CCBHC Worksession

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Overview of CCBHC Model

CCBHCs: Supporting the Clinical Model with Effective Financing

Standard definition	→	**Raises the bar for service delivery**
Evidence-based care	→	**Guarantees the most effective clinical care for consumers and families**
Quality reporting	→	**Ensures accountability**
Prospective payment system	→	**Covers anticipated CCBHC costs**

Care Objectives

"The model is designed to **increase access to behavioral health services**, provide a **comprehensive range of services**, including crisis services, that **respond to local needs**, incorporate **evidence-based practices**, and **establish care coordination** as a linchpin for service delivery. CCBHCs serve their communities, including those most in need of coordinated, integrated, accessible, quality care, with no rejection for services or limiting of services based on a person's ability to pay or place of residence. In addition, CCBHCs are **expected to promote recovery** while fostering resilience and addressing social determinants of health."

What Goes into Being a CCBHC?

CCBHC Criteria

- Organizational Authority
- Staffing
- Access to Care
- Scope of Services
- Care Coordination
- Quality Reporting

CCBHC Payment

- Cost-related Medicaid reimbursement rate (demonstration/SPA participants)

OR

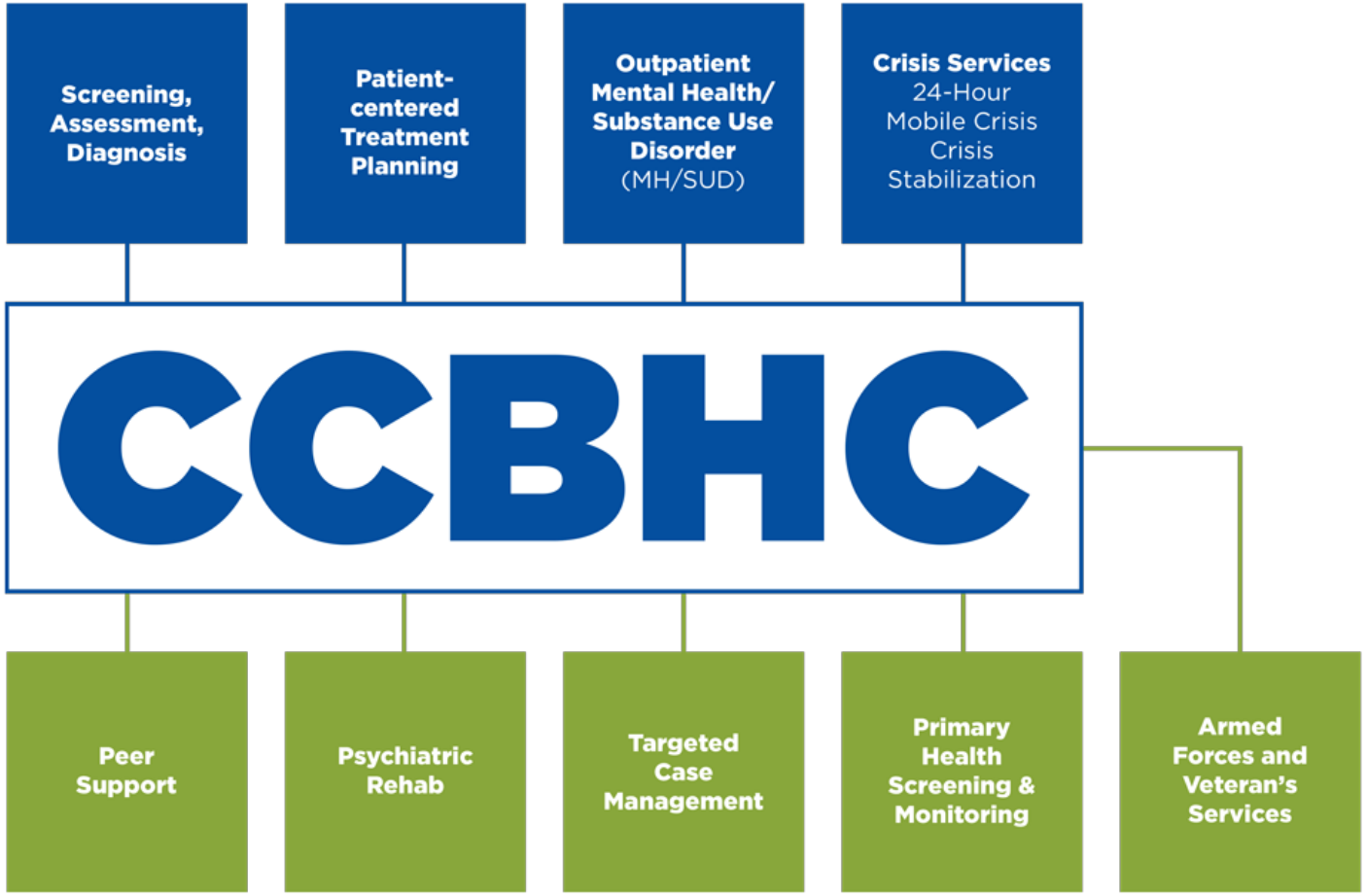
- Grant funds: $1 million/year for 4 years (expansion grantees)

Note: This presentation contains a summary of selected CCBHC certification criteria. To view the full criteria: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

Allowable Providers

- CCBHCs must be:
  - Nonprofits; OR
  - Part of local government behavioral health authority; OR
  - Under the authority of Indian Health Service, Indian Tribe or Tribal organization; OR
  - Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service
- Governing board members are “representative of the individuals being served”
- States are encouraged to require national accreditation (e.g. CARF, COA, Joint Commission)

Required Services



Quality Reporting: CCBHC Reported Measures (9)*

Source of Data	Measure or Other Reporting Requirement	NQF Endorsed
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421
EHR, Encounter data	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)	0024
EHR, Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
EHR, Patient records	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
EHR, Patient records	Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
EHR, Patient records	Consumer follow-up with standardized measure (PHQ-9) Depression Remission at 12 months	0710

*SAMHSA is in a process of updating the CCBHC criteria; changes to the quality measures are being considered.

Quality Reporting: State Reported Measures (12)*

Potential Source of Data	Measure or Other Reporting Requirement	NQF Endorsed
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Claims data/ encounter data	Follow-Up After Emergency Department for Mental Health	2605
Claims data/ encounter data	Follow-Up After Emergency Department for Alcohol or Other Dependence	2605
Claims data/ encounter data	Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Claims data/ encounter data	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932
Claims data/ encounter data	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	N/A
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Claims data/ encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
Claims data/ encounter data	Antidepressant Medication Management (see Medicaid Adult Core Set)	0105
EHR, Patient records	Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
MHSIP Survey	Patient experience of care survey; Family experience of care survey	N/A

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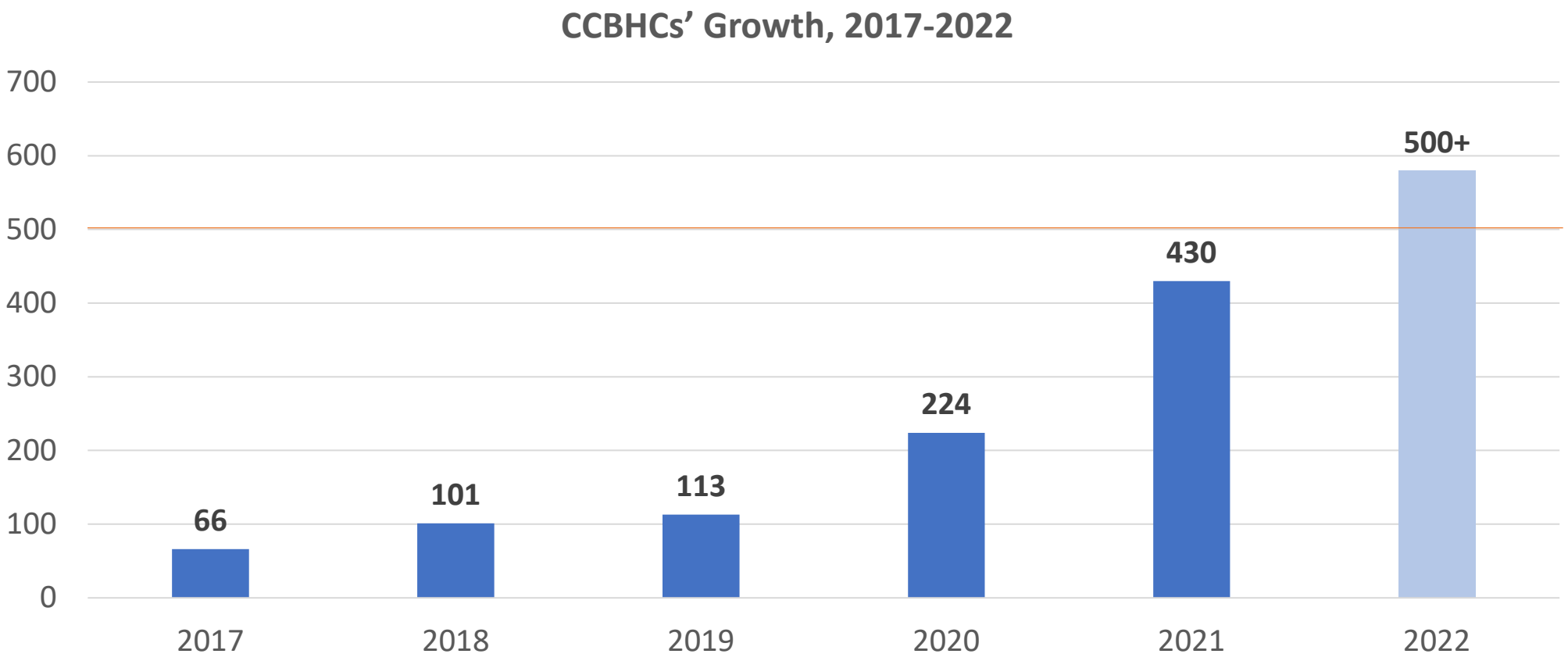
State of the Nation

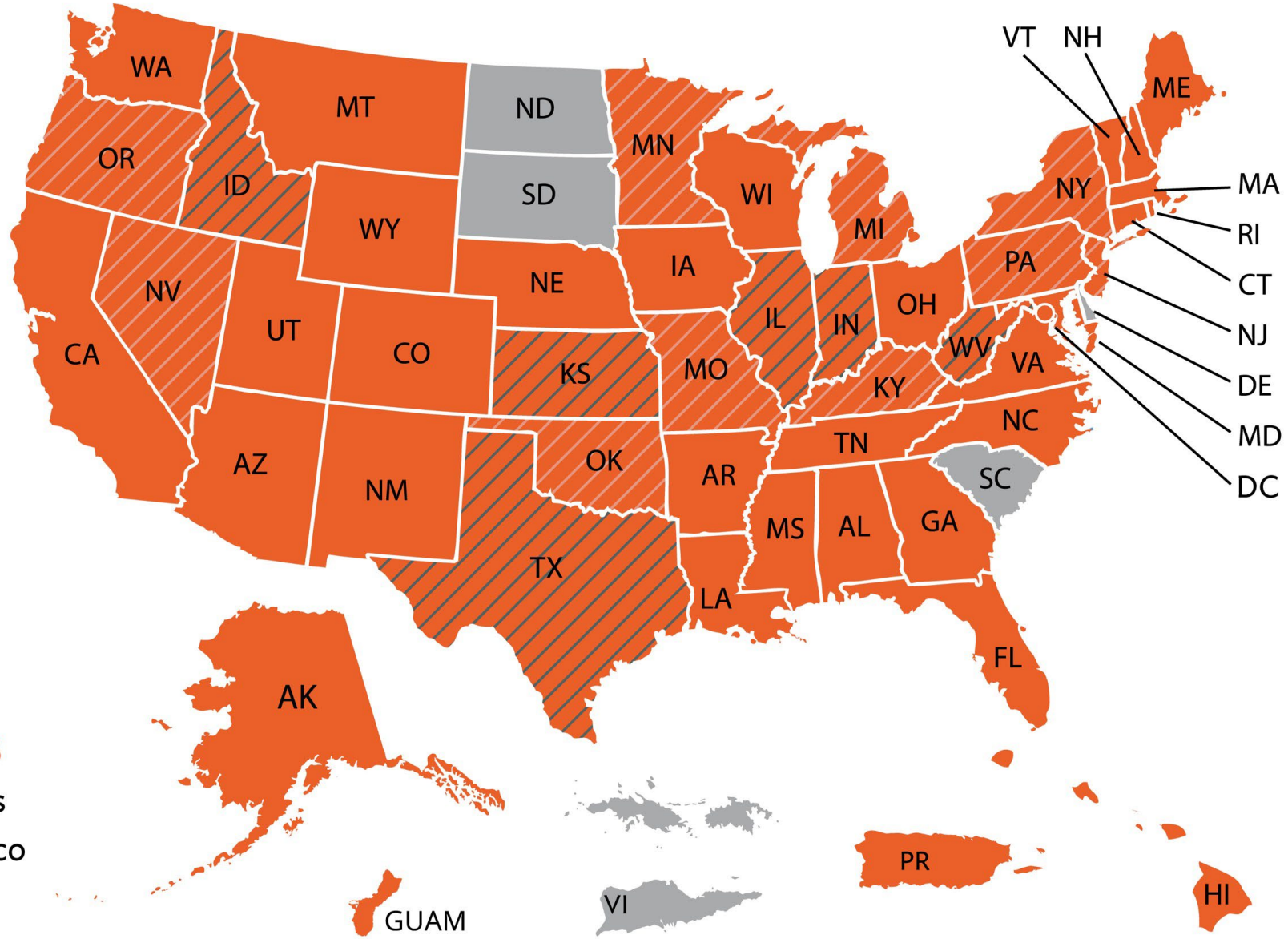
Accelerating growth in number of CCBHCs



Status of Participation in the CCBHC Model

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Current (or working toward) independent statewide implementation
- No CCBHCs

There are **500+ CCBHCs** in the U.S., across 46 states, plus Washington, D.C. and Puerto Rico



Number of Individuals Served

1.2 MILLION CLIENTS

are currently served by 249 responding CCBHCs and grantees

Estimated

2.1 MILLION

people currently served across all 450 active CCBHCs and grantees

This represents a steep increase from the estimated 1.5 million people served across 224 active CCBHCs as of 2021.

Caseload Expansions

77%

CCBHCs & GRANTEES

say their caseload has increased since becoming a CCBHC

Nearly

180,000

total new clients served by these clinics

This represents a 23% increase since becoming a CCBHC

State-certified clinics had larger average caseload increases (**30%** average increase for state-certified sites vs. **18%** for grantee-only sites).*

In 5 demonstration states: Total increases in number of clients served ranged from **4%-152%** over the first 4 years. (Source: ASPE Report to Congress, 2022)

*Difference is statistically significant

Timeliness of Access

- **71%** offer access to services for routine needs **within a week or less**, compared to average wait times of 48 days nationally
- CCBHCs are required to offer **immediate access** for individuals in crisis and access within **1 business day** for individuals with urgent needs

"State officials consistently reported that CCBHCs offer better access to care than non-CCBHC counterparts because there are fewer barriers to care and more supportive policies in place." –ASPE Report to Congress, 2022

Employees and Vacancies

6,220
STAFF HIRED

Across the 249 responding CCBHCs and grantees as a result of becoming a CCBHC

Estimated
11,240
STAFF HIRED

across all 450 active CCBHCs as of August 2022

27
NEW POSITIONS PER CLINIC

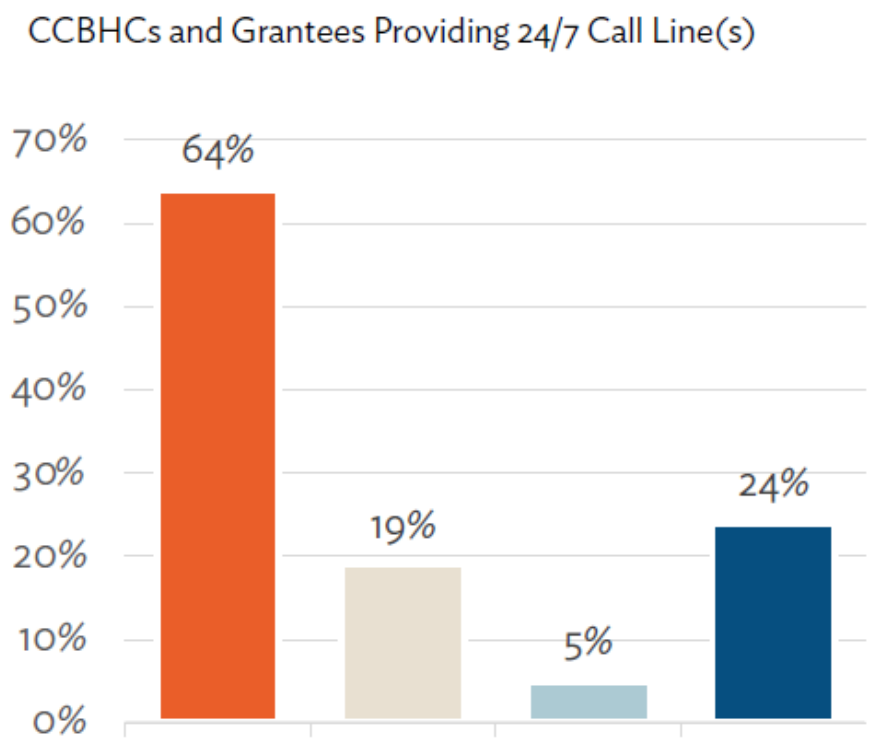
on average since becoming a CCBHC

(82% of organizations have created at least 10 new staff positions)

- **These workforce expansions represent a 13% increase** compared to prior to becoming a CCBHC.
- Grantee-only sites had a **10%** increase in staff, and state-certified sites had a **16%** increase in staff.*

*Difference is statistically significant

Availability of Crisis Call Lines



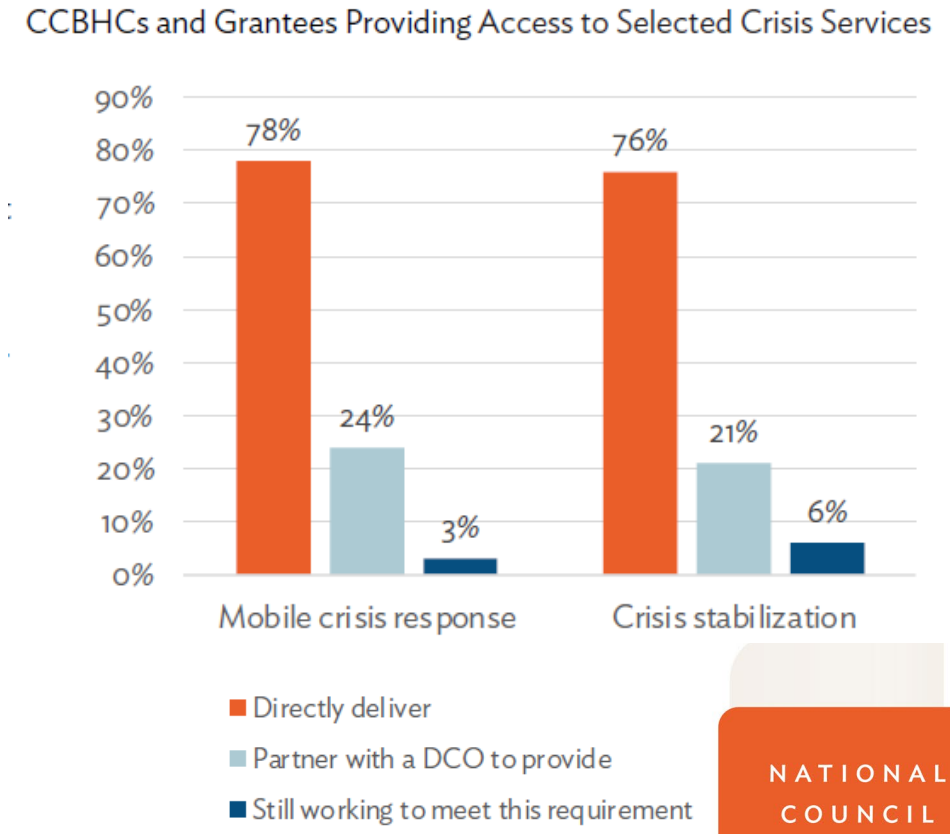
With their array of crisis response services and partnerships, CCBHCs are ideal partners in states' efforts to strengthen their 988 and crisis response systems.

Availability of Mobile Crisis and Crisis Stabilization

CCBHCs are expanding the availability of crisis care in their communities, both directly and through partnerships.

- Among CCBHCs that directly operate 24/7 crisis call line(s), mobile crisis response, or crisis stabilization, nearly half (**49%**) had to add new crisis services or partnerships as a result of CCBHC certification.
- State-certified sites were more likely than grantee-only sites to add mobile crisis (**56% vs. 33%**) and crisis stabilization (**44% vs. 19%**) services or partnerships as a result of certification.*

*Difference is statistically significant



Other Crisis Response Activities

Innovative Practices in Crisis Response	Percentage of participating CCBHCs
Offers post-crisis wrap around services to facilitate linkage and follow-up	83%
Partners with statewide, regional, or local crisis call line to take referrals for non-urgent or post-crisis care	67%
Has mental health and substance use provider co-respond with police / EMS	45%
Operates a crisis drop-in center or similar non-hospital facility for crisis stabilization	38%
Has mobile mental health and substance use teams respond to relevant 911 calls instead of police / EMS	30%
Partners with 911 to have relevant 911 calls screened and routed to CCBHC staff	22%
Other	18%

States reported reductions in emergency department and hospital visits among CCBHC clients, leading to cost offsets.

Oklahoma's three CCBHCs reduced the proportion of their clients seen in emergency departments by 18-47% (rates varied by clinic) and those admitted to inpatient care by 20-69% over the first four years of the program, compared to baseline.

In its first year, **New York** reported a 54% decrease in the number of CCBHC clients using behavioral health inpatient care, which translated to a 27% decrease in associated monthly costs. Similarly, the state reported a 46% decrease in the number of clients using the emergency department, leading to a 26% reduction in monthly costs. New York also saw a 61% decrease in the number of clients using general hospital inpatient services and a 54% decrease in all-cause readmissions.

New Jersey reported a decline in all-cause readmission rates from the first to second demonstration year.

Missouri reported that among clients with a prior emergency department visit engaged in outpatient care at a CCBHC, 76% experienced reduced emergency department visits and hospitalizations. Of those engaged in care who had some type of prior law enforcement involvement, nearly 70% had no further law enforcement involvement at six months.

Other results to date

- Expanded scope of services, including crisis care, MAT
- Population health management, CQI
- Use of technology
- Improved ability to report on quality measures
- Launch of new service lines to meet community need
  - New initiatives designed to reach target populations or address key Medicaid agency goals
- Deploying outreach, chronic health management outside the four walls of the clinic
- Improved partnerships with schools, primary care, law enforcement, hospitals
- Improvements in physical health indicators

"State officials often commented on CCBHCs' role in addressing various state priorities and contributing to various initiatives, **such as crisis system transformation,** primary care integration, and care coordination efforts" –ASPE Report to Congress, 2022

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State of the State

CCBHCs in Montana

- **4 CCBHCs** with active grants
- Key outcomes include:
  - Increases in clients served
  - Growth of workforce
  - Reduced hospitalization & ED utilization
  - Reduced criminal justice system involvement
  - Improved physical health indicators
- Add'l improvements in:
  - Tobacco use
  - Use of illegal substances
  - Regular attendance in school
  - Stable housing
  - Retained in the community
  - And more…

Spotlight: Many Rivers Whole Health
Clients experienced a 70% reduction in criminal justice system involvement, 69.2% reduction in hospitalizations for mental health, 66.7% reduction in ED usage for mental health, and 66.7% reduction in homelessness

CCBHCs in Montana (cont.)

Spotlight: Western Montana Mental Health Center
Enrollees had a **64.3%** reduction in "troubled nights" (in psychiatric hospitalization, in the ER for psychiatric issues, in detox, or homeless)

Spotlight: Rimrock
Enrollees had a 57.5% increase in regular school attendance, a 38.9% increase in having a stable place to live, and a 27.1% increase in everyday functioning.

Questions?

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