most part, engage DCOs to provide services; instead, they elected to offer the full scope of CCBHCs services directly, although reliance on DCOs did increase slightly in the second demonstration year. Officials suggested that CCBHCs preferred to provide services directly out of a clear desire to embrace the model fully and a reluctance to assume responsibility for the oversight of another provider's services. CCBHCs did, however, continue to provide and expand services in collateral agencies such as schools and shelters, and they built and sustained close formal and informal relationships with a range of external providers.

States and clinics alike described a need for flexibility within the CCBHC model to adjust requirements and practices to best suit the needs of the consumers over the course of the demonstration. For example, some states and clinics found that consumers were not availing themselves of certain required EBPs or access requirements as frequently as expected, and modified these practices to better reflect actual patterns of use. Other findings in the report may point to additional experimentation and fine-tuning of demonstration practices from DY1 to DY2. For instance, some changes in staffing or the composition of care teams may be the result of clinics identifying more efficient and effective ways of providing required CCBHC services.

A. Future Evaluation Activities

This report updated the initial snapshot of early implementation of the demonstration based on interviews with state officials and progress reports submitted by CCBHCs. The update includes data from additional interviews with state officials and consumer and family organizations, site visits to CCBHCs, and progress reports submitted by CCBHCs.

In August 2019, we will submit a report summarizing information from the first year of CCBHC cost reports. Drawing on information from our interviews and site visits, the report will provide an overview of clinics' experience with the PPS and the progress made by CCBHCs and states as they work toward submission of the required quality measures. We will update the report in August 2020 to include information from the second year of CCBHC cost reports and will summarize the quality of care provided to CCBHC consumers by using data from the CCBHC-

reported and state-reported quality measures. Our plans to submit these reports as scheduled are dependent on our receipt of the cost reports and quality measures without substantial delays.

We are in the process of obtaining Medicaid claims and encounter data from states to examine changes in service utilization and costs. We plan to examine the impacts of CCBHC services on: (1) hospitalization rates; (2) emergency department service utilization; and (3) ambulatory care relative to within-state comparison groups (Medicaid beneficiaries with similar diagnostic and demographic characteristics who did not receive care from CCBHCs). Depending on the availability of data within each state, we expect that the impact analyses will use approximately four years of Medicaid claims/encounter data (up to a two-year pre-demonstration period and a two-year post-implementation period). We will report these findings in our final report in May 2021, along with updated findings that draw on both years of CCBHC cost reports and quality measures. Table IV.1 provides an overview of the timeline for submission of future deliverables and findings.

TABLE IV.1. Timeline for Reporting Future Evaluation Findings		
Reports to Congress	**Mathematica/RAND Deliverable(s) to Inform Reports to Congress (submission month and year)**	**Data Available for Deliverables (date of data collection)**
3 (December 2019)	Second implementation memorandum (June 2019)	• Third-round state interviews and consumer/family organization representative interviews (March 2019) • CCBHC site visits (December 2018- February 2019) • Second CCBHC progress reports (March 2019)
	Initial cost and quality report (August 2019)	• First-round cost reports (March 2019) and pre-demonstration claims (December 2018) in addition to interviews and site visits listed above
4 (December 2020)	Final cost and quality report (August 2020)	• First and second-round cost reports (March 2019 and March 2020) and Year 1 quality measures (June 2019)
5 (December 2021)	Final report (May 2021)	• All above, Year 2 quality measures (June 2020) and Medicaid claims/encounter data

APPENDIX A. CCBHC DEMONSTRATION EVALUATION PROGRESS REPORT DETAILED AND STATE-LEVEL TABLES

Staff Type	Employed before CCBHC Certification		Hired as Part of CCBHC Certification		Hired after CCBHC Certification		Employed as of March 2018[a]		Employed as of March 2019	
	N	%	N	%	N	%	N	%	N	%
CCBHC medical director	55	82	11	16	6	9	66	99	60	91
Adult psychiatrists	47	70	12	18	23	34	61	91	54	82
Child/adolescent psychiatrists	39	58	12	18	11	16	51	76	42	64
Other psychiatrists	29	43	8	12	9	13	40	60	31	47
Nurses	57	85	22	33	36	54	67	100	65	98
LCSWs	63	94	23	34	30	45	66	99	66	100
Licensed psychologists	30	45	7	10	9	13	35	52	29	44
Licensed marriage and family therapists	40	60	9	13	11	16	42	63	40	61
Case management staff	48	72	32	48	34	51	65	97	64	97
Occupational therapists	11	16	2	3	5	7	17	25	11	17
SUD specialists	61	91	25	37	32	48	67	100	61	92
Bachelor's degree-level counselors	49	73	14	21	19	28	50	75	51	77
Associate's degree-level or non-degree counselors	27	40	5	7	11	16	30	45	32	48
MH professionals	27	40	5	7	10	15	30	45	31	47
Community health workers	18	27	10	15	13	19	27	40	23	35
Medical/nursing assistants	28	42	12	18	15	22	37	55	38	58
Pharmacy staff	8	12	0	0	3	4	10	15	11	17
Peer specialists/recovery coaches	46	69	40	60	38	57	66	99	66	100
Family support staff	25	37	19	28	21	31	45	67	45	68
Interpreters or linguistic counselors	24	36	8	12	10	15	29	43	20	30
Interns	41	61	6	9	22	33	47	70	48	73
Other clinician types	29	43	17	25	22	33	37	55	38	58
Total CCBHCs	67	100	67	100	67	100	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: Columns are not mutually exclusive because CCBHCs may have employed the same staff type before CCBHC certification and hired those staff as part of or after certification.

Consistent with the CCBHC cost-reporting template, the MH professional category includes only providers trained and credentialed for psychological testing.

"Other clinician types" is a write-in category.

a. "Employed as of March 2018" was calculated by combining the other 3 responses to show if the CCBHC either employed that staff type before CCBHC certification or hired that staff type during or after CCBHC certification.

Staff Type	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
CCBHC medical director	83%	100%	33%	100%	92%	100%	83%	100%	87%
Adult psychiatrists	83%	93%	33%	71%	85%	67%	75%	100%	76%
Child/adolescent psychiatrists	33%	67%	0%	57%	77%	67%	67%	86%	57%
Other psychiatrists	0%	73%	33%	43%	62%	67%	17%	57%	44%
Nurses	100%	100%	100%	86%	100%	100%	100%	100%	98%
LCSWs	100%	100%	100%	100%	100%	100%	100%	100%	100%
Licensed psychologists	100%	73%	0%	29%	23%	33%	25%	43%	41%
Licensed marriage and family therapists	100%	60%	67%	71%	38%	67%	67%	43%	64%
Case management staff	100%	93%	100%	100%	92%	100%	100%	100%	98%
Occupational therapists	17%	13%	0%	14%	15%	33%	33%	0%	16%
SUD specialists	83%	93%	100%	86%	92%	100%	100%	86%	93%
Bachelor's degree-level counselors	83%	80%	100%	71%	69%	67%	92%	57%	77%
Associate's degree-level or non-degree counselors	67%	67%	33%	43%	38%	67%	58%	0%	47%
MH professionals	100%	47%	100%	0%	38%	0%	50%	57%	49%
Community health workers	33%	47%	33%	43%	23%	0%	50%	14%	30%
Medical/nursing assistants	83%	47%	33%	57%	62%	100%	58%	43%	60%
Pharmacy staff	33%	20%	0%	29%	15%	33%	8%	0%	17%
Peer specialists/recovery coaches	100%	100%	100%	100%	100%	100%	100%	100%	100%
Family support staff	33%	93%	67%	29%	77%	100%	75%	43%	65%
Interpreters or linguistic counselors	50%	20%	100%	57%	23%	33%	17%	14%	39%
Interns	100%	60%	100%	100%	85%	33%	58%	57%	74%
Other clinician types	33%	67%	67%	71%	54%	100%	42%	57%	61%

TABLE A.2. CCBHC Staffing, by State, 2019

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTES: This table shows the percentage of CCBHCs, by state, that hired each staff type as of March 2019. This table corresponds with the column "Employed as of March 2019" from Appendix Table A.1.

Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

Consistent with the CCBHC cost-reporting template, the MH professional category includes only providers trained and credentialed for psychological testing.

"Other clinician types" is a write-in category.

TABLE A.3. Percentage of CCBHCs with Unfilled Staff Positions for 2 Months or Longer in the Past 12 Months, by State, 2019									
Unfilled Staffing	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Any staff positions have gone unfilled for 2 months or longer during the past 12 months	100%	80%	0%	71%	77%	67%	83%	71%	69%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTES: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.4. CCBHC Staff Training in Required and Other Topics in the Past 12 Months, by State, 2019									
Topic of Training	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Required by CCBHC Certification Criteria									
Risk assessment, suicide prevention, and suicide response	100%	100%	100%	100%	100%	100%	100%	100%	100%
The role of family and peers in the delivery of care	67%	93%	67%	86%	77%	100%	58%	71%	77%
Person and family-centered care	83%	80%	100%	71%	100%	100%	83%	71%	86%
Recovery-oriented care	83%	87%	100%	100%	69%	100%	42%	86%	83%
Evidence-based and trauma-informed care	100%	100%	100%	100%	92%	100%	83%	100%	97%
Cultural competency training to address diversity within the organization's service population	100%	87%	100%	100%	85%	100%	92%	86%	94%
Primary and behavioral health care integration	33%	87%	100%	100%	77%	100%	67%	86%	81%
Other Trainings (not required)									
Other	67%	67%	67%	71%	38%	67%	50%	57%	60%
Any training[a]	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	0%	0%	0%	0%	0%	0%	0%	0%	0%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTES: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.
a.   "Any training" was calculated by combining the other responses to show what proportion of CCBHCs provided any type of training to their staff in the past 12 months.

TABLE A.5. Changes to CCBHCs' Physical Space and Accessibility, by State, 2019									
Change to Physical Space and Accessibility	**State**								**Average Percentage of CCBHCs Across States % 2019**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Expansions or additions to the CCBHC building space	33%	47%	100%	43%	54%	67%	33%	57%	54%
Renovations to existing CCBHC facilities	50%	73%	33%	71%	77%	67%	50%	57%	60%
Improvements to facility safety features	50%	53%	33%	57%	69%	67%	33%	43%	51%
Other changes to CCBHCs' physical space	17%	27%	0%	29%	15%	33%	17%	43%	23%
Offers translation services	100%	100%	100%	100%	100%	100%	100%	100%	100%
Offers transportation or transportation vouchers	100%	100%	100%	86%	85%	100%	100%	57%	91%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.6. Telehealth and Remote Services						
Telehealth and Remote Services	**Offered Service as of March 2018**		**Offered Before CCBHC Certification, 2018**		**Offered Service as of March 2018**	
	N	**%**	**N**	**%[a]**	**N**	**%**
Offers services in locations outside of the clinic[b]	62	93	53	85	64	97
Consumers' homes	52	84	NA	NA	50	78
Schools	34	55	NA	NA	30	47
Courts, police offices, and other justice-related facilities	28	45	NA	NA	21	33
Hospitals and EDs	20	32	NA	NA	19	30
Community service agencies and non-profit organizations	17	27	NA	NA	13	20
Homeless shelters	6	10	NA	NA	7	11
Offers telehealth services	45	67	36	80	46	70
Total CCBHCs	67	100	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: The two 2018 columns are not mutually exclusive.

a. The denominator is the number of CCBHCs that provided the individual service, which varies by row (that is, the denominator is the N reported in the "Offered service" column in the same row).

b. The indented rows are based on a write-in follow-up question regarding specific locations outside of the clinic where CCBHCs offer services. NA reflects that CCBHCs did not report this information for the period before CCBHC certification.

TABLE A.7. CCBHCs that Offered Telehealth and Remote Services, by State, 2019									
Telehealth and Remote Services	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Offers services in locations outside of the clinic	100%	100%	100%	71%	100%	100%	100%	100%	96%
Offers telehealth services	67%	93%	100%	43%	38%	67%	83%	71%	70%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.8. CCBHC Outreach since the Start of the Demonstration (2018) or in the Past 12 Months (2019)				
Targeted Population	**Yes Response, 2018**		**Yes Response, 2019**	
	N	**%**	**N**	**%**
Consumers experiencing homelessness	43	64	57	86
Members of the armed forces or veterans	45	67	42	64
Consumers who were previously incarcerated	45	67	55	83
School-age youth	54	81	55	83
Older adults	33	49	33	50
Other populations	28	42	35	53
None	3	4	2	3
Total CCBHCs	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

TABLE A.9. CCBHC Outreach in the Past 12 Months, by State, 2019									
Targeted Population	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Consumers experiencing homelessness	100%	80%	100%	100%	77%	100%	83%	86%	91%
Members of the armed forces or veterans	67%	40%	100%	57%	62%	67%	75%	86%	69%
Consumers who were previously incarcerated	83%	93%	100%	86%	77%	67%	83%	71%	83%
School-age youth	100%	87%	100%	43%	77%	100%	83%	100%	86%
Older adults	17%	47%	100%	14%	62%	33%	58%	71%	50%
Other populations	67%	67%	100%	57%	54%	33%	33%	29%	55%
None	0%	0%	0%	0%	15%	0%	0%	0%	2%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTES: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.10. AOT Order Referrals, by State, 2019									
Referral Source	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Referred by courts or AOT order	100%	100%	100%	100%	92%	100%	100%	100%	99%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 4, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.11. Services Added as a Result of CCBHC Certification, 2018			
Service Type	**Service Description**	**Added as a Result of CCBHC Certification**	
		N	**%**
Crisis behavioral health services	24-hour mobile crisis teams	31	46
	Emergency crisis intervention	21	31
	Crisis stabilization	21	31
Screening, assessment, and diagnosis	MH screening, assessment, diagnostic services	9	13
	SUD screening, assessment, diagnostic services	15	22
Person and family-centered treatment planning services	Person and family-centered treatment planning services	12	18
Outpatient MH and/or SUD services	ACT[a]	4	6
	Forensic ACT[a]	2	3
	Individual CBT[a]	3	4
	Group CBT[a]	4	6
	Online CBT[a]	0	0
	DBT[a]	5	7
	First-episode/early intervention for psychosis	9	13
	Evidence-based medication evaluation and management[a]	5	7
	MAT for alcohol and opioid use[a]	31	46
	Motivational interviewing[a]	6	9
	Multisystemic therapy[a]	5	7
	Outpatient MH counseling	4	6
	Outpatient SUD treatment	13	19
	Specialty MH/SUD services for children and youth	15	22
	Therapeutic foster care[a]	1	1
	Community wraparound services for youth/children[a]	10	15
Psychiatric rehabilitation services	Community integration services	16	24
	Financial management	17	25
	Illness management and recovery	21	31
	Medication education	14	21
	Psycho-education	13	19
	Self-management	16	24
	Skills training	14	21
	Supported housing	8	12
	Supported employment	18	27
	Supported education	11	16
	Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	24	36
Peer support services	Peer support services for consumers/clients	29	43
	Peer support services for families	23	34

TABLE A.11 (*continued*)			
Service Type	**Service Description**	**Added as a Result of CCBHC Certification**	
		N	**%**
TCM	TCM	27	40
Primary care screening and monitoring	Primary care screening and monitoring	28	42
Intensive community-based MH services for armed forces and veterans	Intensive community-based MH services for armed forces and veterans	30	45

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 data collected by Mathematica and the RAND Corporation, March 2018.

NOTES: The denominator is 67 CCBHCs.

a. EBP included in the CCBHC certification criteria.

TABLE A.12. CCBHCs and DCOs Provided Required Services												
Service Type	**CCBHC, 2018**		**CCBHC, 2019**		**DCO, 2018**		**DCO, 2018**		**Either CCBHC or DCO, 2018**		**Either CCBHC or DCO, 2019**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Crisis behavioral health services												
24-hour mobile crisis teams	49	73	53	80	23	34	19	29	65	97	65	98
Emergency crisis intervention	59	88	63	95	20	30	21	32	67	100	66	100
Crisis stabilization	60	90	59	89	14	21	18	27	66	99	64	97
Screening, assessment, and diagnosis												
MH screening, assessment, diagnostic services	67	100	65	98	4	6	7	11	67	100	65	98
SUD screening, assessment, diagnostic services	67	100	65	98	3	4	4	6	67	100	65	98
Person and family-centered treatment planning services	**66**	**99**	**66**	**100**	**5**	**7**	**7**	**11**	**66**	**99**	**66**	**100**
Outpatient MH and/or SUD services												
Outpatient MH counseling	67	100	66	100	0	0	4	6	67	100	66	100
Outpatient SUD treatment	67	100	66	100	0	0	2	3	67	100	66	100
Motivational interviewing[a]	67	100	66	100	2	3	4	6	67	100	66	100
Individual CBT[a]	67	100	66	100	0	0	3	5	67	100	66	100
Group CBT[a]	56	84	58	88	0	0	3	5	56	84	58	88
Online CBT[a]	7	10	9	14	0	0	0	0	7	10	9	14
DBT[a]	49	73	49	74	0	0	1	2	49	73	50	76
First-episode/early intervention for psychosis	40	60	37	56	0	0	4	6	40	60	38	58
Multisystemic therapy[a]	27	40	36	55	0	0	2	3	27	40	37	56
ACT[a]	30	45	33	50	1	1	1	2	31	46	34	52
Forensic ACT[a]	6	9	10	15	0	0	1	2	6	9	11	17
Evidence-based medication evaluation and management[a]	58	87	62	94	0	0	2	3	58	87	62	94
MAT for alcohol and opioid use[a]	55	82	61	92	2	3	1	2	56	84	61	92
Therapeutic foster care[a]	4	6	5	8	1	1	0	0	5	7	5	8
Community wraparound services for youth/children[a]	50	75	49	74	2	3	2	3	51	76	51	77
Specialty MH/SUD services for children and youth	58	87	56	85	0	0	3	5	58	87	56	85
Psychiatric rehabilitation services												
Medication education	65	97	64	97	3	4	6	9	66	99	65	98
Self-management	63	94	64	97	5	7	6	9	65	97	65	98
Skills training	64	96	64	97	5	7	6	9	66	99	65	98
Psycho-education	64	96	65	98	5	7	5	8	66	99	66	100
Community integration services	61	91	62	94	4	6	6	9	64	96	63	95
Illness management and recovery	62	93	61	92	4	6	6	9	65	97	62	94
Financial management	61	91	58	88	5	7	4	6	64	96	59	89
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	65	97	64	97	6	9	5	8	67	100	65	98
Supported housing	43	64	50	76	5	7	6	9	47	70	52	79
Supported employment	45	67	49	74	5	7	8	12	50	75	54	82
Supported education	33	49	41	62	5	7	7	11	36	54	45	68
Peer support services												
Peer support services for consumers/clients	66	99	66	100	4	6	7	11	67	100	66	100
Peer support services for families	48	72	55	83	4	6	3	5	49	73	55	83

Service Type	CCBHC, 2018		CCBHC, 2019		DCO, 2018		DCO, 2018		Either CCBHC or DCO, 2018		Either CCBHC or DCO, 2019	
	N	%	N	%	N	%	N	%	N	%	N	%
TCM	**62**	**93**	**64**	**97**	**1**	**1**	**3**	**5**	**63**	**94**	**66**	**100**
Primary care screening and monitoring	63	94	56	85	3	4	9	14	65	97	60	91
Intensive community-based MH services for armed forces and veterans	**47**	**70**	**43**	**65**	**1**	**1**	**5**	**8**	**48**	**72**	**44**	**67**
Total CCBHCs	67	100	66	100	67	100	66	100	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

NOTES: Columns are not mutually exclusive.

a. EBP included in the CCBHC certification criteria.

Service Type	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
TABLE A.13. Percentage of CCBHCs that Provided Required Services Directly or Through DCOs, by State, 2019									
Crisis behavioral health services									
24-hour mobile crisis teams	100%	100%	100%	100%	100%	100%	100%	86%	98%
Emergency crisis intervention	100%	100%	100%	100%	100%	100%	100%	100%	100%
Crisis stabilization	100%	93%	100%	100%	100%	100%	92%	100%	98%
Screening, assessment, and diagnosis									
MH screening, assessment, diagnostic services	100%	100%	67%	100%	100%	100%	100%	100%	96%
SUD screening, assessment, diagnostic services	100%	100%	67%	100%	100%	100%	100%	100%	96%
Person and family-centered treatment planning services	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Outpatient MH and/or SUD services									
Outpatient MH counseling	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outpatient SUD treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%
Motivational interviewing[a]	100%	100%	100%	100%	100%	100%	100%	100%	100%
Individual CBT[a]	100%	100%	100%	100%	100%	100%	100%	100%	100%
Group CBT[a]	67%	87%	100%	100%	100%	100%	83%	71%	89%
Online CBT[a]	0%	20%	67%	0%	8%	33%	17%	0%	18%
DBT[a]	50%	73%	67%	43%	85%	67%	92%	100%	72%
First-episode/early intervention for psychosis	50%	40%	100%	57%	54%	67%	83%	43%	62%
Multisystemic therapy[a]	67%	53%	100%	43%	54%	67%	75%	14%	59%
ACT[a]	50%	40%	100%	43%	31%	67%	92%	29%	56%
Forensic ACT[a]	0%	13%	67%	14%	23%	0%	25%	0%	18%
Evidence-based medication evaluation and management[a]	83%	100%	100%	86%	92%	100%	100%	86%	93%
MAT for alcohol and opioid use[a]	83%	100%	100%	100%	100%	100%	67%	100%	94%
Therapeutic foster care[a]	0%	0%	0%	14%	15%	0%	17%	0%	6%
Community wraparound services for youth/children[a]	83%	87%	100%	71%	62%	100%	92%	43%	80%
Specialty MH/SUD services for children and youth	100%	87%	100%	43%	92%	100%	92%	71%	86%

Service Type	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
Psychiatric rehabilitation services									
Medication education	100%	100%	100%	100%	100%	100%	100%	86%	98%
Self-management	83%	100%	100%	100%	100%	100%	100%	100%	98%
Skills training	100%	100%	100%	86%	100%	100%	100%	100%	98%
Psycho-education	100%	100%	100%	100%	100%	100%	100%	100%	100%
Community integration services	100%	93%	100%	86%	100%	100%	92%	100%	96%
Illness management and recovery	83%	100%	100%	100%	92%	33%	100%	100%	89%
Financial management	83%	100%	100%	86%	85%	100%	83%	86%	90%
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	83%	100%	100%	100%	100%	100%	100%	100%	98%
Supported housing	83%	93%	100%	86%	77%	33%	75%	57%	76%
Supported employment	50%	87%	67%	86%	85%	67%	92%	86%	77%
Supported education	67%	53%	100%	71%	85%	67%	58%	71%	72%
Peer support services									
Peer support services for consumers/clients	100%	100%	100%	100%	100%	100%	100%	100%	100%
Peer support services for families	33%	100%	100%	71%	100%	100%	92%	43%	80%
TCM	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Primary care screening and monitoring	83%	80%	100%	100%	100%	100%	100%	71%	92%
Intensive community-based MH services for armed forces and veterans	**67%**	**47%**	**100%**	**57%**	**100%**	**33%**	**67%**	**57%**	**66%**

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTES: This table shows the percentage of CCBHCs, by state, that provided services either through CCBHCs directly or through DCO arrangements. The table corresponds with the column "either CCBHC and/or DCO provided service" from Appendix Table A.12.

Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

a. EBP included in the CCBHC certification criteria.

TABLE A.14. Availability of On-Site Primary Care at CCBHCs				
Primary Care Services	**Yes Response, 2018**		**Yes Response, 2019**	
	N	**%**	**N**	**%**
Provided on-site primary care services (in addition to primary care screening and monitoring)	37	55	36	55
Provided on-site primary care services (in addition to primary care screening and monitoring) before CCBHC certification	31	84[a]	NA[b]	NA[b]
On-site primary care services were new due to CCBHC certification	6	16[a]	NA[b]	NA[b]
CCBHC was also an FQHC	5	8	4	6
Total CCBHCs	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.
NOTES:
a. The denominator is the number of CCBHCs that provided on-site primary care services as of March 2018 (n = 37).
b. NA reflects that CCBHCs were not asked to respond to this question again in DY2.

TABLE A.15. Availability of On-Site Primary Care at CCBHCs, by State, 2019									
Primary Care Service	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Provides on-site primary care services	33%	60%	100%	57%	15%	67%	100%	29%	58%
Also an FQHC	0%	27%	0%	0%	0%	0%	0%	0%	3%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.16. Strategies Used by CCBHCs to Facilitate Crisis Planning, by State, 2019									
Strategy	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Wellness recovery action plan	83%	53%	100%	86%	69%	67%	75%	100%	79%
Psychiatric advance directives	50%	47%	100%	100%	62%	100%	92%	100%	81%
Develop a safety/crisis plan	33%	67%	0%	29%	31%	100%	25%	43%	41%
Other	50%	87%	33%	86%	54%	100%	42%	57%	64%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.17. Types of Providers that Participate on CCBHC Treatment Teams, by State, 2019									
Type of Provider	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
MH clinicians	100%	100%	100%	100%	100%	100%	100%	100%	100%
Case managers	100%	93%	100%	67%	100%	100%	100%	100%	95%
SUD treatment providers	100%	93%	100%	100%	100%	100%	92%	100%	98%
Psychiatrists	83%	87%	100%	67%	92%	100%	92%	100%	90%
Consumers/clients	100%	93%	57%	100%	77%	100%	75%	86%	86%
Community support and social service providers	83%	93%	86%	67%	54%	67%	75%	86%	76%
Consumer/client family members	100%	80%	57%	100%	77%	100%	58%	86%	82%
Primary care physicians	33%	47%	57%	100%	15%	33%	83%	43%	52%
Other	83%	73%	71%	67%	46%	67%	33%	14%	57%

SOURCES: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.18. CCBHC Notification about Consumers' Care Transitions for Physical and Behavioral Health Conditions								
Notification about Care Transition	**Behavioral Health Condition, 2018**		**Behavioral Health Condition, 2019**		**Physical Health Condition, 2018**		**Physical Health Condition, 2019**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Receives notification when hospital treats a client for:	59	88	47	71	38	57	38	58
Receives discharge summary from hospital after a client is treated for:	58	87	58	88	25	37	35	53
Receives notification when ED treats a client for:	48	72	44	67	34	51	35	53
Receives discharge summary from ED after a client is treated for:	41	61	42	64	22	33	22	33
Receives notification by other means (for example, contacts by consumers or families) about:	60	90	64	97	53	79	60	91
Total CCBHCs	67	100	66	100	67	100	66	100

SOURCE: CCBHC Annual Progress Report Demonstration Year 1 and Year 2 data collected by Mathematica and the RAND Corporation, March 2018 and March 2019.

Notification about Care Transition	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
Receives notification when hospital treats a client for a behavioral health condition:	17%	93%	0%	86%	77%	100%	92%	29%	62%
Receives discharge summary from hospital after a client is treated for a behavioral health condition:	33%	93%	67%	86%	100%	100%	92%	100%	84%
Receives notification when ED treats a client for a behavioral health condition:	33%	87%	0%	71%	77%	0%	100%	29%	50%
Receives discharge summary from ED after a client is treated for a behavioral health condition:	17%	47%	67%	57%	100%	33%	100%	29%	56%
Receives notification by other means (for example, contacts by consumers or families) about behavioral health care transitions:	100%	93%	100%	100%	100%	100%	92%	100%	98%

TABLE A.19. CCBHC Notification about Consumers' Care Transitions for Behavioral Health Conditions, by State, 2019

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

TABLE A.20. CCBHC Notification about Consumers' Care Transitions for Physical Health Conditions, by State, 2019									
Notification about Care Transition	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
Receives notification when hospital treats a client for a physical health condition:	17%	80%	0%	57%	69%	0%	92%	14%	41%
Receives discharge summary from hospital after a client is treated for a physical health condition:	17%	60%	33%	43%	62%	0%	75%	57%	43%
Receives notification when ED treats a client for a physical health condition:	0%	80%	0%	57%	69%	0%	83%	0%	36%
Receives discharge summary from ED after a client is treated for a physical health condition:	0%	27%	33%	29%	46%	0%	75%	0%	26%
Receives notification by other means (for example, contacts by consumers or families) about physical health care transitions:	83%	93%	67%	100%	100%	100%	75%	100%	90%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.
NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

Facility/Provider Type[a]	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
FQHCs	0%	0%	0%	14%	15%	0%	8%	14%	7%
Rural health clinics	0%	0%	0%	0%	0%	0%	0%	0%	0%
Primary care providers	0%	0%	33%	14%	8%	0%	0%	0%	7%
Inpatient psychiatric facilities	0%	0%	0%	0%	0%	0%	0%	0%	0%
Psychiatric residential treatment facilities	0%	0%	0%	0%	0%	0%	0%	0%	0%
SUD residential treatment facilities	0%	7%	0%	14%	8%	0%	0%	0%	4%
Medical detoxification facilities	0%	7%	0%	0%	8%	0%	0%	0%	2%
Ambulatory detoxification facilities	0%	7%	0%	0%	8%	0%	0%	0%	2%
Post-detoxification step-down facilities	0%	13%	0%	0%	8%	0%	0%	0%	3%
Residential (non-hospital) crisis settings	0%	7%	0%	0%	8%	0%	0%	0%	2%
MAT providers for substance use	17%	0%	33%	0%	15%	0%	0%	29%	12%
Schools	17%	0%	0%	0%	8%	0%	0%	0%	3%
School-based health centers	17%	0%	0%	0%	0%	0%	0%	0%	2%
Child welfare agencies	0%	0%	0%	0%	0%	0%	0%	0%	0%
Therapeutic foster care service agencies	0%	0%	0%	0%	0%	0%	0%	0%	0%
Juvenile justice agencies	0%	0%	0%	0%	0%	0%	0%	0%	0%
Adult criminal justice agencies/courts	0%	7%	0%	0%	8%	0%	0%	0%	2%
MH/drug courts	0%	7%	0%	0%	8%	0%	0%	0%	2%
Law enforcement	0%	0%	0%	0%	0%	0%	0%	0%	0%
Indian Health Service or other tribal programs	0%	0%	0%	0%	0%	0%	0%	0%	0%
Indian Health Service youth regional treatment centers	0%	0%	0%	0%	0%	0%	0%	0%	0%
Homeless shelters	0%	0%	0%	0%	8%	0%	0%	0%	1%
Housing agencies	0%	0%	0%	0%	8%	0%	0%	0%	1%
Suicide/crisis hotlines and warmlines	0%	73%	0%	14%	31%	0%	0%	57%	22%
Employment services and/or supported employment	0%	7%	0%	14%	15%	0%	0%	14%	6%
Older adult services	0%	0%	0%	0%	0%	0%	0%	14%	2%
Other social and human service providers	0%	7%	0%	0%	8%	0%	8%	14%	5%
Consumer-operated/peer service provider organizations	0%	0%	0%	29%	8%	0%	8%	0%	6%

TABLE A.21. CCBHC DCO Relationships with Other Facilities and Providers, by State, 2019

	State								Average Percentage of CCBHCs Across States
Facility/Provider Type	**Minnesota**	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
VA treatment facilities	0%	0%	0%	14%	0%	0%	0%	0%	2%
Urgent care centers	0%	0%	0%	14%	0%	0%	0%	0%	2%
EDs	0%	0%	0%	57%	0%	0%	0%	0%	7%
Hospital outpatient clinics	0%	0%	0%	0%	0%	0%	0%	0%	0%

TABLE A.21 (*continued*)

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

a. Color shading approximately represents the 5 main care coordination groupings from the CCBHC certification criteria: red (rows 1-3) = FQHCs, rural health clinics, other primary care providers; green (rows 4-10) = inpatient and residential behavioral health treatment; blue (rows 11-28) = community or regional services, supports, and providers; orange (row 29) = VA facilities; gray (rows 30-32) = inpatient acute care hospitals. For more information about the grouping of providers/facilities, see the criteria available at https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf, pp. 27-31.

Facility/Provider Type[a]	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
TABLE A.22. CCBHC Non-DCO (either formal and informal) Relationships with Other Facilities and Providers, by State, 2019									
FQHCs	50%	93%	100%	71%	77%	100%	75%	86%	82%
Rural health clinics	33%	53%	100%	14%	54%	100%	50%	43%	56%
Primary care providers	100%	93%	67%	100%	92%	100%	100%	86%	92%
Inpatient psychiatric facilities	100%	100%	100%	100%	92%	100%	100%	100%	99%
Psychiatric residential treatment facilities	100%	87%	100%	100%	85%	100%	100%	100%	96%
SUD residential treatment facilities	100%	80%	100%	100%	92%	100%	92%	100%	95%
Medical detoxification facilities	50%	93%	100%	86%	92%	100%	100%	100%	90%
Ambulatory detoxification facilities	33%	80%	67%	86%	85%	100%	100%	100%	81%
Post-detoxification step-down facilities	50%	67%	67%	100%	85%	67%	100%	71%	76%
Residential (non-hospital) crisis settings	50%	60%	100%	71%	85%	100%	92%	86%	80%
MAT providers for substance use	83%	87%	67%	100%	77%	100%	100%	86%	87%
Schools	83%	100%	100%	86%	85%	100%	100%	100%	94%
School-based health centers	33%	60%	67%	43%	46%	33%	83%	71%	55%
Child welfare agencies	83%	100%	100%	100%	92%	100%	100%	100%	97%
Therapeutic foster care service agencies	67%	87%	100%	57%	85%	67%	100%	86%	81%
Juvenile justice agencies	83%	100%	100%	71%	85%	100%	100%	100%	92%
Adult criminal justice agencies/courts	67%	93%	100%	100%	92%	100%	100%	100%	94%
MH/drug courts	67%	93%	100%	100%	92%	100%	100%	100%	94%
Law enforcement	100%	100%	100%	100%	92%	100%	100%	86%	97%
Indian Health Service or other tribal programs	50%	13%	100%	0%	46%	67%	67%	0%	43%
Indian Health Service youth regional treatment centers	17%	7%	100%	0%	38%	33%	25%	0%	28%
Homeless shelters	67%	87%	100%	100%	92%	100%	75%	100%	90%
Housing agencies	100%	93%	100%	100%	92%	100%	100%	86%	96%
Suicide/crisis hotlines and warmlines	67%	27%	100%	86%	62%	100%	100%	43%	73%
Employment services and/or supported employment	83%	87%	100%	86%	77%	100%	100%	71%	88%
Older adult services	83%	93%	100%	86%	85%	67%	100%	71%	86%
Other social and human service providers	100%	87%	100%	100%	100%	100%	100%	86%	97%
Consumer-operated/peer service provider organizations	50%	80%	100%	86%	85%	100%	100%	86%	86%

TABLE A.22 (*continued*)									
Facility/Provider Type[a]	**State**								**Average Percentage of CCBHCs Across States**
	Minnesota	**Missouri**	**Nevada**	**New Jersey**	**New York**	**Oklahoma**	**Oregon**	**Pennsylvania**	
VA treatment facilities	100%	80%	100%	71%	85%	100%	100%	100%	92%
Urgent care centers	67%	87%	100%	71%	77%	67%	67%	71%	76%
EDs	100%	100%	100%	71%	92%	100%	100%	100%	95%
Hospital outpatient clinics	83%	87%	100%	86%	92%	100%	100%	86%	92%

SOURCE: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTES: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7.

a. Color shading approximately represents the 5 main care coordination groupings from the CCBHC certification criteria: red (rows 1-3) = FQHCs, rural health clinics, other primary care providers; green (rows 4-10) = inpatient and residential behavioral health treatment; blue (rows 11-28) = community or regional services, supports, and providers; orange (row 29) = VA facilities; gray (rows 30-32) = inpatient acute care hospitals. For more information about the grouping of providers/facilities, see the criteria available at https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf, pp. 27-31.

Function	State								Average Percentage of CCBHCs Across States
	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania	
EHR contains MH records	100%	100%	100%	100%	100%	100%	100%	100%	100%
EHR contains SUD records	100%	100%	100%	100%	100%	100%	100%	100%	100%
EHR contains case management or care coordination records	100%	100%	100%	100%	100%	100%	100%	100%	100%
EHR has quality measure reporting capabilities	83%	93%	100%	100%	85%	100%	92%	100%	94%
EHR generates electronic care plan	83%	80%	100%	86%	100%	100%	100%	100%	94%
Any form of electronic prescribing used	83%	100%	100%	86%	100%	100%	92%	100%	95%
EHR incorporates laboratory results into health record	67%	87%	67%	71%	62%	100%	92%	100%	81%
EHR provides clinical decision support	50%	87%	100%	71%	85%	67%	92%	86%	80%
EHR contains primary care records	17%	47%	100%	57%	62%	67%	75%	43%	58%
EHR communicates with laboratory to request tests or receive results	33%	53%	33%	71%	46%	100%	67%	71%	59%
EHR allows electronic exchange of clinical information with other external providers	33%	40%	33%	43%	46%	67%	58%	43%	45%
EHR allows electronic exchange of clinical information with DCOs	17%	20%	33%	43%	31%	33%	33%	43%	32%

TABLE A.23. Functions of CCBHC EHR and HIT Systems, by State, 2019

SOURCES: CCBHC Annual Progress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019.

NOTE: Cell values are calculated as a proportion of the total number of CCBHCs in each state: Minnesota = 6, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 12, Pennsylvania = 7

APPENDIX B. CCBHC DEMONSTRATION EVALUATION 2018 AND 2019 PROGRESS REPORT TEMPLATES[21]

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[21] According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0461. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington, D.C. 20201. Attention: PRA Reports Clearance Officer.

Certified Community Behavioral Health Clinic Demonstration Annual Clinic Progress Report Demonstration Year 1

Certified Community Behavioral Health Clinic Demonstration
Annual Clinic Progress Report
Demonstration Year 1

FOR REFERENCE AHEAD OF ONLINE PROGRESS REPORT

Mathematica Policy Research and the RAND Corporation are conducting a national evaluation of the Certified Community Behavioral Health Clinic (CCBHC) Demonstration on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and its federal partners the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services. We are asking each CCBHC to complete this progress report as an important component of the national evaluation.

Information and instructions

The purpose of this progress report is to gather information about the experiences of CCBHCs during the first year of the demonstration. The questions in this progress report focus on your clinic's services and activities including: clinic staffing, service accessibility, care coordination, scope of services, and quality and other reporting.

You do not need to complete the progress report in one sitting – follow the steps listed under "hints and tips" on the next screen to save your answers and return later to complete all questions. We ask that you complete the progress report in the next two weeks.

Many questions in this progress report require a "Yes" or "No" answer or can be completed based on your knowledge of the clinic without having to look up information. We anticipate that you will need approximately 3 hours total to complete this progress report, including the time for reviewing instructions, gathering the information needed to answer questions, and responding to the questions.

Your answers to this progress report provide critical information about the implementation of the CCBHC model. As the director of a clinic participating in the CCBHC demonstration, you have a unique perspective on the successes and challenges of this new way of delivering care. Your responses to the questions in this report will provide crucial information about the demonstration to the U.S. Department of Health and Human Services and the evaluation team.

Hints and tips

- You do not need to complete the progress report in one sitting. Your responses to each question are saved *after* clicking the **NEXT** button on each screen. You may close the progress report at any time and reenter it by clicking the link provided in your invitation email and logging in with your user ID and password. The progress report will resume where you left off.

- Click on the "Back" button to go back to a previous question. Do not use the back arrow at the top of the screen, which navigates the browser. Doing so may log you out of the progress report and you may need to log in again.

- This progress report has been optimized to run on a desktop computer.

- We have established one username and password per clinic. The username and password you use to access this progress report may be shared with others in your organization.

- If your CCBHC is providing CCBHC services at more than one location, **please answer for the CCBHC as a whole** (consolidating across all locations).

- Do not consider services provided by designated collaborating organizations (DCOs) in your responses unless instructed to in the question.

Helpful materials to assist with completing the progress report

Before completing the progress report, it may be helpful to gather the following materials to help answer questions:

- Your clinic's CCHBC demonstration application or materials used during the planning phase of the demonstration; and

- Any information about the services that your clinic provides and clinic policies (again, you may know the answers to many of the questions without having to look up information).

We want you to know that

- Your responses to this progress report will provide information critical to the evaluation. **Please answer as many questions as you can.** If you are unable to provide an answer or have questions about completing the progress report please contact the CCBHC Demonstration Evaluation team by e-mail at CCBHCDemoEval@mathematica-mpr.com for assistance.

- This data collection has been approved by the federal Office of Management and Budget (OMB), under OMB Control Number 0990-0461. If you have questions about the evaluation, please contact our evaluation director, Jonathan Brown, by e-mail at CCBHCDemoEval@mathematica-mpr.com.

- Mathematica and RAND are committed to protecting the privacy of individuals who participate in the progress report. All information you provide will be used for research purposes only. Any published findings from the progress reports will be reported in the aggregate. Your name will not be used in any public reports.

Section A. Certified Community Behavioral Health Clinic (CCBHC) staffing
In this section, we would like to learn about how your CCBHC is staffed.

A.1.

Which types of clinical staff are currently employed by your CCBHC?

Please indicate if staff were hired before the CCBHC certification process, or were hired after certification. For example, if one adult psychiatrist was on staff prior to certification and an additional adult psychiatrist was hired as part of certification, please check both categories. Do not report staff who are employed by collaborating agencies/organizations. "Employed" means paid directly as a regular employee or contractor of your CCBHC.

Please check all that apply, or select "Does not employ"

	Employed before certification	Hired as part of certification	Hired after certification	Does not Employ
A.1.a CCBHC Medical director	☐	☐	☐	☐
If yes, is your CCBHC's medical director a psychiatrist? ☐ Yes ☐ No				
If no, please indicate what type of provider your CCBHC's medical director is: Click here to enter description.				
A.1.b adult psychiatrists (other than the CCBHC Medical Director)	☐	☐	☐	☐
A.1.b child/adolescent psychiatrists (other than the CCBHC Medical Director)	☐	☐	☐	☐
A.1.b other physicians	☐	☐	☐	☐
A.1.c nurses (please enter nurse types; for example, nurse practitioners, psychiatric/mental health nurses, substance use disorder specialist nurses): Click here to enter nurse types.	☐	☐	☐	☐
A.1.d licensed clinical social workers	☐	☐	☐	☐
A.1.e licensed psychologists (please specify degree levels of licensed psychologist(s)): Click here to enter degrees.	☐	☐	☐	☐
A.1.f licensed marriage and family therapists	☐	☐	☐	☐
A.1.f case management staff	☐	☐	☐	☐
A.1.g substance abuse specialists	☐	☐	☐	☐
A.1.g occupational therapists	☐	☐	☐	☐
A.1.g bachelor's degree-level counselors	☐	☐	☐	☐

A.1.g associate's degree-level or non-degree counselors	☐	☐	☐
A.1.g mental health professionals (trained and credentialed for psychological testing)	☐	☐	☐
A.1.h community health workers	☐	☐	☐
A.1.h medical/nursing assistants	☐	☐	☐
A.1.h pharmacy staff	☐	☐	☐
A.1.i peer specialists/recovery coaches	☐	☐	☐
A.1.i family support staff	☐	☐	☐
A.1.i interpreters or linguistic counselors	☐	☐	☐
A.1.i interns (not reported above)	☐	☐	☐
A.1.j other clinician types (specify): Click here to enter other clinician types.	☐	☐	☐

A.2.a Have any of these staff positions gone unfilled for two months or longer since the start of the CCBHC demonstration?
☐ Yes ☐ No

A.2.b If yes, please describe why these positions have gone unfilled for two months or longer since the start of the CCBHC demonstration (for example, has a position been difficult to fill?): Click here to enter description.

A.3. Which of the following trainings have staff received since the start of the CCBHC demonstration? Check all that apply, or select "None".

☐ Risk assessment, suicide prevention, and suicide response training
☐ The role of family and peers in the delivery of care
☐ Person-centered and family-centered care
☐ Recovery-oriented care
☐ Evidence-based and trauma-informed care
☐ Cultural competency training to address diversity within the organization's service population
☐ Primary and behavioral health care integration
☐ Other: Click here to describe other trainings.
☐ None

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Section B. Certified Community Behavioral Health Clinic Certified Community Behavioral Health Clinic (CCBHC) accessibility

Questions in this section will help us understand how clients access services at your clinic.

B.1. How are clients referred to CCBHC services? Check all that apply.

☐ Self-referral
☐ Referred by provider
☐ Referred by courts/involuntary or assisted outpatient treatment order
☐ Referred by family
☐ Other (please describe): Click here to enter description.

B.2. Did your CCBHC make any changes to the organization's physical space as a result of CCBHC certification? Check all that apply, or select "None".

☐ Expansions or additions to the CCBHC building space
☐ Renovations to existing CCBHC facilities
☐ Improvements to facility safety features
☐ Other changes: Click here to enter description of changes.
☐ None

B.3.a Does your CCBHC offer services in locations outside of the clinic (for example, in clients' homes)? ☐ Yes ☐ No

B.3.b If yes, were services provided in locations outside of the clinic: ☐ Offered before certification ☐ Offered to achieve/maintain certification

B.3.c If yes, where does your CCBHC provide services outside of the clinic? Please describe: Click here to enter description of locations.

B.4.a Does your CCBHC offer services via telehealth? ☐ Yes ☐ No

B.4.b If yes, were telehealth services: ☐ Offered before certification ☐ Offered to achieve/maintain certification

B.4.c If yes, what telehealth services are available, and to whom? Please describe: Click here to describe.

B.5.a Does your CCBHC offer translation services to clients? ☐ Yes ☐ No

B.5.b If yes, how are translation services delivered? Please check all that apply: ☐ Staff interpreter ☐ Multilingual staff ☐ Other: Click here to describe.

B.6.a Does your CCBHC offer transportation or transportation vouchers? ☐ Yes ☐ No

B.6.b If yes, to whom are transportation/vouchers available? Please describe: Click here to describe.

B.7. Has your CCBHC targeted any of the following populations with outreach or engagement efforts since the start of the CCBHC demonstration? Check all that apply, or select "None".

☐ Consumers experiencing homelessness
☐ Members of the Armed Forces or Veterans
☐ Consumers who were previously incarcerated
☐ School-age youth
☐ Older adults
☐ Other populations (please specify): Click here to enter text.
☐ None

B.8.a Does your CCBHC offer a sliding fee schedule? ☐ Yes ☐ No

B.8.b If yes, is your sliding fee schedule published on your website or elsewhere? ☐ Yes ☐ No

B.8.c If available, please provide the web link to the sliding fee schedule. Click here to enter web address.

B.9.a Does your CCBHC provide services to clients unable to pay? ☐ Yes ☐ No

B.9.b Does your CCBHC provide services to clients with Medicare? ☐ Yes ☐ No

B.9.c Does your CCBHC provide services to clients with private insurance? ☐ Yes ☐ No

B.9.d Does your CCBHC provide services to clients who do not reside in its catchment area? ☐ Yes ☐ No

Section C. Certified Community Behavioral Health Clinic (CCBHC) care coordination
The following questions will help us understand how client care is coordinated at your clinic.

C.1. Which of the following are generally involved in developing and updating a comprehensive treatment plan? Please check all that apply.

☐ Mental health clinicians   ☐ Client family members
☐ Substance use disorder clinicians   ☐ Psychiatrists
☐ Case managers   ☐ Primary care physicians
☐ Consumers/clients   ☐ Other: Click here to enter additional provider types.

C.2.a Which of the following are generally included on treatment teams at your CCBHC? Check all that apply.

☐ Mental health clinicians   ☐ Psychiatrists
☐ Substance use disorder service providers   ☐ Primary care physicians
☐ Case managers   ☐ Community support and social service providers
☐ Consumers   ☐ Other: Click here to enter additional provider types.
☐ Families

C.2.b Were all of the staff selected in the previous question generally included on treatment teams prior to CCBHC certification?
☐ Yes ☐ No

C.2.c Have the members of the organization's treatment teams changed as a result of CCBHC certification? ☐ Yes ☐ No
    C.2.d If yes, please describe how the members of the organization's treatment teams changed as a result of CCBHC certification: Click here to enter description.

C.3.a Does your CCBHC provide on-site primary care services (in addition to primary care screening and monitoring)? ☐ Yes ☐ No
    C.3.b If yes, did your CCBHC provide on-site primary care services (in addition to primary care screening and monitoring) before certification? ☐ Yes ☐ No
C.3.c Is your CCBHC also a federally qualified health center (FQHC)? ☐ Yes ☐ No

C.4. How does your CCBHC learn of clients' care transitions, such as hospitalizations or discharges? Check all that apply, or select "None".

Receives notification when hospital treats a client for: ☐ Physical health condition ☐ Behavioral health condition ☐ None
Receives discharge summary from hospital after a client is treated for: ☐ Physical health condition ☐ Behavioral health condition ☐ None
Receives notification when emergency department treats a client for: ☐ Physical health condition ☐ Behavioral health condition ☐ None
Receives discharge summary from emergency department after a client is treated for: ☐ Physical health condition ☐ Behavioral health condition ☐ None
Receives notification by other means (for example, contacts by consumers or families) about: ☐ Physical health condition ☐ Behavioral health condition
☐ None

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C.5. Please answer the following questions about health information technology (HIT) and Electronic Health Records (EHRs):
a. Did your clinic adopt a new HIT system or EHR as part of CCBHC certification? ☐ Yes ☐ No
b. Has your clinic altered its HIT system or EHR to meet CCBHC certification requirements for coordination and data collection? ☐ Yes ☐ No
c. Does your clinic use any form of electronic prescribing? ☐ Yes ☐ No
d. Please provide the name of your Electronic Health Record (EHR): Click here to enter name.
e. Please provide the name of any other health information technology (HIT) system used by your CCBHC (for example, HIT systems for clinical registries, scheduling, case management, etc.) Click here to enter name(s).

C.6. Which of the following functionalities does your Electronic Health Record (EHR) include? Please select "Yes" or "No," and if "Yes," indicate whether the functionality is new as a result of CCBHC certification.

Contains mental health records	☐ Yes	☐ No	☐ New
Contains substance use disorder records	☐ Yes	☐ No	☐ New
Contains primary care records	☐ Yes	☐ No	☐ New
Contains case management or care coordination records	☐ Yes	☐ No	☐ New
Generates electronic care plan	☐ Yes	☐ No	☐ New
Communication with laboratory to request tests or receive results	☐ Yes	☐ No	☐ New
Incorporation of laboratory results into health record	☐ Yes	☐ No	☐ New
Clinical decision support	☐ Yes	☐ No	☐ New
Allows electronic exchange of clinical information with designated collaborating organizations (DCOs)	☐ Yes	☐ No	☐ New
Allows electronic exchange of clinical information with other external providers	☐ Yes	☐ No	☐ New
Quality measure reporting capabilities	☐ Yes	☐ No	☐ New

C.7. Does your CCBHC have relationships with any of the following types of external facilities or providers? Please check all that apply, or select "No relationship"

	Designated collaborating organization (DCO)	Some other formal relationship*	Some other informal relationship	No relationship
C.7.1 Federally qualified health centers	☐	☐	☐	☐
C.7.1 Rural health clinics	☐	☐	☐	☐
C.7.1 Primary care providers	☐	☐	☐	☐
C.7.1 Urgent care centers	☐	☐	☐	☐
C.7.1 Emergency departments	☐	☐	☐	☐
C.7.2 Inpatient psychiatric facilities	☐	☐	☐	☐
C.7.2 Psychiatric residential treatment facilities	☐	☐	☐	☐
C.7.2 Substance use disorder residential treatment facilities	☐	☐	☐	☐

C.7.3 Medical detoxification facilities	☐	☐	☐
C.7.3 Ambulatory detoxification facilities	☐	☐	☐
C.7.3 Post-detoxification step-down facilities	☐	☐	☐
C.7.3 Hospital outpatient clinics	☐	☐	☐
C.7.3 Medication-assisted treatment providers for substance use	☐	☐	☐
C.7.4 Schools	☐	☐	☐
C.7.4 School-based health centers	☐	☐	☐
C.7.4 Child welfare agencies	☐	☐	☐
C.7.4 Therapeutic foster care service agencies	☐	☐	☐
C.7.5 Juvenile justice agencies	☐	☐	☐
C.7.5 Adult criminal justice agencies/courts	☐	☐	☐
C.7.5 Mental health/drug courts	☐	☐	☐
C.7.5 Law enforcement	☐	☐	☐
C.7.6 Indian Health Service or other tribal programs	☐	☐	☐
C.7.6 Indian Health Service youth regional treatment centers	☐	☐	☐
C.7.6 Department of Veterans Affairs treatment facilities	☐	☐	☐
C.7.7 Homeless shelters	☐	☐	☐
C.7.7 Housing agencies	☐	☐	☐
C.7.7 Suicide/crisis hotlines and warmlines	☐	☐	☐
C.7.7 Residential (non-hospital) crisis settings	☐	☐	☐
C.7.8 Employment services and/or supported employment	☐	☐	☐
C.7.8 Older adult services	☐	☐	☐
C.7.8 Other social and human service providers	☐	☐	☐
C.7.8 Consumer operated/peer service provider organizations	☐	☐	☐

* a formal relationship may include formal agreements such as a memoranda of understanding.

C.8. Does your CCBHC use any of the following to facilitate crisis planning?
Psychiatric advance directives ☐ Yes ☐ No
Wellness recovery action plan ☐ Yes ☐ No
Other (please list): Click here to list others.

C.9. How are consumer and family preferences for care elicited and documented? Please describe: Click here to describe.

D. Certified Community Behavioral Health Clinic (CCBHC) scope of services

In this section, we would like to learn about the services your clinic provides, the extent of their availability, and whether your clinic was providing them prior to certification.

D.1. Which of the services below does your CCBHC or designated collaborating organization(s) (DCO(s)) currently provide?
For each service, please indicate the following:
a. If the service is provided by your CCBHC or a DCO
b. The time of day/week the service is available. Record the number of months each service was available at your CCBHC or DCO during the past twelve months.
c. If your clinic added this service as a result of CCBHC certification

	Provided by:		Available:				Duration	Added
	CCBHC	DCO	Business hours	Evenings	Weekends	Overnight		
D.1.a. Crisis Behavioral Health Services								
24-hour mobile crisis teams	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Emergency crisis intervention	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Crisis stabilization	☐	☐	☐	☐	☐	☐	Enter # of months	☐
D.1.b. Screening, Assessment, and Diagnosis								
Mental health screening, assessment, diagnostic services	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Substance use disorder screening, assessment, diagnostic services	☐	☐	☐	☐	☐	☐	Enter # of months	☐
D.1.c. Person- and Family-Centered Treatment Planning Services	☐	☐	☐	☐	☐	☐	Enter # of months	☐
D.1.d. Outpatient Mental Health and/or Substance Use Disorder (SUD) Services								
Outpatient mental health counseling	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Outpatient SUD treatment	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Motivational interviewing	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Individual cognitive behavioral therapy (CBT)	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Group CBT	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Online CBT	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Dialectical behavioral therapy	☐	☐	☐	☐	☐	☐	Enter # of months	☐
First episode/early intervention for psychosis	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Multi-systemic therapy	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Assertive community treatment (ACT)	☐	☐	☐	☐	☐	☐	Enter # of months	☐
Forensic ACT	☐	☐	☐	☐	☐	☐	Enter # of months	☐

Service	☐	☐	☐	☐	☐	☐	Enter # of months
Evidence-based medication evaluation and management	☐	☐	☐	☐	☐	☐	Enter # of months
Medication-assisted treatment for alcohol and opioid use	☐	☐	☐	☐	☐	☐	Enter # of months
Therapeutic foster care	☐	☐	☐	☐	☐	☐	Enter # of months
Community wraparound services for youth/children	☐	☐	☐	☐	☐	☐	Enter # of months
Specialty mental health/SUD services for children and youth	☐	☐	☐	☐	☐	☐	Enter # of months

D.1.e. Psychiatric Rehabilitation Services

Service	☐	☐	☐	☐	☐	☐	Enter # of months
Medication education	☐	☐	☐	☐	☐	☐	Enter # of months
Self-management	☐	☐	☐	☐	☐	☐	Enter # of months
Skills training	☐	☐	☐	☐	☐	☐	Enter # of months
Psychoeducation	☐	☐	☐	☐	☐	☐	Enter # of months
Community integration services	☐	☐	☐	☐	☐	☐	Enter # of months
Illness management and recovery	☐	☐	☐	☐	☐	☐	Enter # of months
Financial management	☐	☐	☐	☐	☐	☐	Enter # of months
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	☐	☐	☐	☐	☐	☐	Enter # of months
Supported housing	☐	☐	☐	☐	☐	☐	Enter # of months
Supported employment	☐	☐	☐	☐	☐	☐	Enter # of months
Supported education	☐	☐	☐	☐	☐	☐	Enter # of months

D.1.f. Peer Support Services

Service	☐	☐	☐	☐	☐	☐	Enter # of months
Peer support services for consumers/clients	☐	☐	☐	☐	☐	☐	Enter # of months
Peer support services for families	☐	☐	☐	☐	☐	☐	Enter # of months

D.1.g. Targeted Case Management

	☐	☐	☐	☐	☐	☐	Enter # of months

D.1.h. Primary Care Screening and Monitoring

	☐	☐	☐	☐	☐	☐	Enter # of months

D.1.i. Intensive Community-Based Mental Health Services for Armed Forces and Veterans

	☐	☐	☐	☐	☐	☐	Enter # of months

Please describe any specific activities or services that are targeted to members of the Armed Forces or Veterans: Click here to enter description.

D.1.j. Other required CCBHC services (please describe):

Item	☐	☐	☐	☐	☐	☐	Enter # of months
1. Click here to enter additional service.	☐	☐	☐	☐	☐	☐	Enter # of months
2. Click here to enter additional service.	☐	☐	☐	☐	☐	☐	Enter # of months
3. Click here to enter additional service.	☐	☐	☐	☐	☐	☐	Enter # of months

D.2. If your CCBHC has made any changes to the scope of services provided in the past 12 months, please briefly explain those changes and why you made them. Click here to enter text.

E. Certified Community Behavioral Health Clinic (CCBHC) quality and other reporting

Questions in this final section will help us understand your clinic's efforts to monitor and improve its quality of care.

E.1. Does your CCBHC collect any of the following information as described in Program Requirement 5 (https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf) of the CCBHC criteria? For each category, please indicate whether this information is stored in an Electronic Health Record (EHR), clinical registry, or other database. If other database, please describe its type. Select all that apply, or select "None".

	EHR	Clinical registry	Other:	None
Staffing	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Consumer characteristics	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Access to services	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Use of CCBHC services	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Screening	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Prevention	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Treatment	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Care coordination	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Other processes of care	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Costs	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None
Consumer outcomes	☐ EHR	☐ Clinical registry	☐ Other: Click here to describe.	☐ None

E.2. Please describe any current Continuous Quality Improvement projects underway and when they began. Click here to list.

E.3.a In the past 12 months, has your CCBHC used any of the quality measure data collected as part of the demonstration to change clinical practice? ☐ Yes ☐ No

E.3.b If yes, please describe what quality measure(s) your efforts to change clinical practice were based on and the nature of the changes to your clinical practice:
Measure 1: Click here to describe.; Changes to clinical practice: Click here to describe.

Measure 2: Click here to describe.; Changes to clinical practice: Click here to describe.

Measure 3: Click here to describe.; Changes to clinical practice: Click here to describe.

Any other measures: Click here to describe.; Changes to clinical practice: Click here to describe.

E.4.a Is your CCBHC accredited? ☐ Yes ☐ No
E.4.b If yes, please describe the type(s) of accreditation/accrediting agency or agencies through which your CCBHC is accredited: Click here to enter description.

Thank you for your participation in this critical piece of the CCBHC Demonstration evaluation!ibn

Certified Community Behavioral Health Clinic Demonstration Evaluation
Annual Progress Report: Demonstration Year 2

Certified Community Behavioral Health Clinic Demonstration Evaluation

Annual Progress Report: Demonstration Year 2

FOR REFERENCE ONLY

Mathematica Policy Research and the RAND Corporation are conducting a national evaluation of the Certified Community Behavioral Health Clinic (CCBHC) Demonstration on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and its federal partners the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services. We are asking each CCBHC to complete this progress report as an important component of the national evaluation.

Information and instructions

The purpose of this progress report is to gather information about the experiences of CCBHCs during the second year of the demonstration. The questions in this progress report focus on your clinic's services and activities including: clinic staffing, service accessibility, care coordination, scope of services, and quality and other reporting.

You do not need to complete the progress report in one sitting – follow the steps listed under "hints and tips" on the next screen to save your answers and return later to complete all questions. We ask that you complete the progress report within two weeks of receiving the link to the online report.

Many questions in this progress report require a "Yes" or "No" answer or can be completed based on your knowledge of the clinic without having to look up information. We anticipate that you will need approximately 3 hours total to complete this progress report, including the time for reviewing instructions, gathering the information needed to answer questions, and responding to the questions.

NEW THIS YEAR: Before submitting your progress report, you will have the opportunity to view and print or save a copy of your completed report. After viewing and printing or saving a PDF of your responses, please be sure to return to the progress report and click "Submit" to complete.

Your answers to this progress report provide critical information about the implementation of the CCBHC model. As leadership of a clinic participating in the CCBHC demonstration, you have a unique perspective on the successes and challenges of this new way of delivering care. Your responses to the questions in this report will provide crucial information about the demonstration to the U.S. Department of Health and Human Services and the evaluation team.

Hints and tips

- You do not need to complete the progress report in one sitting. Your responses to each question are saved *after* clicking the **NEXT** button on each screen. You may close the progress report at any time and reenter it by clicking the link provided in your invitation email and logging in with your user ID and password. The progress report will resume where you left off.
- Click on the "Back" button to go back to a previous question. Do not use the back arrow at the top of the screen, which navigates the browser. Doing so may log you out of the progress report and you may need to log in again.
- This progress report has been optimized to run on a desktop computer.
- We have established one username and password per clinic. The username and password you use to access this progress report may be shared with others in your organization.
- If your CCBHC is providing CCBHC services at more than one location, **please answer for the CCBHC as a whole** (consolidating across all locations).
- Do not consider services provided by designated collaborating organizations (DCOs) in your responses unless instructed to in the question.

Helpful materials to assist with completing the progress report

Before completing the progress report, it may be helpful to gather the following materials to help answer questions:

- Information about the composition of your clinic's staff, services that your clinic provides, and clinic policies (again, you may know the answers to many of the questions without having to look up information).

We want you to know that

- Your responses to this progress report will provide information critical to the evaluation. **Please answer as many questions as you can.** If you are unable to provide an answer or have questions about completing the progress report please contact the CCBHC Demonstration Evaluation team by e-mail at CCBHCDemoEval@mathematica-mpr.com for assistance.

- This data collection has been approved by the federal Office of Management and Budget (OMB), under OMB Control Number 0990-0461. If you have questions about the evaluation, please contact our evaluation director, Jonathan Brown, by e-mail at CCBHCDemoEval@mathematica-mpr.com.

- Mathematica and RAND are committed to protecting the privacy of individuals who participate in the progress report. All information you provide will be used for research purposes only. Any published findings from the progress reports will be reported in the aggregate. Your name will not be used in any public reports.

Section A. Certified Community Behavioral Health Clinic (CCBHC) staffing

In this section, we would like to learn about how your CCBHC is staffed.

A.1. Which types of clinical staff are currently employed by your CCBHC? Please check all that apply. Do not report staff who are employed by collaborating agencies/organizations. Select all that apply.

☐ A.1.a Medical Director (psychiatrist)

Is your CCBHC's medical director a psychiatrist?
☐ Yes ☐ No

Please indicate what type of provider your CCBHC's medical director is: (open ended response box]

☐ A.1.a Adult psychiatrist(s) (other than CCBHC Medical Director)

☐ A.1.a Child/adolescent psychiatrists (other than CCBHC Medical Director)

☐ A.1.a Other physicians

☐ A.1.a Nurses (please enter nurse types; for example, psychiatric/mental health nurses, substance use disorder specialist nurses): Click here to enter nurse types.

☐ A.1.b Licensed clinical social workers

☐ A.1.b Licensed psychologists (please specify degree levels of licensed psychologists): Click here to enter degrees.

☐ A.1.b Licensed marriage and family therapists

☐ A.1.b Case management staff

☐ A.1.b Occupational therapists

☐ A.1.c Substance abuse specialists

☐ A.1.c Occupational therapists

☐ A.1.c Bachelor's degree-level counselors

☐ A.1.c Associate-degree level or non-degree counselors

☐ A.1.c Mental health professionals (trained and credentialed for psychological testing)

☐ A.1.d Community health workers

☐ A.1.d Medical/nursing assistants

☐ A.1.d Pharmacy staff

☐ A.1.e Peer specialist(s)/recovery coaches

☐ A.1.e Family support staff

☐ A.1.e Interpreters or linguistic counselors

☐ A.1.e Interns (not reported above)

☐ A.1.e Other clinician types (specify): Click here to enter additional clinician types.

A.2.a. Have any of these staff positions gone unfilled for two months or longer during the past twelve months?

[Saff positions: CCBHC medical director, adult psychiatrists, child/adolescent psychiatrists, other physicians, nurses, licensed clinical social workers, licensed psychologists, licensed marriage and family therapists, case management staff, substance abuse specialists, occupational therapists, bachelor's degree-level counselors, associate's degree-level or non-degree counselors, mental health professionals (trained and credentialed for psychological testing), community health workers, medical/nursing assistants, pharmacy staff, peer specialists/recovery coaches, family support staff, interpreters or linguistic counselors, interns, other clinician types]

☐ Yes ☐ No

A.2.b. If so, please describe why (for example, has a position been difficult to fill?): Click here to enter description.

A.3. Which of the following trainings have staff received during the past twelve months? Check all that apply or select None.

☐ Risk assessment, suicide prevention, and suicide response training

☐ The role of family and peers in the delivery of care

☐ Person-centered and family-centered care

☐ Recovery-oriented care

☐ Evidence-based and trauma-informed care

☐ Cultural competency training to address diversity within your CCBHC's service population

☐ Primary and behavioral health care integration

☐ Other: Click here to describe other trainings.

○ None

Section B. CCBHC accessibility

Questions in this section will help us understand how clients access services at your clinic.

B.1. How are clients referred to CCBHC services? Check all that apply.

☐ Self-referral
☐ Referred by provider
☐ Referred by courts/involuntary or assisted outpatient treatment order
☐ Referred by family
☐ Other (please describe): Click here to enter description.

B.2. Has your CCBHC made any changes to your CCBHC's physical space in the past twelve months? Check all that apply, or select "None".

☐ Expansions or additions to the CCBHC building space
☐ Renovations to existing CCBHC facilities
☐ Improvements to facility safety features
☐ Other changes: Click here to enter description of changes.
o None

B.3. Does your CCBHC offer services in locations outside of the clinic (for example, in clients' homes)? ☐ Yes ☐ No
B.3.b. Were services provided in locations outside of the clinic: ☐ Offered before certification ☐ Offered to achieve/maintain certification
B.3.c Where are services provided outside of the clinic? Please describe: Click here to enter description of locations.

B.4.a Does your CCBHC offer services via telehealth? ☐ Yes ☐ No
B.4.b Were telehealth services: ☐ Offered before certification ☐ Offered to achieve/maintain certification
B.4.c What telehealth services are available, and to whom? Please describe: Click here to describe.

B.5.a Does your CCBHC offer translation services to clients? ☐ Yes ☐ No
B.5.b How are translation services delivered? Please check all that apply: ☐ Staff interpreter ☐ Multilingual staff ☐ Other: Click here to describe.Click here to describe.

B.6.a Does your CCBHC offer transportation or transportation vouchers? ☐ Yes ☐ No
B.6.b To whom are transportation/vouchers available? Please describe: Click here to describe.Click here to describe.

B.7 Has your CCBHC targeted any of the following populations with outreach or engagement efforts in the past twelve months? Check all that apply or select "None".

☐ Consumers experiencing homelessness
☐ Members of the Armed Forces or Veterans
☐ Consumers who were previously incarcerated
☐ School-age youth
☐ Older adults
☐ Other populations (please specify): Click here to enter text.
o None

B.8.a Does your CCBHC offer a sliding fee schedule? ☐ Yes ☐ No
B.8.b Is your sliding fee schedule published on your website or elsewhere? ☐ Yes ☐ No
B.8.c If available, please provide the web link to the sliding fee schedule. Click here to enter web address.Click here to enter web address.

B.9.a Does your CCBHC provide services to clients unable to pay? ☐ Yes ☐ No
B.9.b Does your CCBHC provide services to clients with Medicare? ☐ Yes ☐ No

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B.9.c Does your CCBHC provide services to clients with private insurance? ☐ Yes ☐ No
B.9.d Does your CCBHC provide services to clients who do not reside in its catchment area? ☐ Yes ☐ No

Section C. CCBHC care coordination
The following questions will help us understand how client care is coordinated at your clinic.

C.1. Which of the following generally are involved in developing and updating a comprehensive treatment plan? Check all that apply.

☐ Mental health clinicians   ☐ Client family members
☐ Substance use disorder clinicians   ☐ Psychiatrists
☐ Case managers   ☐ Primary care physicians
☐ Consumers/clients   ☐ Other: Click here to enter additional provider types.

C.2.a Which of the following generally are included on treatment teams at your CCBHC? Check all that apply.

☐ Mental health clinicians   ☐ Psychiatrists
☐ Substance use disorder service providers ☐ Primary care physicians
☐ Case managers   ☐ Community support and social service providers
☐ Consumers   ☐ Other: Click here to enter additional provider types.
☐ Families

C.2.b Have the members of your CCBHC's treatment teams changed in the past twelve months? ? ☐ Yes ☐ No
C.2.c. Please describe changes to your CCBHC's treatment teams in the past twelve months: Click here to enter description.

C.3.a Does your CCBHC provide on-site primary care services (in addition to primary care screening and monitoring)? ☐ Yes ☐ No
C.3.b Did your CCBHC provide on-site primary care services (in addition to primary care screening and monitoring) before certification?
☐ Yes ☐ No
C.3.c Is your CCBHC also a federally qualified health center (FQHC)? ☐ Yes ☐ No

C.4.a How does your CCBHC learn of clients' care transitions, such as hospitalizations or discharges? Check all that apply, or select "Does not receive".

C.4.b Receives notification when hospital treats a client for: ☐ Physical health condition ☐ Behavioral health condition ○ Does not receive
C.4.c Receives discharge summary from hospital after a client is treated for: ☐ Physical health condition ☐ Behavioral health condition ○ Does not receive
C.4.d Receives notification when emergency department treats a client for: ☐ Physical health condition ☐ Behavioral health condition ○ Does not receive
C.4.e Receives discharge summary from emergency department after a client is treated for: ☐ Physical health condition ☐ Behavioral health condition
○ Does not receive

C.4.f Receives notification by other means (for example, contacts by consumers or families) about: ☐ Physical health condition ☐ Behavioral health condition ○ Does not receive

C.5.a Has your clinic altered its health information technology (HIT) system or electronic health record (EHR) in the past twelve months?
☐ Yes ☐ No
C.5.b Please describe the HIT or EHR alterations made in the last twelve months: Click here to enter description.

C.6. Which of the following functionalities does your EHR include? Check all that apply and indicate if the functionality is new in the past twelve months.

Contains mental health records	☐ Yes	☐ No	☐ New
Contains substance use disorder records	☐ Yes	☐ No	☐ New
Contains primary care records	☐ Yes	☐ No	☐ New
Contains case management or care coordination records	☐ Yes	☐ No	☐ New
Electronic prescribing	☐ Yes	☐ No	☐ New
Generates electronic care plan	☐ Yes	☐ No	☐ New
Communication with laboratory to request tests or receive results	☐ Yes	☐ No	☐ New
Incorporation of laboratory results into health record	☐ Yes	☐ No	☐ New
Clinical decision support	☐ Yes	☐ No	☐ New
Electronic exchange of clinical information with designated collaborative organizations (DCOs)	☐ Yes	☐ No	☐ New
Electronic exchange of clinical information with other external providers	☐ Yes	☐ No	☐ New
Quality measure reporting capabilities	☐ Yes	☐ No	☐ New

C.7. Does your CCBHC have relationships with any of the following types of external facilities or providers? For each, indicate the type of relationship or that there is no relationship.

	DCO	Formal relationship	Informal relationship	No relationship
C.7.1 Federally qualified health centers	☐	☐	☐	☐
C.7.1 Rural health clinics	☐	☐	☐	☐
C.7.1 Primary care providers	☐	☐	☐	☐
C.7.1 Urgent care centers	☐	☐	☐	☐
C.7.1 Emergency departments	☐	☐	☐	☐
C.7.2 Inpatient psychiatric facilities	☐	☐	☐	☐
C.7.2 Psychiatric residential treatment facilities	☐	☐	☐	☐
C.7.2 Substance use disorder residential treatment facilities	☐	☐	☐	☐

C.7.3 Medical detoxification facilities	☐	☐	☐
C.7.3 Ambulatory detoxification facilities	☐	☐	☐
C.7.3 Post-detoxification step-down facilities	☐	☐	☐
C.7.3 Hospital outpatient clinics	☐	☐	☐
C.7.3 Medication-assisted treatment providers for substance use	☐	☐	☐
C.7.4 Schools	☐	☐	☐
C.7.4 School-based health centers	☐	☐	☐
C.7.4 Child welfare agencies	☐	☐	☐
C.7.4 Therapeutic foster care service agencies	☐	☐	☐
C.7.5 Juvenile justice agencies	☐	☐	☐
C.7.5 Adult criminal justice agencies/courts	☐	☐	☐
C.7.5 Mental health/drug courts	☐	☐	☐
C.7.5 Law enforcement	☐	☐	☐
C.7.6 Indian Health Service or other tribal programs	☐	☐	☐
C.7.6 Indian Health Service youth regional treatment centers	☐	☐	☐
C.7.6 Department of Veterans Affairs treatment facilities	☐	☐	☐
C.7.7 Homeless shelters	☐	☐	☐
C.7.7 Housing agencies	☐	☐	☐
C.7.7 Suicide/crisis hotlines and warmlines	☐	☐	☐
C.7.7 Residential (non-hospital) crisis settings	☐	☐	☐
C.7.8 Employment services and/or supported employment	☐	☐	☐
C.7.8 Older adult services	☐	☐	☐
C.7.8 Other social and human service providers	☐	☐	☐
C.7.8 Consumer operated/peer service provider organizations	☐	☐	☐

C.8. Does your CCBHC use any of the following to facilitate crisis planning?
Psychiatric advance directives ☐ Yes ☐ No
Wellness recovery action plan ☐ Yes ☐ No
Other (please specify what else your CCBHC does to facilitate crisis planning): Click here to list others.

C.9. How are consumer and family preferences for care elicited and documented? Click here to describe.

D. CCBHC scope of services

In this section, we would like to learn about the services your clinic provides, the extent of their availability, and whether your clinic was providing them prior to certification.

D.1. Which of the following services does your CCBHC or designated collaborating organization(s) (DCO(s)) currently provide?
For each serVice, please indicate the following:
a. If the service is provided by your CCBHC or a DCO
b. The time of day/week the service is available. Record the number of months each service was available at your CCBHC or DCO during the past twelve months.
c. If your clinic added this service as a result of CCBHC certification

	Provided by:		Available:				Duration	Added	Does not provide
	CCBHC	DCO	Business hours	Evenings	Weekends	Overnight			
D.1.a. Crisis Behavioral Health Services									
24-hour mobile crisis teams	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Emergency crisis intervention	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Crisis stabilization	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
D.1.b. Screening, Assessment, and Diagnosis									
Mental health screening, assessment, diagnostic services	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Substance use disorder screening, assessment, diagnostic services	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
D.1.c. Person- and Family-Centered Teatment Planning Services	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
D.1.d. Outpatient Mental Health and/or Substance Use Disorder (SUD) Services									
Outpatient mental health counseling	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Outpatient SUD treatment	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Motivational interviewing	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Individual cognitive behavioral therapy (CBT)	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Group CBT	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Online CBT	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Dialectical behavioral therapy	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
First episode/early intervention for psychosis	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Multi-systemic therapy	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Assertive community treatment (ACT)	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐
Forensic ACT	☐	☐	☐	☐	☐	☐	Enter # of months	☐	☐

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Service						# of months	
Evidence-based medication evaluation and management	☐	☐	☐	☐	☐	Enter # of months	☐
Medication-assisted treatment for alcohol and opioid use	☐	☐	☐	☐	☐	Enter # of months	☐
Therapeutic foster care	☐	☐	☐	☐	☐	Enter # of months	☐
Community wraparound services for youth/children	☐	☐	☐	☐	☐	Enter # of months	☐
Specialty mental health/SUD services for children and youth	☐	☐	☐	☐	☐	Enter # of months	☐

D.1.e. Psychiatric Rehabilitation Services

Service						# of months	
Medication education	☐	☐	☐	☐	☐	Enter # of months	☐
Self-management	☐	☐	☐	☐	☐	Enter # of months	☐
Skills training	☐	☐	☐	☐	☐	Enter # of months	☐
Psychoeducation	☐	☐	☐	☐	☐	Enter # of months	☐
Community integration services	☐	☐	☐	☐	☐	Enter # of months	☐
Illness management and recovery	☐	☐	☐	☐	☐	Enter # of months	☐
Financial management	☐	☐	☐	☐	☐	Enter # of months	☐
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	☐	☐	☐	☐	☐	Enter # of months	☐
Supported housing	☐	☐	☐	☐	☐	Enter # of months	☐
Supported employment	☐	☐	☐	☐	☐	Enter # of months	☐
Supported education	☐	☐	☐	☐	☐	Enter # of months	☐

D.1.f. Peer Support Services

Service						# of months	
Peer support services for consumers/clients	☐	☐	☐	☐	☐	Enter # of months	☐
Peer support services for families	☐	☐	☐	☐	☐	Enter # of months	☐

D.1.g. Targeted Case Management ☐ ☐ ☐ ☐ ☐ Enter # of months ☐

D.1.h. Primary Care Screening and Monitoring ☐ ☐ ☐ ☐ ☐ Enter # of months ☐

D.1.i. Intensive Community-Based Mental Health Services for Armed Forces and Veterans ☐ ☐ ☐ ☐ ☐ Enter # of months ☐

Please describe any specific activities or services that are targeted to members of the Armed Forces or Veterans: Click here to enter description.

D.1.j. Other required CCBHC services (please describe):

1. Click here to enter additional service. ☐ ☐ ☐ ☐ ☐ Enter # of months ☐
2. Click here to enter additional service.

3. Click here to enter additional service.	☐	☐	☐	☐	☐	Enter # of months	☐	☐	
	☐	☐	☐	☐	☐	Enter # of months	☐	☐	

D.2. If your CCBHC has made any changes to the scope of services provided in the past twelve months, please briefly explain those changes and why you made them. Click here to enter text.

E. CCBHC quality and other reporting

Questions in this final section will help us understand your clinic's efforts to monitor and improve its quality of care.

E.1. Does your CCBHC collect any of the following information as described in Program Requirement 5 [https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf] of the CCBHC criteria? For each category, please indicate whether this information is stored in an Electronic Health Record (EHR), clinical registry, or other database. If other database, please describe its type. Select all that apply, or select "None".

	EHR	Clinical registry	Other:		None
Staffing	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Consumer characteristics	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Access to services	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Use of CCBHC services	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Screening	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Prevention	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Treatment	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Care coordination	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Other processes of care	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Costs	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None
Consumer outcomes	☐ EHR	☐ Clinical registry	☐ Other:	Click here to describe.	☐ None

E.2. Please list any current Continuous Quality Improvement projects underway and the length of time they have been implemented. Click here to list.

E.3.a In the past 12 months, has your CCBHC used any of the quality measure data collected as part of the demonstration to change clinical practice? ☐ Yes ☐ No
E.3.b Please describe what quality measure(s) your efforts to change clinical practice were based on and the nature of the changes to your clinical practice:
Measure 1: [Describe]; Changes to clinical practice: [Describe]

Measure 2: [Describe]; Changes to clinical practice: [Describe]

Measure 3: [Describe]; Changes to clinical practice: [Describe]

Any other measures: [Describe]; Changes to clinical practice: [Describe]

E.4.a Is your CCBHC accredited? ☐ Yes ☐ No
E.4.b Please describe the type(s) of accreditation/accrediting agency or agencies through which your CCBHC is accredited: Click here to enter description.

Before clicking submit, you have the option to VIEW AND PRINT A COPY OF YOUR COMPLETED PROGRESS REPORT. This printable version will open in a new tab. Please be sure to return to the progress report tab and click "Submit" to complete your report.

F.1. Please use the space below to provide any additional information that you think would help us understand your responses to questions in this progress report. For example, you may wish to tell us if you were unable to answer any questions and why. If you do not have additional information to add, please click next to complete the progress report.

[Text box]

Thank you for your responses to this progress report! To change any of your answers, please click "Back". To complete the progress report, click "Submit"

APPENDIX C. CCBHC DEMONSTRATION EVALUATION STATE OFFICIAL AND CONSUMER/FAMILY REPRESENTATIVE GROUP INTERVIEW GUIDES[22]

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[22] According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0461. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington, D.C. 20201. Attention: PRA Reports Clearance Officer.

Baseline Telephone Interview Protocol State Medicaid Officials

BASELINE TELEPHONE INTERVIEW QUESTIONS- STATE MEDICAID OFFICIALS

During Year 1 of the demonstration (September 2017), telephone interviews will be conducted with officials in state Medicaid offices. The interviews will address implementation of the CCBHC model in the state, addressing specific factors that shape CCBHC policies. They will be tailored based on the information already gathered through applications and other sources—or gaps in that information—regarding participating sites' program characteristics. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general template for baseline telephone interviews is presented below.

A. Introduction

1. Please describe your current role/position.

B. Demonstration planning and administration

1. What were the key areas of focus for the state Medicaid office in the demonstration planning process (for example, prospective payment system [PPS] selection, cost reporting system, clinic certification, and so on)?

   a. What were the critical concerns of the state Medicaid office during the demonstration planning process?

   Probe for the following:

   - Payment/billing for CCBHC services (e.g., what services can be billed, etc.)

   - CCBHC services and program issues (e.g., what constitutes a CCBHC service, what types of providers participate, child/adolescent vs. adult services, crisis services, etc.)

   - Concerns regarding regional differences, rural versus urban settings

   b. How did these concerns influence the state's plans for conducting the demonstration?

   c. What was your experience in collaborating with the state office(s) of mental health and substance abuse services during the CCBHC planning process?

   Probe on the following:

   - How responsibilities/contributions to the CCBHC demonstration planning process were distributed across respective offices/agencies

   - Challenges with respect to collaboration between the state Medicaid agency and office(s) of mental health and substance abuse services

   - What aspects of the collaboration worked well

2. Were clients (including adults with serious mental illness [SMI] and those with long-term and substance use disorders [SUDs]), family members (including of adults with SMI and children with serious emotional disturbances), providers, and other

stakeholders (including American Indian/Alaska Native, and other local and state agencies) involved in developing the demonstration? If so, please describe their role.

   a. What were the critical issues they raised, and how did their input influence your plan to conduct the demonstration?

3. **How was the state Medicaid office involved in certifying clinics as CCBHCs?**

   a. What processes are in place to ensure continued compliance with the certification criteria?

C. Staffing and access to care

1. **Does the state Medicaid agency monitor the staffing criteria for CCBHCs? If so, how?**

   a. Have specific issues arisen?

   b. Did state regulations or policies need to be changed to allow payment for services provided by CCBHC staff?

2. **Did state regulations or policies regarding Medicaid payments need to be altered to accommodate the CCBHC model?**

Probe about the following:

- Same-day billing restrictions
- Payment for designated collaborating organizations (DCOs)
- Any other regulations or policies

3. **What other programs or policies in your state are intended to increase access to behavioral health services? How do they overlap or interact with CCBHCs' services?**

Probe about the following:

- Crisis services
- SUD services, recovery-oriented care
- Centers for Medicare & Medicaid Services (CMS) or health reform demonstrations
- Health homes
- Behavioral health-related waiver or demonstration activity
- Olmstead
- Medicaid expansion
- Affordable Care Act (ACA)

   a. What types of funding sources currently support these efforts (for example, existing grants, county-specific services funded through county taxes, 1115 waivers, general revenue)?

   b. Do efforts/funding vary by region within the state?

   c. How do these efforts interact with CCBHC efforts?

D. Scope of services and coordination of care

1. **Are all services within the CCBHC scope of services reimbursable by Medicaid in your state?**

   a. Which services required by the CCBHC criteria have not historically been reimbursable?

   b. For services required by CCBHC criteria that were reimbursable in the past, how were they reimbursed (for example, block grant, state funding, and so on)?

2. **What provisions does your state make for payment for care coordination?**

   Probe about provisions:
   - In general medical care
   - In behavioral health
   - Targeted to high users of care

   a. How do these compare with coverage for care coordination in CCBHCs?

3. **Are the care coordination services that CCBHCs offer substantially different from those available from other community mental health centers (CMHCs) in your state?**

   a. If different, how are they different? What changes were required to meet the CCBHC standard?

   b. If not different, how are those services paid for in other settings?

4. **Did your state have an assisted outpatient treatment program prior to the CCBHC demonstration?**

5. **How have CCBHCs established care coordination with community or regional supports and providers?**

   Probe about the following:
   - Schools
   - Hospitals (for example, to obtain discharge notifications for inpatient/emergency department [ED] care)
   - Child welfare agencies
   - Juvenile and criminal justice agencies and facilities (including drug, mental health, and veterans and other specialty courts)
   - Active military/U.S. Department of Veterans Affairs (VA) facilities
   - Indian Health Service youth regional treatment centers
   - State licensed and nationally accredited child placing agencies for therapeutic foster care service

- Federally qualified health centers (FQHCs)

- Other social and human services

6. **Does your state have information technology requirements for Medicaid reimbursable providers in general medical or behavioral health care?**

7. **Are the health IT systems required for CCBHCs generally used in CMHCs in your state?**

    a. How do CCBHCs compare with other CMHCs in the use of electronic health registries?

    b. Was the planning grant used to upgrade electronic health registry capabilities?

8. **How are CCBHCs in your state coordinating with hospitals to obtain discharge notifications of inpatient/emergency department visits?**

    a. Are claims data for inpatient/emergency department encounters (discharge information) shared with CCBHCs?

E. Quality of care

1. **How are quality measures data going to be collected during the demonstration?**

    Probe for the following:

    a. CCBHC-reported measures (9 required)

    - New clients—days until initial evaluation/percentage of new clients evaluated within 10 days

    - Preventive care and screening: body mass index (BMI)

    - Preventive care and screening: tobacco

    - Preventive care and screening: alcohol

    - Weight assessment/nutrition counseling; physical activity for child/adolescent

    - Child/adolescent: major depressive disorder (MDD)-suicide risk

    - Adult: MDD-suicide risk

    - Depression screening and follow-up plan

    - Depression remission—12 months

    b. State-reported measures (12 required)

    - Housing status

    - Follow-up after discharge from emergency department for mental health

    - Follow-up after discharge from emergency department for substance use disorder

    - Plan all-cause readmission rate

    - Diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotic meds

    - Adherence to antipsychotic medication for individuals with schizophrenia

- Adult (21+): Follow-up after hospitalization for mental illness
- Child/adolescent: Follow-up after hospitalization for mental illness
- Follow-up for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication
- Antidepressant medication management
- Initiation/engagement of substance use disorder treatment
- Patient/family experience of care (survey measures)

    c. Who is responsible for collecting quality data when care is covered by a managed care organization (MCO) or provided by a DCO?

2. **How are quality measures data going to be used during the demonstration?**

    Probe for the following:

    - Reporting to CCBHC
    - Compliance monitoring
    - Quality bonus payment
    - Public reporting
    - Other benchmarking

3. **How has the state Medicaid office evaluated CCBHCs' capacity to report quality measures?**

    a. Are quality measures a part of the electronic health record (EHR)?

    b. Are there specific populations of interest?

    c. Are the validity or timeliness of the data of concern?

    d. Does the state have other systems in place for monitoring the quality of behavioral health care?

    e. Do you anticipate a need for technical assistance among CCBHCs for reporting to state Medicaid agencies?

4. **How will information on CCBHC quality measures be shared among various state agencies and with CCBHCs, consumers, families, and the public?**

    a. How will CCBHC quality data be shared between clinics, MCOs, state Medicaid offices, and state mental health departments?

5. **Please describe the required quality reporting systems for Medicaid in your state.**

    Probe for the following:

    - HEDIS?
    - Adult and Child Core sets?
    - What are the requirements for mental health?

- What are the requirements for substance abuse treatment?

- How is the information used to contribute to quality improvement?

- What has the state's experience been with reporting in the past?

- Do you anticipate a need for technical assistance to CCBHCs related to quality reporting?

F. Cost and payment

1. **What are current cost reporting requirements for community behavioral health clinics in the state?**

    a. What is the content of current cost reports?

    Probe for the following:

    -Cost of the CCBHC demonstration overall by year

    b. How do these compare with CCBHC cost reports?

    c. If new, what were the challenges in creating cost report templates and cost reporting systems and protocols?

    Probe for the following:

    - Total cost

    - Cost by resource

    - Cost per consumer/provider/encounter

    d. What did the state or clinics learn during this process?

2. **How does the PPS system for CCBHCs differ from existing funding mechanisms for behavioral health care in the state?**

    a. For example, how does the PPS system differ from existing funding mechanisms for CMHCs?

    b. How does the PPS system for CCBHCs differ from existing funding mechanisms for specific types of behavioral health services?

    Probe about the following:

    - Peer support

    - Day treatment/partial hospitalization programs

    - Social services for people with serious mental illness

3. **Are mental health or substance use disorder services covered by a Medicaid PPS-type system in your state (other than the CCBHC)?**

   Probe about the following:

   - Mental health?

   - Substance use disorders?

   a. If yes, how does the CCBHC PPS compare with those systems?

4. **What data sources were used to calculate the CCBHC prospective payment rates?**

   a. How were initial rates calculated for payment stratification by patient severity, outlier payments, and quality bonus payments?

   b. To what extent was the state Medicaid office involved in the rate calculation process (for example, versus clinic and/or managed care entity involvement)?

   c. Were there specific challenges to the rate-setting process?

   - Costing the full scope of services?

   -Incorporating managed care payments?

   -Other challenges?

   g. How were the quality bonus payment systems structured?

5. **How are cost data being collected for rate setting?**

   a. Please describe the cost data reporting requirements for CCBHCs.

   b. Do you anticipate that CCBHCs will need further technical assistance on reporting costs?

   c. How are outliers being defined and identified (PPS-2 only)?

6. **Do you anticipate any issues that may arise regarding payment of DCOs in your state through the CCBHC PPS?**

   a. How do the state and clinics handle billing if a client is receives services from more than one DCO in a single day?

7. **Do you anticipate any issues that may arise with MCOs regarding payment?**

   a. How might these issues vary depending on the type of MCO?

   b. How might issues vary depending on types of services provided?

   c. For patients enrolled with multiple MCOs, how will your state ensure that duplication of MCO services or payments will not occur?

   d. How will MCOs know what amount they are to pay to CCBHCs?

   e. Have actuarial certification letters been revised or will they be revised to show how much of the capitation payment is associated with CCBHC services?

8. Do you anticipate any issues related to claims or PPS payments for dual enrolled (enrolled in both Medicaid and Medicare) populations? What about recipients of 1915(c) Waivers?

G. Data availability

1. **How has your state established reporting requirements for CCBHC encounters?**

    a. How are CCBHC PPS claims reported and identified in claims data?

    b. Is the state encouraging or requiring the use of the modifiers with the designated CCBHC HCPCS codes (T1040 and T1041)?

    c. How are encounters recorded?

    d. Does the state monitor utilization to identify potential unbundling of care; that is, care that should be covered by the PPS but is billed outside of the PPS?

    e. How does the state monitor care provided by DCOs and payments to them?

2. **What data are available to capture current consumer and payer spending across multiple providers and settings?**

3. **What data are available for measuring non-Medicaid or dual enrolled (enrolled in both Medicaid and Medicare) populations?**

4. **What is the timeline for the availability of claims and encounter data?**

5. **What sources are available for comparison data (that is, national surveys)?**

    a. What populations would be good to use for comparison? For example, should we choose other providers or sites of care for comparison, or focus on other types of consumers?

    b. How difficult will it be to identify and measure the comparison populations?

    c. What challenges do you anticipate when we try to compare performance among the states? For example, similar services may be coded differently by different states.

    d. Are historical data available to use as comparison?

    e. Can you provide any good examples of linking multiple data sources to get *current* information?

    f. Can you provide any bad examples of linking data sources to get *current* information?

H. Interviewee feedback/open discussion

1. **What information have we missed? What else do we need to know that we haven't asked you?**

2. **Is there anyone else from the state Medicaid office who should be included in these interviews?**

BASELINE TELEPHONE INTERVIEW QUESTIONS- STATE BEHAVIORAL HEALTH OFFICIALS

During Year 1 of the demonstration (September 2017), telephone interviews will be conducted with officials in state Medicaid offices. The interviews will address implementation of the CCBHC model in the state, addressing specific factors that shape CCBHC policies. They will be tailored based on the information already gathered through applications and other sources—or gaps in that information—regarding participating sites' program characteristics. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general template for baseline telephone interviews is presented below.

A. Introduction

1. **Please describe your current role/position and responsibilities.**

B. Demonstration planning and administration

   -

1. **What were the key areas of focus for the state office(s) of mental health and substance abuse services in the demonstration planning process (e.g., PPS selection, clinic certification, etc.)?**

   a. What were your critical concerns and how did they influence how the state plans to conduct the demonstration?

   Probe for the following:

   - Concerns regarding regional differences, frontier vs. rural vs. urban?

   b. What aspects of the CCBHC requirements were most challenging during the demonstration planning process in your state?

   c. What was the experience of collaborating with the state office of Medicaid like?

   - How were responsibilities/contributions to the CCBHC demonstration planning process distributed?

   - Did you encounter any challenges with respect to collaboration? What aspects of the collaboration worked well?

2. **Were consumers (including adults with serious mental illness [SMI] and those with long term and serious substance use disorders [SUDs]), family members (including of adults with SMI and children with serious emotional disturbances), providers, and other stakeholders (including American Indian/Alaskan Native, and other local and state agencies) involved in developing the demonstration? If so, please describe their role.**

   a. What were the critical issues they raised, and how did their input influence your plan to conduct the demonstration?

3. **Were the state office(s) of mental health and substance abuse services involved in certifying clinics as CCBHCs? Please describe this involvement if so.**

   a. What processes are in place to ensure continued compliance with the certification criteria?

4. **What are the major differences between the way that CCBHCs and non-CCBHC community behavioral health clinics operate in your state?**

   Probe separately for:

   - - Differences between CCBHCs and mental health clinics

   - Differences between CCBHCs and substance use disorder clinics

   a. What types of facilities became CCBHCs in your state (e.g., Federally Qualified Health Centers [FQHCs], community mental health centers, SUD clinics, etc.)?

   b. Did your state have an assisted outpatient treatment program prior to the CCBHC demonstration?

C. Staffing and access to care

1. **What were the primary concerns regarding staffing for CCBHCs in your state when the demonstration was being developed?**

   Probe about the following:

   - Cultural competence for specific populations

   - Workforce limitations

   - Licensing

   - Monitoring staff in

   - designated collaborating organizations (DCOs)

   - Staffing for new services offered at CCBHCs

2. **What are CCBHCs in your state doing to improve access to care?**

   Probe about the following:

   - Expanding hours of service

   - Increasing number of locations for accessing care

   - Outreach efforts (community-based; print advertising; online social networks; etc.) to specific underserved groups, such as children or homeless

   - Telemedicine

   - Internet/text/app based access

   Probe separately for:

- Mental health services
- Substance use disorder services

3. **Have CCBHCs attempted to expand access to other specific types of services?**

   Probe about the following:

   a. Substance use disorder treatment

   b. Services across the lifespan (e.g., child and adolescent; adult; geriatric)

   c. Specific evidence-based practices (EBPs) and evidence-based medications listed in the state demonstration application. For example:

      - Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT)

      - Medications for psychiatric conditions; medication assisted treatment for alcohol and opioid substance use disorders; prescription long-acting injectable medications for both mental and substance use disorders; smoking cessation medications

      - Community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth

4. **What are CCBHCs in your state doing to ensure access to services for consumers regardless of ability to pay?**

   Probe about the following:

   - Duration of efforts to ensure access to services regardless of ability to pay (e.g., Are these programs/policies/procedures new or longstanding?)

   - Provision of services on a sliding scale basis or provision of services regardless of ability to pay

5. **Are CCBHCs in your state conducting any outreach or other activities to ensure access to services for those who live outside a clinic's service area or are experiencing homelessness?**

   Probe about the following:

   - Protocols regarding addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state

6. **In addition to the CCBHC, is your state implementing other delivery system reforms designed to improve access to or quality of mental health or substance use services?**

   Probe about the following:

   - Crisis services

- Substance use disorder services, recovery-oriented care
- CMS or health reform demonstrations
- Health homes
- Behavioral health-related waiver or demonstration activity
- Olmstead
- Medicaid expansion
- Affordable Care Act

a. What types of funding sources currently support these efforts (e.g., existing grants, county-specific services funded through county taxes, 1115 waivers, general revenue)?

b. Do efforts/funding vary by region within the state?

c. How do these efforts interact with CCBHC efforts?

D. Scope of services and coordination of care

1. Are all services within the CCBHC scope of services reimbursable by Medicaid in your state?

a. Which services required by the CCBHC criteria were not historically provided in CMHCs in your state?

b. Prior to the CCBHC demonstration, were any services (i.e., that are now required by CCBHC criteria) that were previously provided to Medicare clients provided through different funding streams? Please describe.

c. Were DCO arrangements important to providing the full scope of services by CCBHCs? If so, which services in particular are being provided by DCOs?

d. What are the barriers that clinics in your state might face in providing the full CCBHC scope of services?

e. Do you anticipate any challenges surrounding care coordination for individuals who are dually eligible/enrolled in both Medicaid and Medicare?

f. Do you anticipate any challenges surrounding care coordination for individuals who recipients of 1915(c) Waivers?

2. Are the care coordination services that CCBHCs offer substantially different from those available from other CMHCs in your state?

a. If different, how are they different? What changes were required to meet the CCBHC standard?

b. If not different, how are those services paid for in other settings?

3. **How have CCBHCs established care coordination with community or regional supports and providers?**

    Probe about:

    - Schools

    - Hospitals (e.g., to obtain discharge notifications for inpatient/emergency department care)

    - Child welfare agencies

    - Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts)

    - Active military/Veterans Affairs facilities

    - Indian Health Service youth regional treatment centers

    - State licensed and nationally accredited child placing agencies for therapeutic foster care service

    - FQHCs

    - Other social and human services

4. Are the health IT systems required for CCBHCs generally used in CMHCs in your state?

    a. How do CCBHCs compare with other CMHCs in use of electronic health records?

    b. Was the planning grant used to upgrade electronic health registry capabilities?

5. **How are CCBHCs in your state coordinating with hospitals to obtain discharge notifications of inpatient/ED visits?**

    a. Are CCBHCs obtaining inpatient/emergency department discharge information from hospitals?

        - If not, why not (e.g., what are the primary barriers)?

    b. Are records obtained electronically? Via fax?

E. Quality of care

1. **How are quality measures data going to be collected during the demonstration?**

    Probe for:

    a. CCBHC reported measures (9 required)

        - New clients – days until initial evaluation/percent of new clients evaluated within 10 days

        - Preventive care and screening: BMI

        - Preventive care and screening: Tobacco

        - Preventive care and screening: Alcohol

- Weight assessment/nutrition counseling; Phys Activity for child/adolescent
- Child/adolescent: MDD-Suicide risk
- Adult: MDD-Suicide risk
- Depression screening and follow-up plan
- Depression remission- 12 months

b. State reported measures (12 required)

- Housing status
- Follow-up after discharge from emergency department for mental health
- Follow-up after discharge from emergency department for substance use disorders
- Plan all-cause readmission rate
- Diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotic meds
- Adherence to antipsychotic medication for individuals with schizophrenia
- Adult (21+): Follow-up after hospitalization for mental illness
- Child/adolescent: Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication
- Antidepressant medication management
- Initiation/engagement of substance use disorder treatment
- Patient/family experience of care (Survey Measures)

c. Who is responsible for collecting quality data when care is covered by an MCO or provided by a DCO?

2. **How will quality measures data be used during the demonstration (e.g., performance monitoring)?**
   a. Reporting to CCBHC?
   b. Compliance monitoring?
   c. Quality bonus payment?
   d. Public reporting?
   e. Other benchmarking?

3. **How will information on CCBHC quality measures be shared among various state agencies, with CCBHCs, consumers, families, and with the public?**
   a. How will CCBHC quality data be shared between clinics, managed care organizations, state Medicaid offices and state mental health departments?
   b. How will this information be used?

4. **Does your state currently require CMHCs or other behavioral health providers to report quality measures?**

   a. If so, which measures?

   b. Which providers?

   c. What is done with the information?

5. **Does your state analyze claims data to help improve the quality of behavioral health care?**

   a. Does the state share claims data with the office(s) of mental health and substance use disorders?

   b. How is the information used?

   c. How does your state collect data on the National Outcomes Measures (NOMs) to meet your block grant reporting obligations?

   d. Does your state share Health Care Effectiveness Data Information Set (HEDIS) and Medicaid core set analyses with your agency?

6. **Does the state office of mental health (OMH) and/or substance use disorders monitor utilization of care in the CCBHCs?**

   a. What are the data sources for the OMH or office for substance use disorders?

   b. Who receives information on the CCBHCs and how do they respond?

   c. Does monitoring for CCBHCs differ from other community behavioral health clinics in the state?

   d. Does the state OMH monitor utilization of care at DCOs?

F. Cost and payment

1. **Does your state have any prior experience with prospective payment systems (PPS)?**

   a. In behavioral health?

   b. How does the CCBHC PPS compare with those systems?

   c. Does your state have dually certified FQHC/CMHCs?

2. **Are there services that were formerly not reimbursed by Medicaid, but are under the CCBHC demonstration? If yes, please describe.**

   Probe for the following:

   -What implications does this have with respect to state reporting, billing, budget, etc.(e.g., additional burden, revisions to previously existing protocols, etc.)?

3. **What are current cost reporting requirements for community behavioral health clinics in your state?**

   a. What is the content of current cost reports?

  b. How do these compare with CCBHC cost reports?

  c. If new, what were the challenges in creating cost report templates, and cost reporting systems and protocols for CCBHCs?

G. Data availability

1. **We would like to compare clients who visit clinics that are similar to CCBHCs, but are not certified, to clients who visit CCBHCs. What information about the clinics and caseload characteristics would you use to choose a comparison group?**

H. Governance

1. **Does your state require national accreditation for CCBHCs?**

  a. What type/agency (e.g., Commission on the Accreditation of Rehabilitation Facilities, Council on Accreditation, or Joint Commission)?

2. **How does your state ensure that CCBHC boards are "reasonably" representative of the communities they serve (e.g., demographically, consumer perspectives, etc.)?**

  a. How does your state ensure that perspectives of behavioral health consumers, families, and communities are represented in CCBHC governance?

  b. What steps are taken to verify representation of consumer/family/community perspectives in CCBHCs?

I. Interviewee feedback/open discussion

1. **What have we missed? What else do we need to know that we haven't asked you?**

2. **Is there anyone else from the state office(s) of mental health and substance abuse services who should be included in these interviews?**

Demonstration Midpoint Telephone Interview Protocol
State Medicaid Officials

Demonstration midpoint telephone Interview questions - state medicaid officials

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In spring of 2018, follow-up telephone interviews will be conducted with state behavioral health officials to obtain feedback regarding CCBHC implementation in their state. Telephone interviews will address specific factors that shape CCBHC policies and implementation, and will focus on changes in key CCBHC implementation domains since the first (year 1) interview. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for demonstration midpoint telephone interviews is presented below.

A. Introduction

1. **Please describe your current role/position and responsibilities.**

B. Implementation successes and barriers

1. **How is CCBHC demonstration implementation going in your state?**

   a. What kind of feedback have you received from other stakeholders since [insert month and year of the first interview] (e.g., since the first year of the demonstration)?

   b. What are the key successes that the demonstration has had?

   - What factors have played a role in demonstration successes?

   c. What problems or barriers has the demonstration in your state faced since [insert month and year of the first interview]?

   - Were these barriers anticipated or unexpected?

   - What steps have been taken to address or resolve these problems? Have these actions been effective?

   - How could these problems be avoided or managed in the future?

C. Demonstration administration

1. **In our first interview we heard that the state Medicaid office was involved in monitoring compliance of CCBHCs with the certification criteria by [provide description from baseline interview]. Has this changed since [insert month and year of the first interview]?**

   a. Have any challenges arisen for CCBHCs in maintaining certification or continuing to meet all of the certification criteria?

   - If yes, what steps have been taken to address these issues?

2. **How have consumers (including adults with serious mental illness [SMI] and those with long term and serious substance use disorders), family members (including of adults with SMI and children with serious emotional disturbances), providers, and**

other stakeholders (including American Indian/Native Alaskans, and other local and state agencies) been involved in ongoing demonstration administration?

a. What critical issues have they raised?

b. How has their input influenced the demonstration in your state?

D. Staffing and access to care

1. **Have there been any changes with respect to how the state Medicaid agency monitors the staffing criteria for the CCBHCs?**

a. Have particular issues come up?

b. Did state regulations or policies need to be changed to allow payment for services provided by CCBHC staff?

2. **Since [insert month and year of the first interview], did regulations or policies regarding Medicaid payments need to be altered to accommodate the CCBHC model? Please describe.**

Probe about:

- Same day billing restrictions

- Payment for Designated Collaborating Organizations (DCOs)

- Payment/billing for CCBHC services (e.g., what services can be billed, which types of providers can bill for CCBHC services, child/adolescent vs. adult services, etc.)

- Payment for crisis services

- Any other regulations or policies

E. Scope of services and coordination of care

1. **What are some barriers that clinics in your state have faced in providing the full CCBHC scope of services since [insert month and year of the baseline interview]?**

2. **Since [insert month and year of the baseline interview], have there been any changes to provisions that your state makes for payment for care coordination? If yes, what changes?**

Probe about changes:

- In general medical care

- In behavioral health

- Targeted to high users of care

a. How do the changes to these provisions compare with coverage for care coordination in CCBHCs?

3. **In our first interview we heard that your state [does/does not] have IT requirements for Medicaid reimbursable providers in general medical or behavioral health care. Have there been any changes to these requirements? If yes, what changes?**

F. Quality of care

1. **How have quality measures data been collected during the demonstration?**

    Probe for the following:

    a. CCBHC reported measures (9 required)

        -   New clients – days until initial evaluation/percent of new clients evaluated within 10 days

        -   Preventive care and screening: BMI

        -   Preventive care and screening: Tobacco

        -   Preventive care and screening: Alcohol

        -   Weight assessment/nutrition counseling; Phys Activity for child/adolescent

        -   Child/adolescent: Major depressive disorder (MDD)-Suicide risk

        -   Adult: MDD-Suicide risk

        -   Depression screening and follow-up plan

        -   Depression remission- 12 months

    b. State reported measures (12 required)

        -   Housing status

        -   Follow-up after discharge from emergency department for mental health

        -   Follow-up after discharge from emergency department for substance use disorders

        -   Plan all-cause readmission rate

        -   Diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotic meds

        -   Adherence to antipsychotic medication for individuals with schizophrenia

        -   Adult (21+): Follow-up after hospitalization for mental illness

        -   Child/adolescent: Follow-up after hospitalization for mental illness

        -   Follow-up for children prescribed ADHD medication

        -   Antidepressant medication management

        -   Initiation/engagement of substance use disorder treatment

        -   Patient/family experience of care (Survey Measures)

    c. Who is responsible for collecting quality data when care is covered by an MCO or provided by a DCO?

2. **How have these data been used?**

   a. Reporting to CCBHC?

   b. Compliance monitoring?

   c. Quality bonus payment?

   d. Public reporting?

   e. Other benchmarking?

3. **How is quality of care information being used to improve clinical performance?**

   a. Have any issues arisen with respect to collecting quality measures?

4. **How has the state Medicaid office evaluated CCBHCs' ability to report quality measures?**

   a. Are there particular populations of interest?

   b. Are there concerns about the validity or timeliness of the data?

   c. Does the state have any other systems for monitoring the quality of behavioral health care?

5. **Since [insert month and year of the baseline interview], how has information on CCBHC quality measures been shared among various state agencies, with CCBHCs and with the public?**

   a. Probe on changes from proposed approach for sharing CCBHC quality data between clinics, managed care organizations, state Medicaid offices and state mental health departments [provide description from baseline interview].

6. **In our first interview we heard that there [are/are not] required quality reporting systems for Medicaid in your state. Have these requirements changed since [insert month and year of the baseline interview]? If yes, how?**

   a. What are the requirements?

   b. In behavioral health?

   c. What has been done with the information to contribute to quality improvement?

7. **How has the state Medicaid office collected, reported, and used CCBHC information on service utilization?**

   a. How does the state Medicaid office identify that a claim is coming from a CCBHC (e.g., have new codes been created to identify CCBHCs)?

   b. How are CCBHC encounter records (or procedure codes) specified and processed (i.e., as opposed to claims for PPS)?

   c. How will CCBHCs use data to inform population health management?

G. Cost and payment

1. **In our first interview we heard that cost reporting requirements for community behavioral health clinics in your state include [provide description from baseline interview]. Have any requirements changed since [insert month and year of the baseline interview]? If yes, how?**

   a. What is the content of current cost reports?

   b. How do these **compare with CCBHC** cost reports?

2. **Have there been any changes to funding mechanisms for behavioral health care in your state since [insert month and year of the baseline interview]? If yes, how?**

   a. In what ways do these differ from the PPS system for CCBHCs?

      - For example, how does the PPS system differ from existing funding mechanisms for CMHCs?

      - How does the PPS system for CCBHCs differ from existing funding mechanisms for specific types of behavioral health services?

      Probe about:

         - Peer support

         - Day treatment/partial hospitalization programs

         - Social services for people with serious mental illness

3. **In our first interview we heard that the process used for setting and revising payment rates for CCBHCs [provide description from baseline interview]. Has this process changed in any way since [insert month and year of the baseline interview]? If yes, how?**

   [If not answered above]

   a. What data sources were used to derive initial rates?

   b. How are rates being calculated for payment stratification of by patient severity, outlier payments and quality bonus payments?

4. **We heard that cost data are being collected and used for rate setting by [provide description based on baseline interview]. Has this changed since our last discussion? If yes, how?**

   a. Are data being collected to update rates? Rebalance payments?

   b. How are cost data being used for rate revisions?

   c. How are outliers being defined and identified?

5. **Have you encountered any issues regarding payment with Managed Care Organizations (MCOs)? If yes, please describe.**

   Probe for specific issues depending upon:

   - Type of MCO
   - Types of services provided
   - Patients enrolled with multiple MCOs
   - Duplication of MCO services or payments
   - Confusion regarding how MCOs determine what amount they are to pay to CCBHCs
   - Actuarial certification letters
   - Amount of capitation payment associated with CCBHC services

6. **Have CCBHCs encountered any issues regarding payment of DCOs in your state through the CCBHC prospective payment system? Please describe.**

   a. If yes, what steps have been taken to address/resolve these issues?

   b. How do the state and clinics handle billing if a client is receives services from more than one DCO in a single day?

7. Have there been any challenges related to claims or PPS payments for dual enrolled (enrolled in both Medicaid and Medicare) populations? What about recipients of 1915(c) waiver services?

   a. If yes, what steps have been taken to address/resolve these issues?

8. **Have CCBHC costs been consistent with your expectations? Please describe.**

H. Data availability

1. **We heard in our first interview that your state [had/had not] established reporting requirements for CCBHC encounters. Have reporting requirements changed since [insert month and year of the baseline interview]? If yes, how?**

   a. How are CCBHC PPS claims reported and identified in claims data?

   b. How are encounters recorded?

   c. Does the state monitor utilization to identify potential unbundling of care, i.e. care that should be covered by the PPS that is billed outside of the PPS?

   d. How does the state monitor care provided by DCOs and payments to DCOs?

2. What data are available to capture current consumer and payer spending across multiple providers and settings? Has this changed since [insert month and year of the baseline interview]? If yes, how?

3. What data are available for measuring non-Medicaid or dual enrolled (enrolled in both Medicaid and Medicare) populations? Has this changed since [insert month and year of the baseline interview]? If yes, how?

4. What is the current timeline for availability of claims and encounter data?

5. Have you identified any new sources of comparison data since [insert month and year of the baseline interview]?

I. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Is there anyone else from the state office(s) of Medicaid who should be included in these interviews?

Demonstration Midpoint Telephone Interview Protocol State Behavioral Health Officials

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Demonstration midpoint telephone Interview questions - state BEHAVIORAL HEALTH officials

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In spring of 2018, follow-up telephone interviews will be conducted with state behavioral health officials to obtain feedback regarding CCBHC implementation in their state. Telephone interviews will address specific factors that shape CCBHC policies and implementation, and will focus on changes in key CCBHC implementation domains since the first (year 1) interview. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for demonstration midpoint telephone interviews is presented below.

A. Introduction

1. **Please describe your current role/position and responsibilities.**

B. Implementation successes and barriers

1. **Have there been any changes to the way that non-CCBHC community behavioral health clinics are administered in your state since [insert month and year of baseline interview]? In our first interview we heard that non-CCBHC community behavioral health clinics in your state … (*tailor summary of characteristics or examples based on responses provided in baseline interview*). If yes, how?**

    a. What are the major differences between the way that CCBHCs are administered compared with how non-CCBHC community behavioral health clinics are currently administered in your state?

2. **How is the CCBHC demonstration process going in your state? Has anything changed since [insert month and year of baseline interview] (i.e., baseline telephone interview)?**

    a. What kind of feedback have you received from CCBHCs since [insert month and year of baseline interview] (e.g., since the first year of the demonstration)?

    b. What are some of the key successes that CCBHCs have had?

    c. What factors have played a role in CCBHC successes?

    d. What problems or barriers have CCBHCs in your state faced since [insert month and year of baseline interview]? Were these barriers anticipated or unexpected?

    e. What steps have been taken to address or resolve these problems? Have these actions been effective?

    f. How could these problems be avoided or managed by other CCBHCs in the future?

C. Demonstration administration

1. **How are the state office(s) of mental health and substance abuse services involved in monitoring compliance of CCBHCs with the certification criteria?**

    Probe separately for:

    - Mental health clinics

- Substance use disorder clinics

   a. Has this changed since [insert month and year of baseline interview]?

   b. Have any challenges arisen for CCBHCs in maintaining certification or continuing to meet all of the certification criteria?

2. **How have consumers (including adults with serious mental illness [SMI] and those with long term and serious substance use disorders), family members (including of adults with SMI and children with serious emotional disturbances), providers, and other stakeholders (including American Indian/Native Alaskans, and other local and state agencies) been involved in ongoing demonstration implementation?**

   a. What were the critical issues they raised?

   b. How did their input influence the demonstration implementation?

D. Staffing and access to care

1. **Since [insert month and year of baseline interview], have there been any changes regarding staffing concerns of the CCBHCs in your state?**

   Probe about the following:

   - Cultural competence for specific populations
   - Workforce limitations
   - Licensing
   - Monitoring staff in
   - designated collaborating organizations (DCOs)
   -
   - Staffing for new services offered at CCBHCs

2. **Since [insert month and year of baseline interview], what have CCBHCs in your state done to improve access to care?**

   Probe about the following:

   - Expanding hours of service
   - Increasing number of locations for accessing care
   - Outreach efforts (community-based; print advertising; online social networks; etc.) to specific underserved groups, such as children or homeless
   - Telemedicine
   - Internet/text/app based access

   Probe separately for:

   - Mental health services
   - Substance use disorder services

3. **Have CCBHCs attempted to expand access to other specific types of services?**

   Probe about the following:

   a. Substance use disorder treatment

   b. Services across the lifespan (e.g., child and adolescent; adult; geriatric)

   c. Specific EBPs and evidence-based medications listed in the state demonstration application. For example:

      - Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT)

      - Medications for psychiatric conditions; medication assisted treatment for alcohol and opioid substance use disorders; prescription long-acting injectable medications for both mental and substance use disorders; smoking cessation medications

      - Community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth

4. **What did CCBHCs in your state do to ensure access to services for consumers regardless of ability to pay?**

   Probe about the following:

      - Duration of efforts to ensure access to services regardless of ability to pay (e.g., Are these programs/policies/procedures new or longstanding?)

      - Provision of services on a sliding scale basis or provision of services regardless of ability to pay

5. **Are CCBHCs in your state conducting any outreach or other activities to ensure access to services for those who live outside a clinic's service area or are experiencing homelessness?**

   Probe about the following:

      - Protocols regarding addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state

6. **In addition to the CCBHC, is your state implementing other delivery system reforms designed to improve access to or quality of mental health or substance use disorder services?**

   Probe about the following:

      - Crisis services

      - Substance use disorder services, recovery-oriented care

      - CMS or health reform demonstrations

- Health homes
- Behavioral health-related waiver or demonstration activity
- Olmstead
- Medicaid expansion
- ACA

a. What types of funding sources currently support these efforts (e.g., existing grants, county-specific services funded through county taxes, 1115 waivers, general revenue)?

b. Do efforts/funding vary by region within the state?

c. How do these efforts interact with CCBHC efforts?

E. Scope of services and coordination of care

1. **What are some barriers that clinics in your state have faced in providing the full CCBHC scope of services since [insert month and year of baseline interview]?**

2. **In our first interview, we heard that all services within the CCBHC scope of services [are/are not] reimbursable by Medicaid in your state. Have there been any changes since [insert month and year of baseline interview]? If yes, what changes?**

   a. Which services required by the CCBHC criteria were not historically provided in community behavioral health clinics in your state?

   b. Have DCO arrangements been important to providing the full scope of services by CCBHCs? If so, which services in particular are being provided by DCOs?

   c. What are the barriers that clinics in your state might face in providing the full CCBHC scope of services?

   d. Have CCBHCs experienced any challenges surrounding care coordination for individuals who are dually eligible/enrolled in both Medicaid and Medicare?

   e. Have CCBHCs experienced any challenges surrounding care coordination for individuals who recipients of 1915(c) Waivers?

3. **In our first interview, we heard that the care coordination services in the CCBHCs [are/are not] substantially different from what is available in other non-CCBHC community behavioral health clinics in your state. Has this changed since [insert month and year of baseline interview]? If yes, how?**

   a. If different, how are they different? What changes were required to meet the CCBHC standard?

   b. If not different, how are those services paid for in other settings?

4. **In our first interview, we heard that CCBHCs established care coordination with community or regional supports and providers by [provide description from baseline**

interview]. Have there been any changes in these care coordination efforts since [insert month and year of baseline interview]? If yes, what changes?

Probe about the following:

- Schools

- Hospitals (e.g., to obtain discharge notifications for inpatient/ED care)

- Child welfare agencies

- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts)

- Active military/VA facilities

- Indian Health Service youth regional treatment centers

- State licensed and nationally accredited child placing agencies for therapeutic foster care service

- FQHCs

- Other social and human services

5. **Have there been any changes to health IT systems requirements or utilization of IT systems by non-CCBHC community behavioral health clinics since [insert month and year of baseline interview]? If yes, what changes? How do CCBHCs compare with non-CCBHC community behavioral health clinics in use of electronic health records?**

   a. Has demonstration funding been used to upgrade electronic health record capabilities?

F. Quality of care

1. **How have quality measures data been collected during the demonstration?**

   a. Are quality measures data being collected according to plan? Have there been any changes to plans for collecting quality measures data?

   Probe for:

   a. CCBHC reported measures (9 required)

   - New clients – days until initial evaluation/percent of new clients evaluated within 10 days
   - Preventive care and screening: BMI
   - Preventive care and screening: Tobacco
   - Preventive care and screening: Alcohol
   - Weight assessment/nutrition counseling; Phys Activity for child/adolescent
   - Child/adolescent: MDD-Suicide risk
   - Adult: MDD-Suicide risk
   - Depression screening and follow-up plan
   - Depression remission- 12 months

   b. State reported measures (12 required)

   - Housing status
   - Follow-up after discharge from ED for mental health
   - Follow-up after discharge from ED for substance use disorders
   - Plan all-cause readmission rate
   - Diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotic meds
   - Adherence to antipsychotic medication for individuals with schizophrenia
   - Adult (21+): Follow-up after hospitalization for mental illness
   - Child/adolescent: Follow-up after hospitalization for mental illness
   - Follow-up for children prescribed ADHD medication
   - Antidepressant medication management

- Initiation/engagement of substance use disorder treatment
- Patient/family experience of care (Survey Measures)

c. Who is responsible for collecting quality data when care is covered by an MCO or provided by a DCO?

Probe for:

-Have there been any changes in this arrangement (i.e., who is responsible for collecting this quality data) since the beginning of the demonstration?

-How is this process working so far? Any challenges or barriers to collecting quality data when care is covered by an MCO or provided by a DCO?

2. **How has your state used CCBHC information on quality of care in the last year?**
   a. Reporting to CCBHC?
   b. Compliance monitoring?
   c. Quality bonus payment?
   d. Public reporting?
   e. Other benchmarking?

3. **Since [insert month and year of baseline interview], how has information on CCBHC quality measures been shared among various state agencies, with CCBHCs and with the public?**
   a. How has CCBHC quality data been shared between clinics, managed care organizations, state Medicaid offices and state mental health departments?

4. **In our first interview, we heard that your state [does/does not] require CMHCs or other behavioral health providers to report quality measures. Has this changed? If yes, how?**
   Probe about changes in:
   - Which measures
   - Which providers
   - What is done with the information

5. **In our first interview, we heard that your state [does/does not] analyze claims data to help improve the quality of behavioral health care. Has this changed?**
   a. If so, how?
   b. Which measures are monitored?
   c. How is the information used?

d. How does your state collect data on the National Outcomes Measures (NOMs) to meet your block grant reporting obligations?

6. **In our first interview, we heard that the state office of mental health [monitors/does not monitor] utilization of care in the CCBHCs. Has this changed since [insert month and year of baseline interview]?**

a. What are the data sources for the Office of Mental Health (OMH)?

b. Who receives information on the CCBHCs and how do they respond?

c. Does monitoring for CCBHCs differ from other community behavioral health clinics in the state?

d. Does the state OMH monitor utilization of care at DCOs?

7. **How has your state used CCBHC information on utilization?**

G. Cost and payment

1. **Since [insert month and year of baseline interview], have you received any feedback from CCBHCs regarding use of the prospective payment system? Please describe.**

a. How burdensome has the PPS been for CCBHCs in your state?

b. Have CCBHCs encountered any issues regarding use of the PPS (e.g., payment of DCOs)?

c. If yes, what steps have been taken to address/resolve these issues? Please describe.

2. **Since [insert month and year of baseline interview], have CCBHC costs been consistent with your expectations? Please describe.**

a. How do costs compare with those under the previous payment system?

b. How do costs vary across CCBHCs? Is the PPS appropriate/fair for different CCBHCs in your state?

H. Data availability

1. **In our first interview, we heard [provide description of NOMs data collection from baseline interview]. Has this changed since [insert month and year of baseline interview]? If yes, how?**

2. **Have you identified any new sources of comparison data since [insert month and year of baseline interview]?**

I. Governance

1. **Have there been any changes to state requirements surrounding accreditation for CCBHCs?**

a. If yes, what type/agency (e.g., CARF, COA, TJC) is required?

b. Have CCBHCs encountered any issues with accreditation?

2. **Have there been any changes to the process for ensuring that CCBHC boards are "reasonably" representative of the communities they serve (e.g., demographically, consumer perspectives, etc.)?**

   Probe for the following:

   a. Perspectives of behavioral health consumers, families, and communities are represented in CCBHC governance?

   b. Representation of consumer/family/community perspectives in CCBHCs?

J. Interviewee feedback/open discussion

1. **What have we missed? What else do we need to know that we haven't asked you?**

2. **Is there anyone else from the state office(s) of mental health and substance abuse services who should be included in these interviews?**

3. **Is there anyone else from the state office(s) of Medicaid who should be included in these interviews?**

Demonstration End Telephone Interview Protocol State Officials

DEMONSTRATION END TELEPHONE INTERVIEW QUESTIONS - STATE OFFICIALS

In the spring of 2019, follow-up telephone interviews will be conducted with state behavioral health officials to obtain feedback regarding CCBHC implementation in their state. Telephone interviews will address specific factors that shape CCBHC policies and implementation, and will focus on changes in key CCBHC implementation domains since the second (demonstration midpoint) interview. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for demonstration end telephone interviews is presented below.

A. Introduction

1. Please describe your **current role/position and responsibilities**.

B. Implementation successes and barriers

1. Overall, how do you think the CCBHC demonstration implementation went in your state?

   Probe for:

   -Differences in implementation across CCBHCs within the state (e.g., urban vs. rural, type of clinic prior to CCBHC certification, populations served, etc.)

   a. How did your experience compare with your expectations for the demonstration?

   b. What kind of feedback have you received from CCBHCs since [insert month and year of the midpoint interview]?

   c. What are some of the key successes the demonstration has had?

      - What factors have played a role in demonstration successes?

   d. What problems or barriers have CCBHCs in your state faced since [insert month and year of the midpoint interview]?

      - Were these barriers anticipated or unexpected?

   e. What steps have been taken to address or resolve these problems?

      - Have these actions been effective?

C. Demonstration administration

1. In previous interviews we heard that the state Medicaid office has been involved in monitoring compliance of CCBHCs with the certification criteria by [provide description from baseline and midpoint interviews]. Has this changed?

   a. Have any challenges arisen for CCBHCs in maintaining certification or continuing to meet all of the certification criteria?

      - If yes, what steps have been taken to address these issues?

2. How have consumers (including adults with serious mental illness [SMI] and those with long term and serious substance use disorders), family members (including of adults with SMI and children with serious emotional disturbances), providers, and other stakeholders

(including American Indian/Native Alaskans, and other local and state agencies) been involved in ongoing demonstration implementation?

    a.   What critical issues have they raised?

    b.   How has their input influenced the demonstration in your state?

D. Staffing and access to care

1.   Since [insert month and year of the midpoint interview], were there any changes with respect to how the state Medicaid agency monitored the staffing criteria for the CCBHCs?

    a.   Were there particular issues that arose?

    b.   Were there any regulations that needed to be changed to allow payment for CCBHCs?

2.   Since [insert month and year of the midpoint interview], did regulations or policies regarding Medicaid payments need to be altered to accommodate the CCBHC model?

    Probe about:

       -   Same day billing restrictions

       -   Payment for designated collaborating organizations (DCOs)

       -   Any other regulations/policies

E. Scope of services and coordination of care

1.   What are some barriers that clinics in your state have faced in providing the full CCBHC scope of services over the course of the demonstration? Have any new barriers or issues come to light since [insert month and year of the midpoint interview]?

2.   Since [insert month and year of the midpoint interview], have there been any changes to provisions that your state makes for payment for care coordination? If yes, what changes?

    Probe about changes:

       -   In general medical care

       -   In behavioral health

       -   Targeted to high users of care

    a.   How do the changes to these provisions compare with coverage for care coordination in CCBHCs?

3.   In [insert month and year of the midpoint interview] we heard that your state [does/does not] have IT requirements for Medicaid reimbursable providers in general medical or behavioral health care. Have there been any changes to these requirements? If yes, what changes?

F. Quality of care

1.   How were quality measures data collected during the demonstration?

    Probe for the following:

    a.   CCBHC reported measures (9 required)

- New clients – days until initial evaluation/percent of new clients evaluated within 10 days
- Preventive care and screening: BMI
- Preventive care and screening: Tobacco
- Preventive care and screening: Alcohol
- Weight assessment/nutrition counseling; Phys Activity for child/adolescent
- Child/adolescent: MDD-Suicide risk
- Adult: MDD-Suicide risk
- Depression screening and follow-up plan
- Depression remission- 12 months

b. State reported measures (12 required)

- Housing status
- Follow-up after discharge from emergency department for mental health
- Follow-up after discharge from emergency department for substance use disorders
- Plan all-cause readmission rate
- Diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotic meds
- Adherence to antipsychotic medication for individuals with schizophrenia
- Adult (21+): Follow-up after hospitalization for mental illness
- Child/adolescent: Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication
- Antidepressant medication management
- Initiation/engagement of substance use disorder treatment
- Patient/family experience of care (Survey Measures)

c. Who is responsible for collecting quality data when care is covered by an MCO or provided by a Designated Collaborating Organization (DCO)?

2. How was this data used?

a. Reporting to CCBHC?

b. Compliance monitoring?

c. Quality bonus payment?

d. Public reporting?

e. Other benchmarking?

3. How was quality of care information being used to improve clinical performance?

    a. Did any issues arise with respect to collecting quality measures?

4. How did the state Medicaid office evaluate CCBHCs' capacity to report quality measures with acceptable validity and reliability, in adherence to the agency's expectations?

    a. Were there particular populations of interest?

    b. Were there concerns about the validity or timeliness of the data?

    c. Did the state utilize any other systems for monitoring the quality of behavioral health care?

5. Since [insert month and year of the midpoint interview], how has information on CCBHC quality measures been shared among various state agencies, with CCBHCs and with the public?

    a. How has CCBHC quality data been shared between clinics, managed care organizations, state Medicaid offices and state mental health departments?

6. In [insert month and year of the midpoint interview] we heard that there [are/are not] required quality reporting systems for Medicaid in your state. Have these requirements changed? If yes, how?

    a. What are the requirements?

    b. In behavioral health?

    c. What has been done with the information to contribute to quality improvement?

7. How has the state Medicaid office collected, reported, and used CCBHC information on service utilization?

    a. How does the state Medicaid office identify that a claim is coming from a CCBHC (e.g., have new codes been created to identify CCBHCs)?

    b. How are CCBHC encounter records (or procedure codes) specified and processed (i.e., as opposed to claims for PPS)?

    c. How will CCBHCs use data to inform population health management?

G. Cost and payment

1. In [insert month and year of the midpoint interview] we heard that cost reporting requirements for community behavioral health clinics in your state include [provide description from baseline and midpoint interview]. Have any requirements changed? If yes, how?

    a. What is the content of current cost reports?

    Probe for the following:

    -   Total cost (e.g., per quarter, per year)
    -   Cost by resource

- Cost per consumer/provider/encounter

b. How do these compare with CCBHC cost reports?

c. Did CCBHCs encounter any difficulties with respect to cost reporting? Please describe.

d. Who is responsible for collecting/reporting cost data when care is covered by an MCO or provided by a DCO?

2. Have there been any changes to funding mechanisms for behavioral health care in your state since [insert month and year of the midpoint interview]? If yes, how?

   a. In what ways do these differ from the PPS for CCBHCs? For example, how does the PPS differ from existing funding mechanisms for CMHCs?

   b. How does the PPS for CCBHCs differ from existing funding mechanisms for specific types of behavioral health services?

   Probe about:

   - Peer support

   - Day treatment/partial hospitalization programs

   - Social services for people with serious mental illness

3. In [insert month and year of the midpoint interview] we heard that the process used for setting and revising payment rates for CCBHCs [provide description from baseline and midpoint interview]. Has this process changed in any way? If yes, how?

   [If not answered above]

   a. What data sources were used to derive initial rates?

   b. How are rates being calculated for payment stratification of by patient severity, outlier payments and quality bonus payments?

4. We heard that cost data are being collected and used for rate setting by [provide description based on baseline and midpoint interview]. Has this changed since [insert month and year of the midpoint interview]? If yes, how?

   a. Are data being collected to update rates? Rebalance payments?

   b. How are cost data being used for rate revisions?

   c. How are outliers being defined and identified?

5. Have you encountered any issues regarding payment with Managed Care Organizations (MCOs)? If yes, please describe.

   Probe for specific issues depending upon:

   - Type of MCO

- Types of services provided
- Patients enrolled with multiple MCOs
- Duplication of MCO services or payments
- Confusion regarding how MCOs determine what amount they are to pay to CCBHCs
- Actuarial certification letters
- Amount of capitation payment associated with CCBHC services

6. Have CCBHCs encountered any issues regarding payment of DCOs in your state through the CCBHC prospective payment system? Please describe.

   a. If yes, what steps have been taken to address/resolve these issues?

   b. How do the state and clinics handle billing if a client is receives services from more than one DCO in a single day?

7. Have there been any challenges related to claims or PPS payments for dual enrolled (enrolled in both Medicaid and Medicare) populations? What about recipients of 1915(c) Waivers?

   a. If yes, what steps were taken to address/resolve these issues?

8. Have CCBHC costs been consistent with your expectations? Please describe.

9. Did CCBHC costs change in your state change from the first to the second year of the demonstration? How?

   a. Were changed expected or unexpected?

   b. What factors do you think contributed to changes?

H. Data availability

1. Have reporting requirements for CCBHC encounters changed since [insert month and year of the midpoint interview]? If yes, how?

   [Assess for any changes to the following:]

   a. How are CCBHC PPS claims reported and identified in claims data?

   b. How are encounters recorded?

   c. Does the state monitor utilization to identify potential unbundling of care, i.e. care that should be covered by the PPS that is billed outside of the PPS?

   d. How does the state monitor care provided by DCOs and payments to DCOs?

2. What data are available to capture current consumer and payer spending across multiple providers and settings? Has this changed since [insert month and year of the midpoint interview]? If yes, how?

3. What data are available for measuring non-Medicaid or dual enrolled (enrolled in both Medicaid and Medicare) populations? Has this changed since [insert month and year of the midpoint interview]? If yes, how?

4. What is the current timeline for availability of claims and encounter data?

5. Have you identified any new sources of comparison data since our last discussion?

I. Sustainment

1. What are your plans regarding sustaining any aspects of the CCBHCs after the demonstration ends?

    a. What barriers or challenges might affect CCBHC sustainability?

    b. How might those barriers/challenges be overcome?

    c. What factors might facilitate sustainability?

J. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Is there anyone else from the state office(s) of mental health and substance abuse services who should be included in these interviews?

3. Is there anyone else from the state office(s) of Medicaid who should be included in these interviews?

Demonstration End Telephone Interview Protocol Consumer and Family Representative Groups

DEMONSTRATION END TELEPHONE INTERVIEW QUESTIONS – CONSUMER AND FAMILY REPRESENTATIVES

In the spring of 2019, telephone interviews will be conducted with representatives of identified patient and family advocacy groups involved with state CCBHC implementation to obtain feedback regarding CCBHC implementation in their state. Telephone interviews will emphasize consumer perspectives that may be relevant to the CCBHC demonstration, and will focus on the role and experiences of consumers and families in demonstration implementation. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for baseline telephone interviews is presented below.

A. Introduction

1. Please describe your **current role/position and responsibilities**.

B. Implementation successes and barriers

1. How were consumers [*tailor description of consumers to the relevant population of representative's organization …* including adults with serious mental illness (SMI) and those with substance use disorders] and family members involved in developing the demonstration?

   a. What were the critical issues they raised, and how did their input influence how the demonstration was conducted?

C. Demonstration administration

1. What other programs or policies are in place in your state that are intended to help improve or expand consumer access to behavioral health services? Do existing programs currently meet the needs of consumers? How?

   Probe about the following:

   - Programs/policies specific to adult mental health services

   - Programs/policies specific to child mental health services

   - Programs/policies specific to substance use disorder treatment

   a. How do these efforts interact with CCBHC efforts?

2. Overall, how do you think the CCBHC demonstration went in your state? Have you heard any feedback from consumers regarding CCBHCs?

   a. What kind of feedback have you received from consumers?

   b. What are some of the key benefits that CCBHCs have had for consumers?

   c. What problems or challenges have consumers faced regarding accessing care through CCBHCs? Were these barriers anticipated or unexpected?

   d. How could these problems be avoided or addressed in the future?

   e. What were consumer and family perceptions of CCBHC implementation successes and barriers?

Probe separately for:

- Consumers of mental health services
- Individuals in recovery from substance use disorders

D. Staffing and access to care

1. What are some of the main concerns or issues regarding different types of behavioral health care services in your state for consumers? What types of concerns/issues have consumers shared with you?

Probe separately for:

- Consumers of mental health services

- Individuals in recovery from substance use disorders

2. Are the following types of services readily available to consumers in your state?

Probe about the following:

- Mental health counseling
- Crisis care
- Substance use disorder treatment
- Medication management
- Physical health care
- Armed services/veteran specialty care
- Culturally competent care for specific populations
- Peer and family support
- Case management
- Psychiatric rehabilitation
- Community supports
- Inpatient care
- Evidence-based practices

3. How has the introduction of CCBHCs in your state affected consumers' ability to access to behavioral health services?

Probe about the following:

- Mental health counseling
- Crisis care
- Substance use disorder treatment
- Medication management
- Physical health care
- Armed services/veteran specialty care
- Culturally competent care for specific populations
- Peer and family support
- Case management
- Psychiatric rehabilitation
- Community supports
- Inpatient care
- Evidence-based practices

  o Probe separately for specific populations:
    - Dual eligible/enrolled (Medicare/Medicaid)
    - Recipients of 1915(c) Waivers

a. Have CCBHCs filled any gaps or addressed any needs regarding consumer access to behavioral health care that were not addressed by existing programs or policies in your state?

Probe for:

-Specific feedback from consumers

Probe separately for:

- Consumers of mental health services
- Individuals in recovery from substance use disorders

b. Have CCBHCs in your state affected use of emergency services (e.g., ED visits, ambulance calls for mental health crises, 911 calls, etc.)?

Probe for:

- Specific feedback from consumers

- Changes in law enforcement/police response to mental health crises

c. Have CCBHCs in your state reduced wait times for consumers?

Probe for:

-Specific feedback from consumers

Probe separately for:

- Consumers of mental health services
- Individuals in recovery from substance use disorders

d. Have CCBHCs in your state provided same-day services?

Probe for:

-Specific feedback from consumers

Probe separately for:

- Consumers of mental health services
- Individuals in recovery from substance use disorders

e. Did you observe the CCBHCs doing any of the following?
- Expanding hours of service?
- Increasing number of locations for accessing care?
- Outreach efforts (community-based; print advertising; online social networks; etc.) to specific underserved groups, such as children or homeless?
- Offering telemedicine?
- Internet/text/app based access?
- Making services more available and affordable to people with low income, uninsured, or with private insurance?
- Making services available to anyone, regardless of where they live?
- Were other specific types of services expanded?

E. Scope of services and coordination of care

1. Do consumers served by CCBHCs use a broader range of services than other behavioral health consumers in your state? In what way/how do types of services differ for these consumer groups?

   Probe separately for:

   - Consumers of mental health services

   - Individuals in recovery from substance use disorders

   Probe about the following:

   - Mental health counseling
   - Crisis care
   -
   - Substance use disorder treatment
   - Medication management
   - Physical health care
   - Armed services/veteran specialty care
   - Culturally competent care for specific populations
   - Peer and family support
   - Case management
   - Psychiatric rehabilitation
   - Community supports (e.g., transportation, housing, etc.)
   - Inpatient care
   - Evidence-based practices (e.g., wraparound services for children, supported employment, etc.)

2. Did your state have an assisted outpatient treatment program prior to the CCBHC demonstration?

   a. What has been the role of the CCBHCs in providing or expanding the availability of assisted outpatient treatment?

   b. How do consumers feel about that? Have you received any specific feedback from consumers?

   Probe separately for:

   - Consumers of mental health services
   - Individuals in recovery from substance use disorders

F. Quality of care

1. Have you observed or heard from other consumers about any differences in the quality of care provided by CCBHCs compared to other mental health centers or before the demonstration?

    Probe separately for:

    - Consumers of mental health services

    - Individuals in recovery from substance use disorders

2. Have any state agencies or CCBHCs shared information with consumers or the public about the quality measures they collect for CCBHCs?

    a. If so, how and for what purpose?

       Probe separately for:

       -

       - Consumers of mental health services

       - Individuals in recovery from substance use disorders

G. Benefits and challenges of CCBHCs for consumers

1. What other feedback have you received from consumers (or individuals in recovery [substance use]) regarding the introduction of CCBHCs in your state? Please describe.

    a. What were the benefits of CCBHCs as reported by consumers in your state? What aspects of CCBHCs do consumers like?

    b. Have consumers reported any problems or barriers with respect to accessing care through CCBHCs?

    c. How do you think these challenges could be addressed in the future to maximally benefit consumers?

    Probe separately for:

    - Consumers of mental health services

    - Individuals in recovery from substance use disorders

H. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Is there anyone else (i.e., representatives of behavioral health consumers/individuals in recovery and families) who should be included in these interviews?

APPENDIX D. CCBHC DEMONSTRATION EVALUATION SITE VISIT INTERVIEW GUIDES[23]

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[23] According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0461. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington, D.C. 20201. Attention: PRA Reports Clearance Officer.

CCHBC Demonstration Evaluation Site Visit Interview Guide: CCBHC Leadership

SITE VISIT INTERVIEW QUESTIONS- CCBHC LEADERSHIP

On-site interviews will be conducted with program leadership, providers, and administrative staff from CCBHC demonstration sites in 4 states. The interviews will address specific factors that shape CCBHC policies, and will be tailored based on the information already gathered through applications and other sources—or gaps in that information—regarding participating sites' program characteristics. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for site visit interviews with CCBHC leadership is presented below.

A. Introduction

1. We would like to learn about your current role/position.

   a. For how long have you held this position?

   b. What are your key responsibilities in the CCBHC?

   c. If you were at this agency prior to CCBHC certification, how has your role changed with CCBHC certification?

B. CCBHC characteristics

1. Please describe your organization [questions will be tailored to reflect information gathered from demonstration applications and other sources]:

   a. What type of organization is your CCBHC? (e.g., non-profit, local government, Indian Health Service, etc.)?

   Probe for:

   -Prior to CCBHC certification, was your clinic a Federally Qualified Health Center? Provider-based clinic owned by a hospital? Other? [If other, describe.]

   b. Is your organization part of a larger health-care system or regional network?

   - If yes, how does larger system influence CCBHC policies?

   c. What location/geographic region(s) does your CCBHC serve?

   - Urban/rural/highly rural/frontier and remote [note: categories refer to federal definitions]?

   d. How many unique clients does your organization serve (e.g., per year)?

   e. Please describe your client demographics

   - Percent of clients under age 18? Over age 65?

   - Percent of clients experiencing homelessness?

   f. Please describe your client population (e.g., case mix; common problems/types of diagnoses; co-occurring disorders).

   - Percent of clients with serious mental illness or serious emotional disturbance? Adults vs. children (<18 years)?

   - Percent of clients with substance use disorder? Adults vs. children (<18 years)?

- Percent of clients who are armed service members or veterans? Adults vs. children (<18 years)?
- Percent of clients who are dually eligible or enrolled (Medicare/Medicaid)?

g. Please describe your CCBHC's facility (e.g., size and space, number of locations)

h. Please describe the socio-demographics of the area/community where the CCBHC is located

2. What are the major differences between the way that CCBHCs are administered and the way non-CCBHC community behavioral health clinics (e.g., CMHCs) are administered in your state?

3. What are some things that make your CCBHC unique or different from other behavioral health organizations in your area?

a. What is unique about your client population (e.g., healthcare needs, barriers to care, types of diagnoses, demographics, etc.)?

b. Are there any unique programs, services, or other resources that are geared specifically toward the types of clients that you serve?

C. Staffing

1. Please describe the structure of your CCBHC management team.

a. Does the team include a designated CCBHC CEO/Executive Director/Project Director? Psychiatrist as Medical Director?

b. How many non-clinical and clinical staff are part of your management team?

2. Does the staff composition of your CCBHC include the following?

Probe about:

- Providers with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED)

- Providers with expertise in addressing trauma and promoting recovery in adults with serious mental illness

- Providers with credentialed substance abuse specialists promoting recovery in individuals with substance use disorders

- Medically trained behavioral health provider able to prescribe and manage medication

3. Please describe the number and types of clinical services providers (defined as staff who interact directly with clients in a clinical capacity) employed by the CCBHC.

a. What is the full time equivalent (FTE) distribution for CCBHC clinical service providers in the following disciplines? We'll discuss them one by one.

  – Psychiatrist
  – Psychiatric nurse
  – Child psychiatrist
  – Adolescent psychiatrist
  – Substance abuse specialist

- Case manager
- Recovery coach
- Peer specialist
- Family support specialist
- Licensed clinical social worker
- Licensed mental health counselor
- Mental health professional (trained and credentialed for psychological testing, such as licensed psychologists)
- Licensed marriage and family therapist
- Occupational therapist
- Interpreters or linguistic counselor
- General practice (performing CCBHC services)
- Other staff (such as pharmacy staff, medical assistants, community health workers, etc.)s

   b. How many active staff (non-clinical are employed by the CCBHC?

   c. How many clinical service providers are available to serve CCBHC clients through a designated collaborating organization (DCO)?

4. What type of cultural competencies do you seek in CCBHC service providers in order to work with your clients?

   a. Do staff receive cultural competency training to ensure that they can meet the needs of the client population? If yes, please describe:

   b. Are staff monitored to ensure they are providing culturally competent services?

D. Services

1. What services do CCBHC staff provide? Are each of these services available to all CCBHC clients or only to subgroups of CCBHC clients? We'll discuss them one by one.

   a. Services: [If yes, who are they available to?]

- ☐ Outpatient mental health services
- ☐ Outpatient substance use disorder services
- ☐ Assisted Outpatient Treatment
- ☐ Management of psychoactive drugs
- ☐ Medication assisted treatment
- ☐ Crisis planning services. If yes, who are they available to?
- ☐ Screening/assessment/diagnostic services. If yes, who are they available to?
- ☐ Crisis services/Urgent care
- ☐ Treatment planning services
- ☐ Psychiatric rehabilitation services
- ☐ Peer support services for clients
- ☐ Support services for families
- ☐ Targeted case management
- ☐ Primary health screening and monitoring
- ☐ Armed forces and veteran's services

☐ Other (specify)

b. Evidence-based behavioral health practices
   - ☐ Motivational Interviewing
   - ☐ Cognitive Behavioral individual, group, and on-line therapies (CBT)
   - ☐ Dialectical Behavioral Therapy (DBT)
   - ☐ Addiction technologies
   - ☐ Recovery supports
   - ☐ First episode early intervention for psychosis
   - ☐ Multi-systemic therapy
   - ☐ Assertive Community Treatment (ACT)
   - ☐ Forensic Assertive Community Treatment (F-ACT)
   - ☐ Medication evaluation and management
   - ☐ Community wrap-around services for youth
   - ☐ Specialty clinical interventions to treat youth
   - ☐ Other (describe)

2. Has your CCBHC adopted any new evidence-based practices since CCBHC certification? Please describe.

   a. Have you held/sponsored any new trainings in evidence-based practices (EBPs) for providers? Please describe.

3. Please describe client flow in your CCBHC. What happens when a new client accesses services for the first time?

   Probe about when the following occur and what staff are involved:

   - Initial evaluation
   - How do new clients access other CCBHC services when initial presentation was through crisis services?
   - Person and family-centered evaluation and treatment planning
   - Clinician assignment
   - Ongoing treatment planning

4. The next set of questions are about screening for physical and behavioral health conditions. By screening, we mean the use of specific tools to assess or monitor physical or behavioral health conditions and symptoms. For each type of condition, we'd like to know who receives screenings and when, what tools you use, and what happens if an individual screens positive.

   a. Are clients who receive care at your CCBHC screened for physical health conditions? (By screening, we mean the use of specific tools used to assess/monitor physical health symptoms.)

   - What conditions are clients screened for?
   - Which clients receive screenings?

- When are initial screenings provided?

- What screening tools do you use, and for which clients?

- What happens when someone screens positive for a physical health problem, such as hypertension?

    b. Are clients who receive care at your CCBHC screened for mental health conditions? (By screening, we mean specific tools used to assess/monitor mental health symptoms.)

- Which clients receive screenings?

- When are initial screenings provided?

- What screening tools do you use, and for which clients?

- What happens when someone screens positive for a mental health condition, such as depression?

    c. Are clients who receive care at your CCBHC screened for substance use? (By screening, we mean specific tools used to assess/monitor substance use.)

- Which clients receive screenings?

- When are initial screenings provided?

- What screening tools do you use, and for which clients?

- What happens when someone screens positive for substance use, such as opioid use?

5. Is repeat screening for CCBHC clients conducted at regular intervals? If so, what screenings and how often?

E. Program structure

1. Does your CCBHC have a Designated Collaborating Organization (DCO) or multiple DCOs?

    a. Please list DCO(s)

    b. Are relationships with DCO(s) new (since CCBHC certification), pre-existing informal, or pre-existing formal (i.e., prior contractual agreement with DCO)?

    c. For each DCO, does the CCBHC-DCO service agreement include the following?

- Guidelines on how rapidly clients will be seen

- Policies detailing communication (i.e. sharing of clinical information about clients in a timely fashion)

- Sharing of the clinical records for DCO visits

- Policies detailing coordination (e.g., scheduling CCBHC and DCO visits on the same day, which group is responsible for providing certain services, etc.)

- Policies detailing payment mechanism to DCO(s)

- Specific instructions on the proper procedure for scheduling a primary care consult

    d. Are DCOs part of a larger health-care system or regional network? If yes, how does larger system influence CCBHC policies?

    e. Please describe the DCO's facilities.

2. Describe the services that your DCO(s) provide(s) for CCBHC clients, and reasons why they are provided by a DCO rather than provided in CCBHC.

    a. If multiple DCOs, which DCOs provide which services?

    b. Staff: Who provides what services?

    c. Services: Are regular visits scheduled?

3. What has been challenging or successful about these relationships with DCOs?

4. Please describe the relationship between the CCBHC and DCO(s) (if applicable):

    a. What is the distance between CCBHC and DCO(s)?

    b. How do clients get from one location to another?

       - Does the program CCBHC assist with transportation between locations [note: transportation of clinic users is not an allowed cost under the CCBHC demonstration]?

    c. How is information shared between CCBHC and DCO?

    d. How many clients have been referred to DCO? How are they identified?

    e. How does CCBHC monitor quality of care at DCO?

5. Does your CCBHC have arrangements with other organizations that are *not* formally designated as DCOs? If yes, please describe:

Probe about:

    - Types of services provided

    - Description of any formal service agreements. Would it be possible for us to obtain a copy of the agreement(s)?

    - If not previously mentioned, probe about coordination with hospitals regarding client discharge notifications.

F. Care coordination

1. How is client care coordinated (i.e., designated care manager, case manager, care coordinator; direct communication between providers)?

Probe for:

-Challenges regarding care coordination?

-Challenges regarding care coordination for dual eligible patients? Patients who are recipients of 1915(c) Waivers

2. What types of staff are involved in care management for CCBHC clients?

3. What types of staff are involved in person- and family-centered planning?

4. What is done to manage CCBHC clients' medications across different prescribers?

   a. Does the program keep up-to-date lists of clients' current medications?

5. Are CCBHC clients expected to select a personal primary care physician (e.g., for primary health screening and monitoring)? If yes, please describe:

   a. Is their choice documented?

   b. Does the program monitor the percentage of client visits with a specific clinician or team?

   c. How are physical health conditions monitored at CCBHC?

6. What is the average CCBHC client caseload for full-time care managers and other providers?

G. Referral practices

1. Please describe the process for referrals to external healthcare services:

   a. What is the process for referring clients to services at a DCO (if applicable)?

   b. What is the process for receiving referrals to the CCBHC (e.g., from crisis center, hospital, etc.)?

   c. How are referrals to external services (e.g., specialists) managed? Are Care Managers involved, or other staff?

   d. How are referrals tracked, with follow-up? [e.g., paper or electronically, sharing clinical information, tracking status of referrals, following up to obtain specialist reports] How often?

   e. Which staff are responsible for follow-up with referrals?

2. Please describe your CCBHC's standard discharge procedures and continuity of care processes. What exchanges of information regarding discharges do you initiate or receive?

3. Please describe the process for referrals to *non-healthcare* community or social services.

   a. How are client's non-healthcare needs (e.g., housing authority, transportation, child care, legal etc.) managed, and by whom?

   b. How often are clients linked to community resources? Are these referrals tracked?

   c. What kinds of partnerships does your organization have with community organizations? How does the integrated care team interface with other organizations in the community?

H. Data sharing

1. Please describe your CCBHC's use of electronic health records.

   a. Does your CCBHC use an electronic health record (EHR)?

   b. Did your CCBHC use an EHR prior to certification?

c. Are electronic records shared between mental health and primary care providers? What information is shared and how?

d. Who uses records (mental health providers, primary care providers, care managers, consumers)?

e. Describe the flow of information in the record system. Who collects what data, and when? Who enters data? Who checks data? Who is responsible for sharing data (e.g., with DCOs)?

Probe specifically for:

-Sharing of cost/billing data

f. Are electronic records shared between CCBHC and DCO providers?

- Describe the process for sharing data between CCBHCs and DCOs.

g. Does the EHR have a clinical registry function or tool included in EHR that is utilized?

If yes:

- What types of information does the embedded registry function/tool include?

- Describe the flow of information for the registry. Who collects what data, and when? Who enters data? Who checks data?

- Who uses the registry, and for what purpose?

- How often is the registry checked for accuracy and by whom?

If no:

Does the CCBHC have a standalone clinical registry—a system for tracking client information—used for documenting CCBHC clients' physical health and/or mental health conditions? If so:

- Is the registry electronic or paper?

- What types of information are included?

- Describe the flow of information for the registry. Who collects what data, and when? Who enters data? Who checks data?

- Who uses the registry, and for what purpose?

- How often is the registry checked for accuracy and by whom?

2. What information and/or services are available to CCBHC clients through a secure electronic system? (e.g., health information, clinical visit summaries, 2-way communication with the practice, emails to notify clients about needs.) Does the CCBHC have an interactive website or patient portal to support CCBHC client access?

3. Does your CCBHC have a system to track and follow-up on lab test or imaging orders?

a. If yes, is the system paper or electronic? Please describe.

b. Does the system have a documented process for notifying CCBHC clients of normal and abnormal results?

c. Does the system have a documented process to flag and follow-up on results that are overdue to be shared with a client?

I. **Accessibility**

1. What hours/days are various services available for clients <u>at your CCBHC</u>, in person? We'll discuss them one by one.

   ☐ Outpatient mental health services
   ☐ Outpatient substance use disorder services
   ☐ Assisted Outpatient Treatment
   ☐ Management of psychoactive drugs
   ☐ Medication assisted treatment
   ☐ Crisis planning services
   ☐ Screening/assessment/diagnostic services
   ☐ Crisis services/Urgent care
   ☐ Treatment planning services
   ☐ Psychiatric rehab
   ☐ Peer support services for clients
   ☐ Support services for families
   ☐ Targeted case management
   ☐ Primary health screening and monitoring
   ☐ Armed forces and veteran's services
   ☐ Other (specify)

2. Can appointments for mental health and primary care visits (if applicable) be made during the same call, or scheduled for the same day?

   a. What is the approximate time between an appointment request and the appointment/ receipt of services?

   b. Are services available on a walk-in basis? If yes, what types of services?

   c. Are there waiting lists for services or visits?

   d. How are appointments made and coordinated with DCOs?

3. What services (e.g., mental health / primary care advice, community or social supports) are available to clients by phone or electronically? During what hours?

   a. If clinical advice is provided by phone or electronically, does the program have relevant written policies, defined standards, and performance monitoring about the timeliness of this advice?

4. What happens if clients seek routine or urgent-care mental health or primary care appointments outside regular business hours (e.g., weekends / evenings)?

   a. If after-hours care is available at a site other than an emergency room, does the CCBHC have written policies, defined standards, and performance monitoring about after-hours access?

   b. Is medical record information for care and advice after hours integrated with business hours records [or systematically shared with daytime staff]?

   c. Is there a 24-hour hotline available for CCBHC clients?

5. How accessible is the clinic by public transportation?

    a. Do you offer support to clients in accessing clinic, such as shuttle service, Medicaid cab?

6. Are you carrying out any outreach activities to reach clients who are not engaged in services?

    a. What kinds of outreach (e.g., developing relationships with community organizations, advertising, etc.)?

    b. Specific target population(s)?

7. Are any Internet, text messaging, or mobile device applications being used to reach clients or improve clients' access to the CCBHC?

Probe for:

-Telehealth services

-Care delivery via computer contact

-Off-site interpreter and translation services

J. Quality and other reporting

1. How do you monitor the performance of your CCBHC? [Open-ended, then prompt with the following:]

    a. What sources of data do you use?

    b. How are quality measures calculated and reported?

    c. Do you track CCBHC clients' utilization information related to health care costs? (e.g., emergency room visits, hospital admissions, generic vs. prescription medications)?

    d. Do you solicit and/or receive feedback from CCBHC clients about their experiences with the program and care? In what format?

    e. Do you use any of the data you collect for the CCBHC in any additional ways? How? And how often? (e.g., quarterly, bi-annual or annual presentations to the team?)

2. Are the required quality measures appropriate for measuring and improving the quality of your CCBHC/quality of the care that your CCBHC provides?

    a. Why or why not?

    b. Does your CCBHC collect and use additional performances measures?

    c. Are you able to calculate the quality measures for the entire CCBHC population? If so, have you experienced any difficulties?

3. How do you ensure person-centered care in the CCBHC?

    a. How is person-centered care monitored?

    b. What data sources does your CCBHC use to assess person-centered care? How is this data used (e.g., for continuous quality improvement)?

4. How does your CCBHC share data on quality measures with other parties (e.g., state agencies, other clinics, public)?

5. How are staff qualifications for contracted providers or providers at DCOs who have contact with CCBHC clients assessed and monitored?

   a. How is information on quality of care used to improve performance?

6. Does your CCBHC have a quality improvement plan in place? If yes, please describe.

   a. Do clinicians receive feedback on care for individual consumers?

   b. Is information on quality used in care team meetings?

   c. Do quality measures inform changes in clinic policies?

   d. Can you provide us with a copy of the written quality improvement plan?

K. CCBHC implementation successes and barriers

1. How has your organization changed since CCBHC implementation?

   a. What have been your CCBHC implementation successes to date?

2. What barriers have you faced in implementing the steps for CCBHC certification? (If necessary, prompt with: types of barriers may include problems hiring qualified staff, coordinating mental health and DCO leadership, billing/financing issues, collecting outcome data, and lack of client interest in the program.) What strategies have you used to overcome them?

3. What aspects of becoming a CCBHC or maintaining certification is your CCBHC still working toward?

   a. What plans do you have for maintenance and sustainability of the program?

   b. What policies have driven the way that you provide and sustain CCBHC services and processes (e.g., services offered, collaboration with DCOs, etc.)? These could include federal, state, local or agency-level policies.

4. How is your CCBHC paying for CCBHC client care?

   a. What payment system is used at your CCBHC?

   b. How have Medicaid reimbursement levels changed?

   Probe for:

   -Prior to CCBHC demonstration, was payment under a prospective payment system or fee-for-service?

5. How is the payment system working for your clinic?

   a. Have you encountered any difficulties with the following?

      - Cost reports?

         (1) Difficult to produce or update?

         (2) Personnel to complete them?

      - Setting rates?

      - Coordination with managed care?

   b. How accurate or fair do you think the PPS rates are for your clinic?

   c. Have you received any feedback from staff or clients?

   d. What steps have been taken to address these issues?

   e. How does the clinic handle billing if a client receives services from more than one DCO in a single day?

   f. If PPS2: How are the various components of the rate mechanism working at your clinic (i.e., stratification of rates by patient severity, outlier payments and quality bonus payments)?

L. Governance

1. Is your CCBHC accredited?

   a. What type/agency (e.g., Commission on the Accreditation of Rehabilitation Facilities, Council on Accreditation, or Joint Commission)?

   b. Were you encouraged or required to seek accreditation by your state as part of CCBHC certification?

2. Please describe the composition/membership of your CCBHC board.

   a. What factors determined the composition of the board? How are board members selected?

   Probe for:

   - If the clinic is dually certified as a Federally Qualified Health Center (FQHC) and CCBHC, do the same board members serve for both lines of business?

   b. How engaged/active are board members in decision-making for the CCBHC? What kinds of input do board members provide?

   c. For how long do board members serve? Is turnover/retention a problem?

   d. What challenges have you encountered in selecting and retaining board members?

3. How do you ensure that your CCBHC board is "reasonably" representative of the communities that your clinic serves (e.g., demographically, patient/consumer perspectives, etc.)?

   a. How do you ensure that perspectives of behavioral health consumers, families, and communities are represented in your CCBHC governance?

   b. Has this requirement posed any challenges for your CCBHC?

M. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Is there anyone else in CCBHC leadership who should be included in these interviews?

CCHBC Demonstration Evaluation Site Visit Interview Guide: CCBHC Providers

SITE VISIT INTERVIEW QUESTIONS- CCBHC PROVIDERS

On-site interviews will be conducted with program leadership, providers, and administrative staff from CCBHC demonstration sites in 4 states. The interviews will address specific factors that shape CCBHC policies, and will be tailored based on the information already gathered through applications and other sources—or gaps in that information—regarding participating sites' program characteristics. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for site visit interviews with CCBHC providers is presented below.

A. Introduction

1. Please describe your current role/position.

    a. For how long have you held this position?

    b. [For CCBHC staff] What are your key responsibilities in the CCBHC?

    c. [For CCBHC staff] If you were at this agency prior to CCBHC certification, how has your role changed with CCBHC certification?

B. Changes associated with CCBHC certification

1. In what ways has your clinic changed since CCBHC certification? How has care in the clinic changed since it became a CCBHC?

    a. How is your work at the CCBHC different now (e.g., services you provide, certifications or training requirements, documentation practices, etc.) relative to before CCBHC certification?

    b. Compared to other community behavioral health clinics (e.g., CMHCs) in which you have worked?

C. Scope of services

1. What services do you provide? Let's talk about them one by one.

    a. Services:

        ☐ Outpatient mental health services
        ☐ Outpatient substance use disorder services
        ☐ Assisted Outpatient Treatment
        ☐ Management of psychoactive drugs
        ☐ Medication assisted treatment
        ☐ Crisis planning services
        ☐ Screening/assessment/diagnostic services
        ☐ Crisis services/Urgent care
        ☐ Treatment planning services
        ☐ Psychiatric rehabilitation services
        ☐ Peer support services for clients
        ☐ Support services for families
        ☐ Targeted case management

   ☐ Primary health screening and monitoring
   ☐ Armed forces and veteran's services
   ☐ Other (specify)

Probe for:

−How are these services provided (e.g., in-person, phone, telehealth, etc.)

 b. Evidence-based behavioral health practices
   ☐ Motivational Interviewing
   ☐ Cognitive Behavioral individual, group, and on-line therapies (CBT)
   ☐ Dialectical Behavioral Therapy (DBT)
   ☐ Addiction technologies
   ☐ Recovery supports
   ☐ First episode early intervention for psychosis
   ☐ Multi-systemic therapy
   ☐ Assertive Community Treatment (ACT)
   ☐ Forensic Assertive Community Treatment (F-ACT)
   ☐ Medication evaluation and management
   ☐ Community wrap-around services for youth
   ☐ Specialty clinical interventions to treat youth
   ☐ Other (describe)

2. Please describe the types of clients that you serve (e.g., demographic characteristics, diagnoses, languages, etc.).

 Probe for:

 -What are the ages of the clients you serve?

 -Do you specialize in treating certain client populations?

3. Do you screen clients for physical health conditions? For mental health conditions? For substance use disorders? [By screening, we mean specific tools used to assess/monitor symptoms or behaviors.]

 a. Which clients receive screenings?

 b. When are initial screenings provided?

 c. What screening tools do you use, and for which clients? [Evaluate whether screening tools are standardized and validated for the client population.]

 d. When someone screens positive, how do you go about connecting them with treatment or support?

 e. Do you conduct follow-up screenings at regular intervals? If so, what screenings and how often?

D. Care coordination

1. Who in the clinic do you work with on a regular basis to coordinate care for your clients (e.g., care manager, other providers, etc.)?

    a. Describe the care planning process.

    - Who is responsible for overseeing/updating care plans?

2. What is done to manage CCBHC clients' medications across prescribers?

    a. Does the program keep up-to-date lists of clients' current medications?

3. What is your role, if any, in connecting CCBHC clients with a personal primary care physician (e.g., for primary health screening and monitoring)?

    a. How is their primary care physician choice documented?

    b. How do you know if a client visits with a specific clinician or team and receives care for physcial health conditions?

    c. How do you know if a client visits the emergency department for physical health problems?

E. Referral practices

1. When you refer a patient to see another clinician in the CCBHC, how do you know whether the patient actually saw that clinician?

    a. What if the clinician is at a designated collaborating organization (DCO)?

    b. What if the clinician is at an unaffiliated community provider?

    c. Are there any systems that you use to track these referrals?

    d. How do you know if your client accessed crisis services or was admitted to a hospital?

F. Data sharing

1. Please describe your CCBHC's use of an electronic health record (EHR)?

    a. Does your CCBHC use and EHR?

    b. Is it new or was it in place prior to becoming a CCBHC (e.g., as part of CCBHC certification)?

    c. Other than for simply recording patient information, what do you use the EHR for?

    - Referral tracking?

    - Checking medical information from other mental health providers? DCO providers?

    - Checking medical information from primary care or other general medical providers?

    d. Are there limitations to the medical information you can access through the clinic EHR?

    e. How do you access medical information that is not available in the EHR?

2. Does your CCBHC have a system to track and follow-up on lab test or imaging orders?

    a. If yes, please describe.

     b. Does the system have a documented process for notifying CCBHC clients of normal and abnormal results?

     c. Does the system have a documented process to flag and follow-up on results that are overdue to be shared with a client?

G. Accessibility

1. Are resources now available to you to offer your clients that were not available before your organization became a CCBHC? Please describe.

     a. How have you discussed these with your clients?

2. Are you carrying out any outreach activities to reach clients who are not engaged in services?

     a. What kinds of outreach (e.g., developing relationships with community organizations, advertising, etc.)?

     b. Specific target population(s)?

H. Quality and other reporting

1. Have paperwork or other reporting requirements changed since the clinic became a CCBHC? How has this affected your work?

2. Are you involved with any quality measurement activities going on in the clinic?

     a. What kind of activities?

     b. Are you required to report any information related to quality of care?

     c. Do you participate in any quality improvement projects within the clinic?

     d. Do you receive information from clinic administration on the quality of care provided by the clinic as a whole? By you personally?

3. Do you receive feedback about your own performance or productivity? How about for CCBHC -specific measures? If yes, please describe feedback and how it's used.

4. Do you receive information about the performance or productivity of the CCBHC program? If yes, describe feedback and how it's used.

I. CCBHC benefits and challenges

1. What do you think has been the best part or greatest benefits of working in a CCBHC?

2. What do you think have been the most challenging parts of working in a CCBHC?

     a. Is there anything you would like to change/anything that could be improved? How?

J. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Are there any other providers (e.g., individuals who have an integral role in the CCBHC) who should be included in these interviews?

CCHBC Demonstration Evaluation Site Visit Interview Guide: CCBHC Care Managers

SITE VISIT INTERVIEW QUESTIONS- CCBHC CARE MANAGERS

On-site interviews will be conducted with program leadership, providers, and administrative staff from CCBHC demonstration sites in 4 states. The interviews will address specific factors that shape CCBHC policies, and will be tailored based on the information already gathered through applications and other sources—or gaps in that information—regarding participating sites' program characteristics. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for site visit interviews with CCBHC care managers is presented below.

A. Introduction

1. Please describe your current role/position.

   a. For how long have you held this position?

   b. [For CCBHC staff] What are your key responsibilities in the CCBHC?

   c. [For CCBHC staff] If you were at this agency prior to CCBHC certification, how has your role changed with CCBHC certification?

2. What are the most important ways that your work in the CCBHC differs from your prior work in this site before certification or in other places you've worked with this population?

B. Care coordination

1. How is client care coordinated (i.e., designated care manager, case manager, care coordinator; direct communication between providers)?

   a. Describe the process for care planning?

      - Who is responsible for updating the treatment plan and when?

2. What types of staff are involved in care management for CCBHC clients (i.e., the interdisciplinary treatment team for directing, coordinating, and managing care)?

3. How many clients do you typically manage at any given time?

   a. What is the average caseload of CCBHC clients for full-time care managers, or the CCBHC staff who manage care coordination?

4. Please describe the process for linking patients to external healthcare services.

   a. Describe the process for referring clients to services at a designated collaborating organization (DCO), if applicable?

      - For each DCO, probe on whether the relationship with DCO is new since CCBHC certification or pre-existing, and if a pre-existing relationship, how has the process for referring changed since certification.

   b. How are referrals to external services (e.g., specialists) managed?

    c. How are referrals tracked, with follow-up? [e.g., paper or electronically, sharing clinical information, tracking status of referrals, following up to obtain specialist reports] How often?

    d. Which staff are responsible for follow-up with referrals?

    e. Describe the process for exchange of information regarding discharges from external healthcare entities?

       - Are there discharge planning procedures?

       - If yes, please describe discharge planning procedures and reasons for them.

    f. What is the process for exchange of information regarding crisis services provided via a DCO, outside entity, or state-sanctioned crisis service system?

5. Please describe the process for linking patients to other community/social services.

    a. How are client's non-healthcare needs (e.g., housing authority, transportation, child care, legal, peer support, etc.) managed, and by whom?

    b. How often are clients linked to community resources? Are these referrals tracked?

    c. Is the referral process new or was it in place prior to CCBHC certification?

       - How has the processed changed since CCBHC certification, if at all?

    d. What kinds of partnerships do you have with community organizations? How does the CCBHC interdisciplinary treatment team interface with other organizations in the community?

6. Which providers do you work with most closely within the CCBHC?

    a. How do you share information with those providers?

    b. Do you have regularly scheduled meetings with those providers?

7. Which providers do you work with most closely in the community?

    a. DCOs?

    b. Primary care providers?

    c. Social services providers?

    d. Other community providers?

    e. If any, what are the differences between working with DCOs and working with other providers?

8. Has becoming a CCBHC affected how you interact with those providers?

9. Are electronic health records used by your CCBHC?

    a. Do you have full access to electronic health record (EHR) information on your patients in the CCBHC?

b. Are EHR information and/or services available to CCBHC clients through a secure electronic system? (e.g., health information, clinical visit summaries, 2-way communication with the practice, emails to notify clients about needs.)

c. Do you have an interactive website to support CCBHC client access?

d. Does the EHR have a clinical registry function or tool to track patients with certain conditions?

C. Accessibility

1. Has the range of services that you can provide your clients changed under the CCBHC model?

2. What hours/days are care coordination services available to clients?

   a. Over the phone?

   b. In person?

   c. Electronically?

3. What hours/days are various services available for clients <u>at your CCBHC</u>, in person? Let's talk about them one-by-one.

   ☐ Outpatient mental health services
   ☐ Outpatient substance use disorder services
   ☐ Assisted Outpatient Treatment
   ☐ Management of psychoactive drugs
   ☐ Medication assisted treatment
   ☐ Crisis planning services
   ☐ Screening/assessment/diagnostic services
   ☐ Crisis services/Urgent care
   ☐ Treatment planning services
   ☐ Psychiatric rehabilitation services
   ☐ Peer support services for patients
   ☐ Support services for families
   ☐ Targeted case management
   ☐ Primary health screening and monitoring
   ☐ Armed forces and veteran's services
   ☐ Other (specify)

4. Can appointments for mental health and primary care visits be made during the same call, or scheduled for the same day?

5. Are services available on a walk-in basis? If yes, what types of services?

6. Are there waiting lists for services or visits?

   a. If yes, approximately how many people are on waiting lists?

b. What is the duration of time on waiting list until service is received?

7. How are appointments made and coordinated with DCOs?

8. What services (e.g., mental health / primary care advice, community or social supports) are available to clients by phone or electronically? During what hours?

   ☐ Outpatient mental health services
   ☐ Outpatient substance use disorder services
   ☐ Assisted Outpatient Treatment
   ☐ Management of psychoactive drugs
   ☐ Medication assisted treatment
   ☐ Crisis planning services
   ☐ Screening/assessment/diagnostic services
   ☐ Crisis services/Urgent care
   ☐ Treatment planning services
   ☐ Psychiatric rehabilitation services
   ☐ Peer support services for patients
   ☐ Support services for families
   ☐ Targeted case management
   ☐ Primary health screening and monitoring
   ☐ Armed forces and veteran's services
   ☐ Other (specify)

   a. If clinical advice is provided by phone or electronically, does the program have relevant written policies, defined standards, and performance monitoring about the timeliness of this advice?

9. What is the process for talking to clients directly about the range of services available to them under the CCBHC model?

   a. Are you carrying out any outreach activities to reach clients who are not engaged in CCBHC services?

   b. What kinds of outreach (e.g., developing relationships with community organizations, advertising, etc.)?

   c. Specific types of clients/target population(s)?

D. CCBHC benefits and challenges

1. What do you think have been the best part or benefits of working in a CCBHC?

2. What do you think have been the most challenging parts of working in a CCBHC?

   a. Is there anything you would like to change/anything that could be improved? How?

E. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Is there anyone else who works in care management/coordination who should be included in these interviews?

CCHBC Demonstration Evaluation Site Visit Interview Guide: CCBHC Administration and Finance

SITE VISIT INTERVIEW QUESTIONS- CCBHC ADMINISTRATION AND FINANCE STAFF

On-site interviews will be conducted with program leadership, providers, and administrative staff from CCBHC demonstration sites in 4 states. The interviews will address specific factors that shape CCBHC policies, and will be tailored based on the information already gathered through applications and other sources—or gaps in that information—regarding participating sites' program characteristics. The interviewer will transfer the information gathered from the interviews into a Debrief Template that organizes data by criteria domain and corresponding research questions. The general protocol for site visit interviews with CCBHC administration and finance staff is presented below.

A. Introduction

1. Please describe your current role/position.

   a. For how long have you held this position?

   b. [For CCBHC staff] What are your key responsibilities in the CCBHC?

   c. [For CCBHC staff] If you were at this agency prior to CCBHC certification, how has your role changed with CCBHC certification?

B. Changes associated with CCBHC certification

1. What are the major ways that administrative and financial systems changed when the clinic became a CCBHC?

   a. What are the major differences between the way that the CCBHC is administered and how other non-CCBHC community behavioral health clinics (e.g., CMHCs) are administered in your state?

2. How do billing processes differ for the PPS from usual practice with other clients/payers? For clients served prior to CCBHC?

C. Quality and other reporting

1. Aside from the demonstration, how do you generally monitor your clinic's performance?

2. How is the performance of your CCBHC monitored for the demonstration?

   a. What sources of data are used?

      - Any challenges getting necessary data?

   b. How are required quality measures calculated and reported by your CCBHC?

      - Any challenges performing calculations or defining populations for measures?

   c. Do you track CCBHC clients' utilization information related to health care costs?

3. Are any performance measures, in addition to the required quality measures, collected and used by your CCBHC?

4. Does the state provide you with feedback on state reported quality measures associated with the demonstration?

D. Data collection and sharing

1. How are data required for billing claims and encounter records collected?

2. What types of data are collected?

    a. Who records data?

    b. Who has access to data?

3. Are electronic health records used in the CCBHC?

    a. What is the name and version of the electronic health record (EHR) software?

    b. Is billing information integrated into the EHR system?

        - If not integrated, what is the name and version of the billing software?

    c. Do all clinicians use the same system? Including providers at designated collaborating organizations (DCOs)?

    d. If not, how are billing records compiled from multiple information systems?

    e. Describe the flow of information that goes into clinic claims and encounters. Who collects what data, and when? Who enters data?

    f. How often are records checked for accuracy and by whom?

    g. Is quality reporting information integrated into the EHR system?

    h. If yes, was this an existing function/tool, or did it require modification to the system?

4. How are encounter records (reports of clinical procedures submitted along with PPS reimbursement claims) captured and reported for the CCBHC? For DCOs?

    a. How does the clinic monitor reporting of PPS claims and encounter data?

    b. How significant is the additional administrative burden associated with the PPS, relative to other payment systems you've worked with?

5. Describe any burdens/challenges associated with data collection?

    a. What technical assistance tools would help?

6. In what way are the data analyzed? What are plans for ongoing/future data analysis?

    a. Who is responsible for data analysis (e.g., internal staff member, contracted external evaluator, etc.)?

    b. How will data collection and analysis be used to benefit the CCBHC, for example, for quality improvement initiatives?

    c. Describe any challenges and solutions associated with data sharing and analysis?

7. Are any data or data reports shared with clients or their families?

    a. Does the CCBHC have an interactive website or patient portal to support CCBHC client access to data or data reports?

8. Are you involved in required CCBHC reporting to the state or federal government?

Probe about the following:

- Quality measures
- Cost Reports
- Other reporting requirements

9. What reporting requirements are in place between CCBHC and DCO(s)?

a. Do DCOs report encounter data?

b. How is the information shared?

c. Is a health information exchange (HIE) function integrated in the EHR system?

- If no, what is the name and version of the HIE system?
- Is HIE system or integrated HIE function compliant with 42 CFR 2 (substance abuse confidentiality) requirements?

d. Have you had any challenges in managing payment for care provided in DCOs?

E. Payment systems

1. What type of payment system is used at your CCBHC?

a. [If PPS-1 with Bonus or PPS-2 system] Do you track or target performance on measures linked to the Quality Bonus Payment?

b. What proportion of your billing work involves the PPS as opposed to other payers?

- Is the administrative burden of submitting claims different for consumers covered by the PPS system? In what ways?

2. Thinking about client caseload and their payers, approximately how many patients are (approximate percentage of total patients seen):

a. Have Medicaid?

b. Are uninsured?

c. Are privately insured?

d. Are sliding scale fee patients?

e. Have Medicare only vs. dual eligible?

f. Are dual eligible patients payed through PPS?

g. Are recipients of 1915(c) waivers?

h. Others?

3. How are clients covered by the PPS system distinguished from other consumers?

a. Are Medicaid clients tracked separately from other consumers? And dual eligible?

b. Are services for clients covered by the PPS managed differently from the way services are managed for other consumers?

4. How are clients notified about payment options?

Probe about:

- Medicaid enrollment

- Sliding fee scale

5. Are clients required to pay co-payments or other fees?

If yes, probe on type, amount, and frequency.

6. How is the payment system working for your clinic? Have you encountered any difficulties or received any feedback from staff or clients?

a. What steps have been taken to address these issues?

b. [If PPS-2 system]: How are the various components of the rate mechanism working at your clinic (i.e., stratification of rates by patient severity, outlier payments, and quality bonus payments)?

c. Have you encountered any issues regarding payment for clients who are dually eligible/enrolled (Medicare/Medicaid)? For individuals who are recipients of 1915(c) waivers?

7. Who in the clinic prepares the required cost reports?

a. What is the process for preparing the cost reports?

- How are the costs and clients documented or estimated?

- Has this changed over time?

(1) Did your clinic have experience preparing cost reports prior to CCBHC certification?

(2) If yes, how did previous cost-reporting process differ from CCBHC reporting?

- Have you encountered any difficulty producing or updating the cost reports? Please describe the major challenges in preparing the cost reports.

b. Are costs monitored on an ongoing basis?

- How frequently are costs assessed/reviewed?

- What costs are examined (e.g., total quarterly cost, cost by resource, cost per client/provider/encounter, etc.)

F. CCBHC implementation successes and barriers

1. What features of the CCBHC model have worked well so far during the implementation process? How have these improved work/processes in your clinic?

2. What barriers have you faced in implementing the CCBHC model? (If necessary, prompt with: Types of barriers may include problems hiring qualified staff, coordinating mental health and DCO leadership, billing/financing issues, and poor client engagement and/or retention.)

a. What strategies have you used to overcome them?

3. What plans do you have for maintenance and sustainability of the CCBHC services?

    a. Do you have any concerns regarding CCBHC program sustainability?

G. Interviewee feedback/open discussion

1. What have we missed? What else do we need to know that we haven't asked you?

2. Is there anyone else from administration/finance who should be included in these interviews?

EVALUATION OF THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION PROGRAM

Reports Available

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS DEMONSTRATION PROGRAM: REPORT TO CONGRESS, 2019

HTML   https://aspe.hhs.gov/basic-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019

PDF   https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019

IMPLEMENTATION FINDINGS FROM THE NATIONAL EVALUATION OF THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION

HTML   https://aspe.hhs.gov/report/implementation-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration

PDF   https://aspe.hhs.gov/pdf-report/implementation-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration

PRELIMINARY COST AND QUALITY FINDINGS FROM THE NATIONAL EVALUATION OF THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION

HTML   https://aspe.hhs.gov/basic-report/preliminary-cost-and-quality-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration

PDF   https://aspe.hhs.gov/pdf-report/preliminary-cost-and-quality-findings-national-evaluation-certified-community-behavioral-health-clinic-demonstration