NATIONAL COUNCIL for Mental Wellbeing

The Certified Community Behavioral Health Clinic (CCBHC) Model: *Past, Present and Future!*

October 27, 2022

What is a CCBHC?

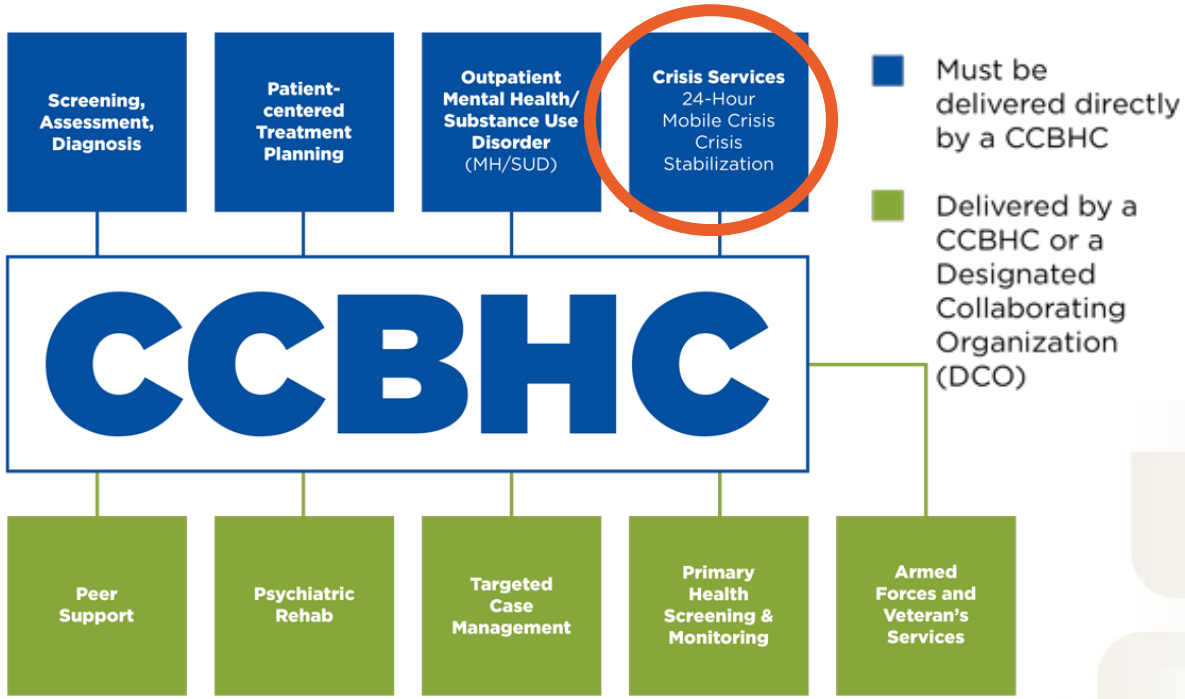
A CCBHC is a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community to ensure high-quality care for underserved populations.

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

CCBHC Criteria

CCBHC Criteria

1. Staffing
2. Availability & Accessibility of Services
3. Care Coordination
4. Scope of Services
5. Quality & Other Reporting
6. Organizational Authority, Governance and Accreditation

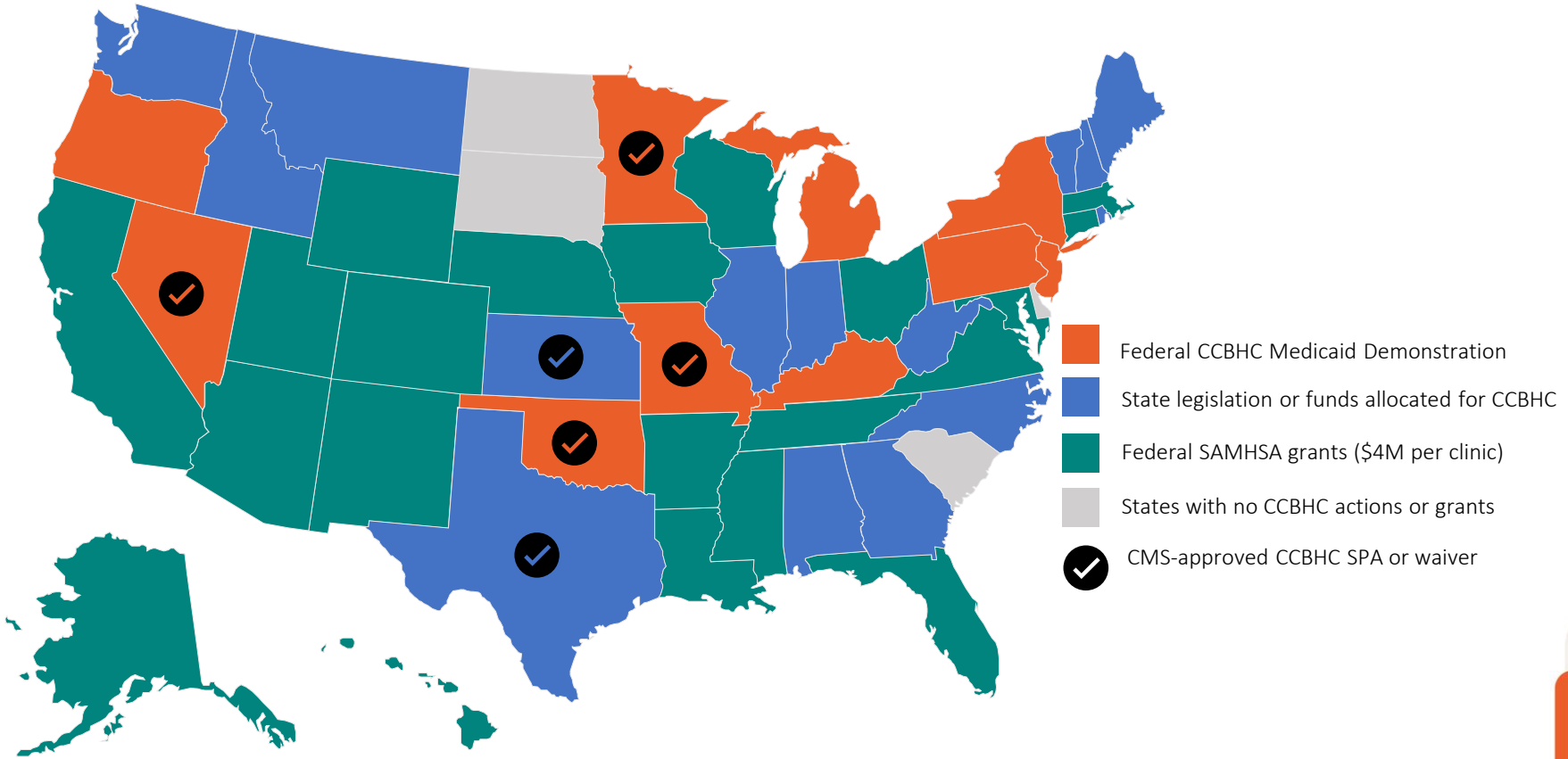


Note: This presentation contains a summary of selected CCBHC certification criteria. To view the full criteria: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

Incredible Growth with the CCBHC Model!

2017	2019	2020	2021	2022
8 states	21 states	33 states	42 states	49 states
66 clinics	113 clinics	229 clinics	430 clinics	500+ clinics

CCBHCs Across the Country



Also: District of Columbia, Guam and Puerto Rico

CCBHC in Federal Legislation

Current Demonstration States

- Extends the demo with enhanced match for the original 8 states to Sept. 30, 2025
- Gives the newer 2 demo states (KY & MI) 6 years of enhanced match
  - Moves MI to Oct. 2027 and KY to Jan. 2028
- Clarifies that if a state implements a CCBHC SPA or waiver after its demo is over, FFP continues to be available for CCBHC services or continuing PPS

Reporting

- Requires annual reports to Congress through the year in which the last demonstration ends
- Postpones the report, including recommendations on whether the demo should be continued, to Sept. 30, 2025, and specifies that the recommendations should include "data collected after 2019, where feasible"
- Adds a final evaluation of the program, due 24 months after all demo programs have ended

Demonstration Expanded

- Beginning July 1, 2024, and every 2 years thereafter, ≤10 additional states may participate in the demo
- New states get 4 years of enhanced match
- Makes planning grants available for new states to develop proposals to participate
  - Participation in the demo appears to be open to states that either received a planning grant in 2016 or those that receive new planning grants under this law
  - States wishing to participate must submit a new application
- Appropriates $40M in FY23 for planning grants and technical assistance to states applying for the grants, "to remain available until expended"
  - The statute doesn't specify whether the new planning grant funding is available all at once or if it will be parceled out to a new group of states every 2 years

CCBHC 2022 Impact Survey Data

Respondent characteristics

- 249 of 450 CCBHCs responded to the survey, for a response rate of 55%. Response rates were roughly equivalent among grantees and state-certified sites but grantees and newer CCBHCs made up a larger proportion of respondents. Raw data were not weighted and are therefore only representative of the individuals who completed the survey.
- Definitions:
  - **State-certified clinics** are those certified by their states under the demo, a SPA or a waiver, regardless of whether they also received a grant or not (N = 73).
  - **Grantee-only clinics** are those that have received a SAMHSA CCBHC grant but are not certified by their states (N = 176)
- 57 respondents (23%) are located in rural areas
- 24 respondents (10%) are dually certified as FQHCs.

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).*

*Difference is statistically significant

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

Most Common Types of Staff Hired

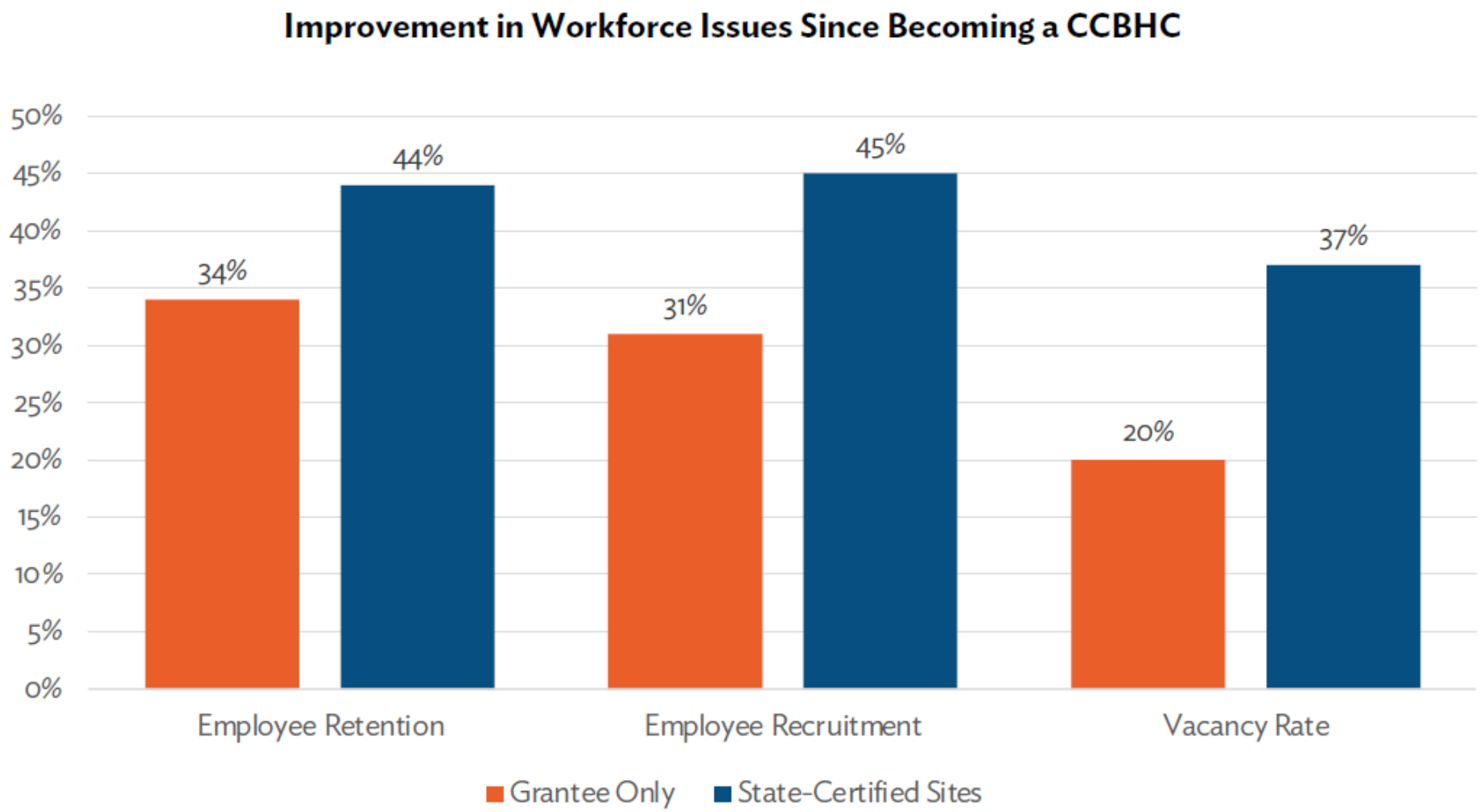
Which of the following types of staff has your organization hired, or is currently looking to hire, since becoming a CCBHC? Please select all that apply.

Type of staff hired or looking to hire	Percent*
Peer support specialists or recovery specialists	84%
Data analysts or other staff focused on data reporting/management	79%
Primary care providers (e.g., physicians, nurses, MAs, etc.)	68%
Substance use disorder counselors	67%
Psychiatrists	51%
Community health workers	50%
Buprenorphine prescribers (i.e., DATA 2000 waivered clinicians)	45%
Psychologists	16%
Other	15%

*Among respondents that indicated they hired staff as a result of becoming a CCBHC

Recruitment, Retention and Vacancy Rates

State-certified sites were more likely than grantee-only sites to report that since becoming a CCBHC they have had a better experience with recruitment, retention and vacancy rates.



Strategies to Mitigate the Workforce Shortage

The most common strategy respondents are using to mitigate the effects of the workforce shortage is raising salaries or offering bonuses (**92%**). State-certified sites were more likely than grantee-only sites to report engaging in this strategy (**97%** vs. **89%**).*

Strategies to Mitigate the Effects of the Workforce Shortage	All respondents
Raising salaries and/or offering bonuses	92%
Engaging in staff wellbeing efforts, revamping employee benefits, or other strategies to improve staff satisfaction and retention	86%
Partnerships with clinician training programs (e.g., universities)	62%
Revising job descriptions and care teams to allow staff to practice at the top of their license	59%
Enhancing the provision of integrated behavioral health and primary care so more needs can be addressed in a single visit	57%
Serving as a National Health Service Corps (NHSC)-eligible site for loan repayment	46%
Participating in another kind of loan repayment program (not NHSC)	35%
Registered apprenticeships	14%
Other	22%
None	1%

Themes from Respondent Comments

- Respondents frequently noted that becoming a CCBHC has been critical in filling staffing gaps and allowing CCBHCs to hire for non-clinical positions.
- Many commenters shared that staff enjoy working at a CCBHC more than other practice settings or industries, which is helping with staff retention.
- On the other hand, paperwork was frequently cited as a reason for burnout and staff turnover.

"We have several positions to fill, but once filled, we are retaining employees for longer periods of time. We are finally more competitive with other area behavioral health agencies/positions/schools. We've had an increased interest in practicums, so much so that we don't have room for all of the interested students!"

–Central Kansas Mental Health Center

Number of Clients Engaged in Medication Assisted Treatment

38,396 CLIENTS

with substance use disorder currently engaged in MAT across responding clinics

Estimated

69,400 CLIENTS

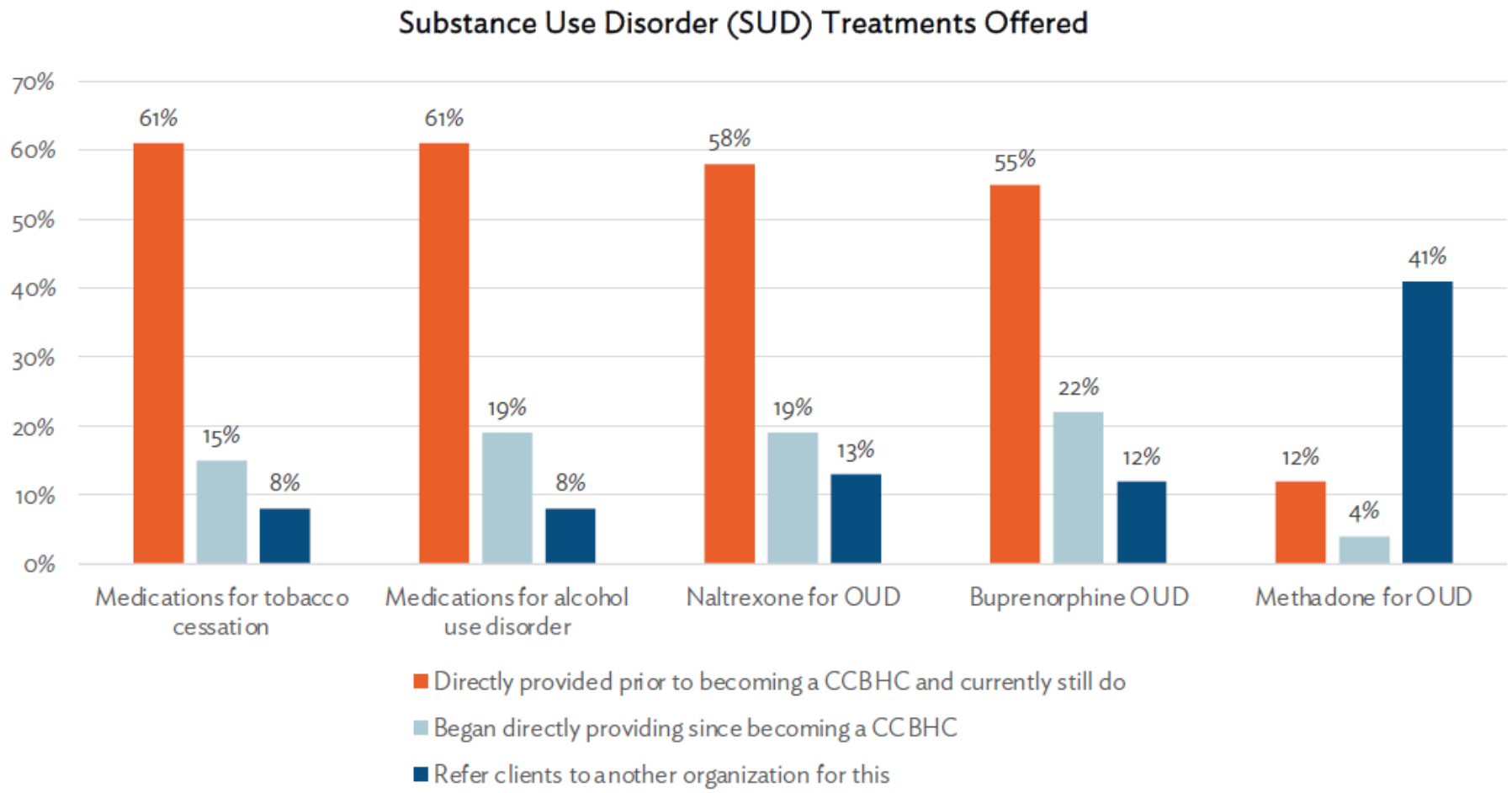
nationwide engaged in MAT across all 450 active CCBHCs.

State-certified sites were more likely to say their number of clients on MAT has increased significantly (**51%** of state-certified respondents vs. **17%** of grantee-only respondents)*

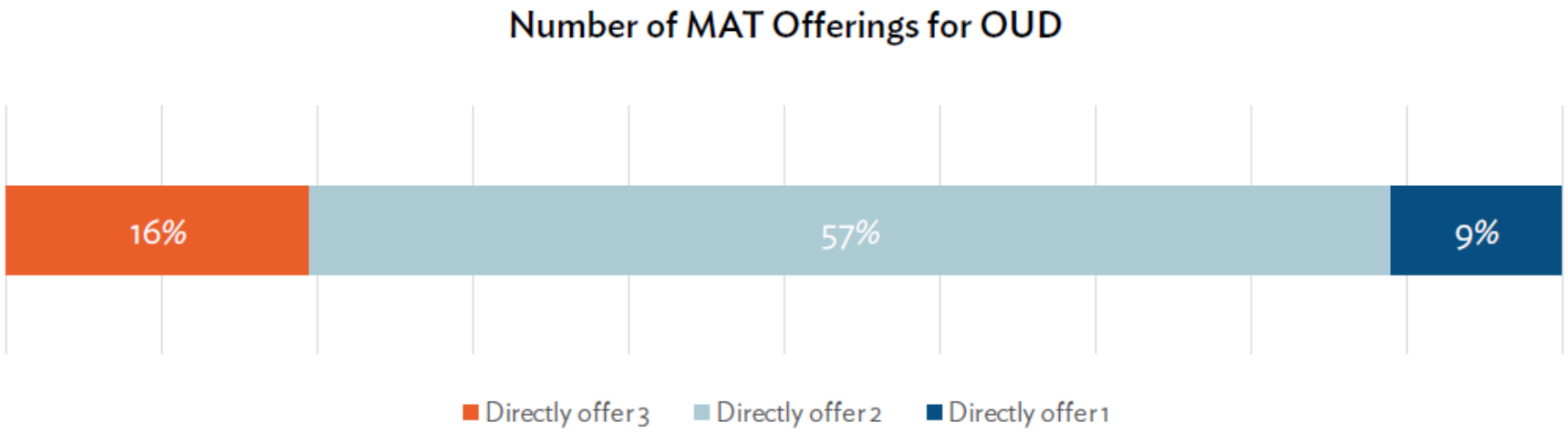
*Difference is statistically significant

Expansion of Access to MAT

94% of CCBHCs and grantees directly provide medications for substance use disorder (SUD) treatment. Many respondents added access to these medications as a direct result of becoming a CCBHC.



MAT for Opioid Use Disorder (OUD)



82% of CCBHCs directly offer at least one type of MAT for OUD vs. 56% nationwide

Among respondents who do not currently directly offer these medications, many make them available via referral and others intend to add them in the future.

Primary Care Partnerships & Referrals

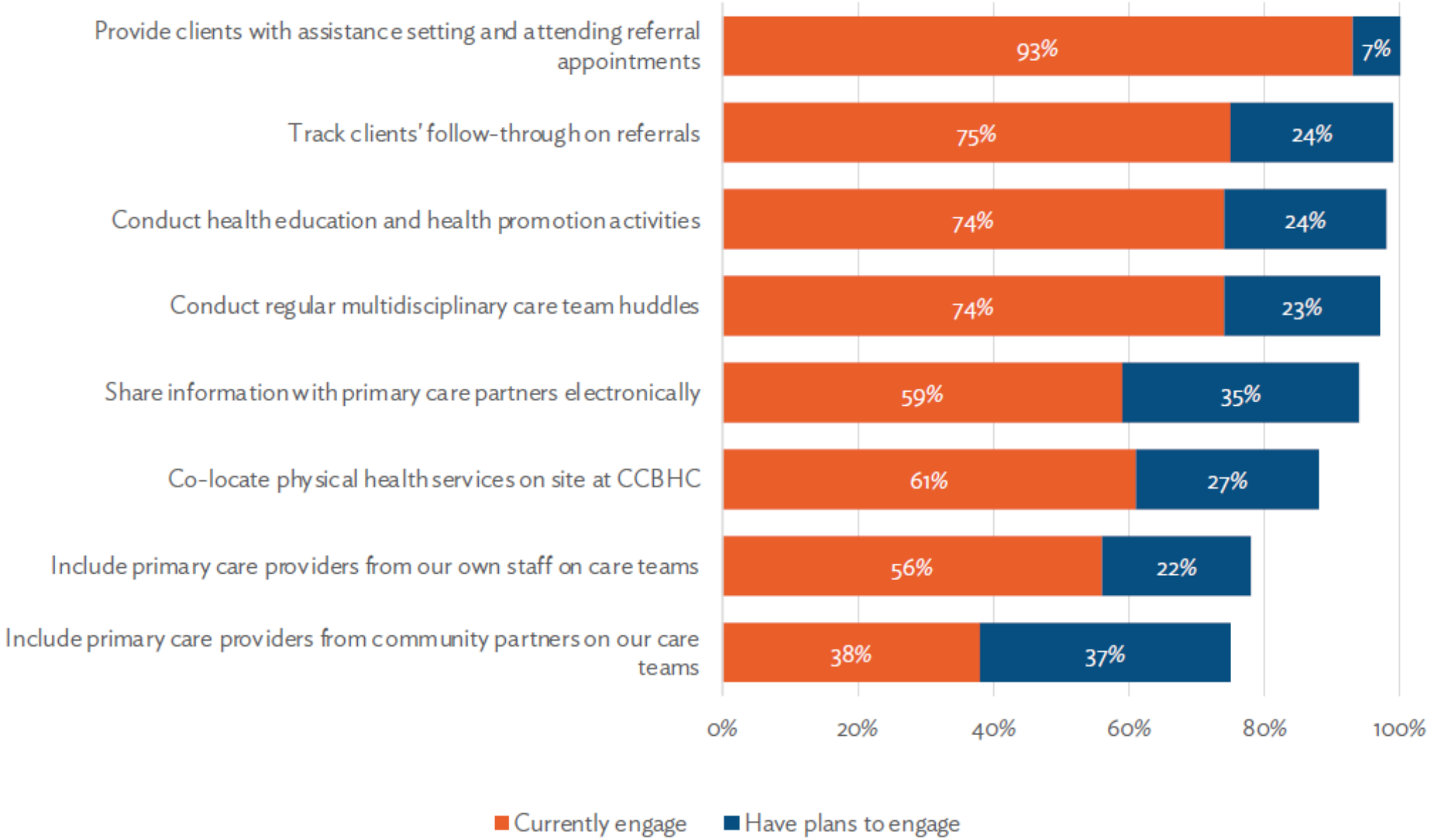
- Most respondents (73%) deliver primary care screening and monitoring directly.
- FQHCs are the most common DCO partner for this service.
- 81% of respondents who track referrals to primary care partners report that their number of referrals to primary care has increased since becoming a CCBHC.

How does your organization meet the primary care screening and monitoring requirements in the CCBHC criteria? Please select all that apply.

	% of all respondents
Directly	73%
Through partnership with an FQHC as a DCO	32%
Through partnership with a different primary care provider as a DCO	9%
Provide services directly AND have a DCO	17%
Still working to meet this requirement	7%

What is a DCO? A DCO is an organization that works with a CCBHC to deliver the full array of required services. CCBHCs and DCOs establish formal agreements ensuring delivery of care in alignment with the federal criteria. The DCO relationship represents an opportunity to align and integrate other community providers under the "umbrella" of the CCBHC model.

Respondents' Integrated Care Activities



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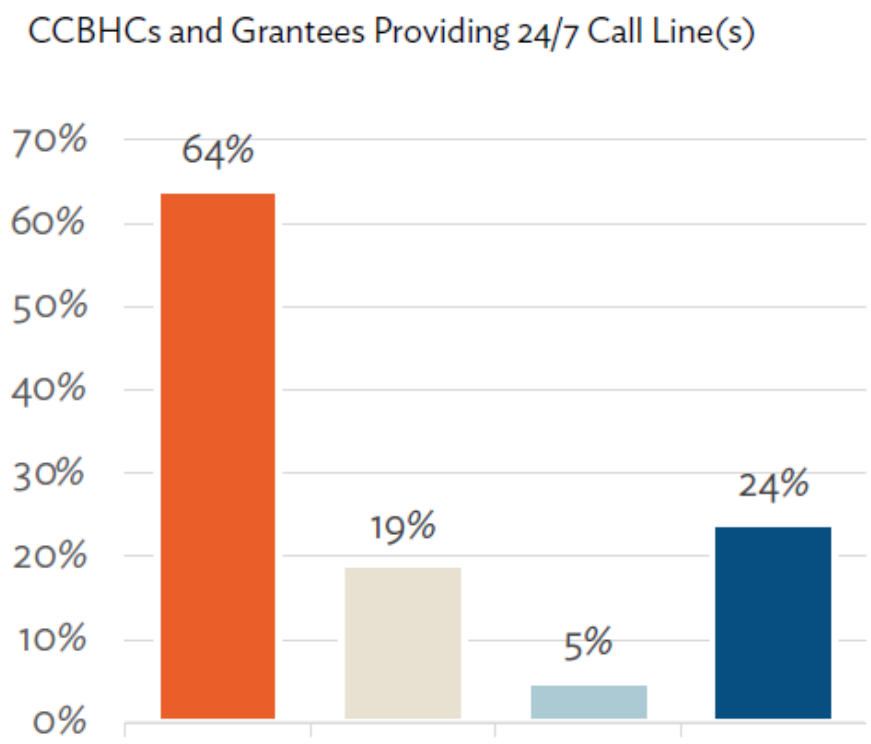
Availability of Crisis Call Lines



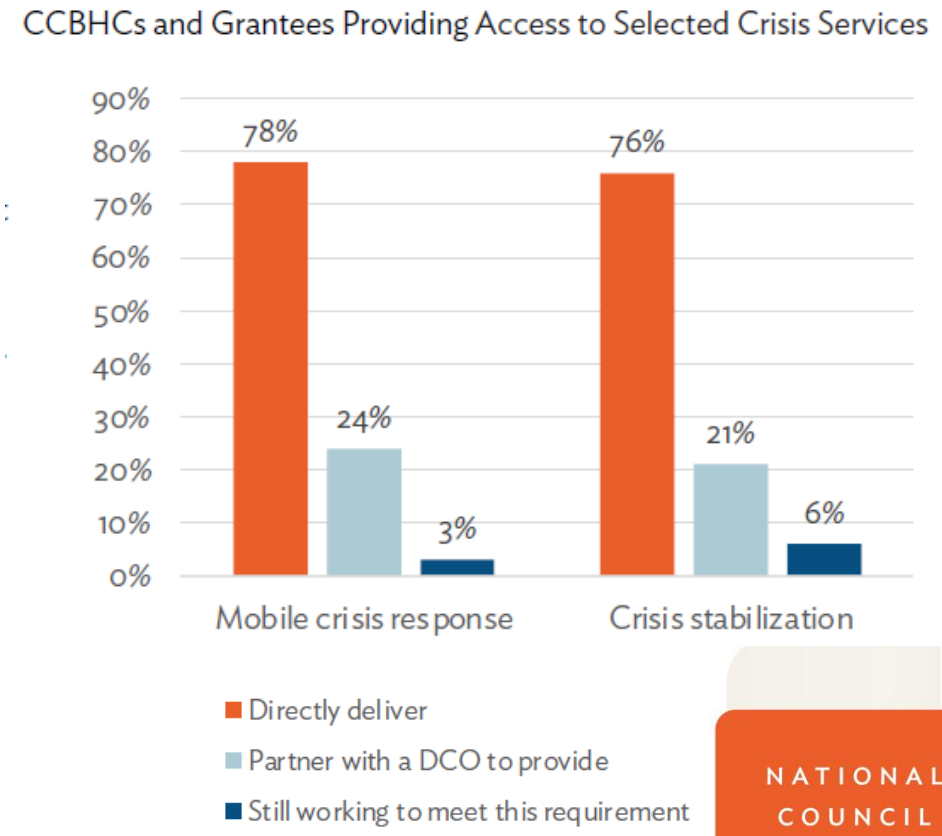
With their array of crisis response services and partnerships, CCBHCs are ideal partners in states' efforts to strengthen their 988 and crisis response systems.

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

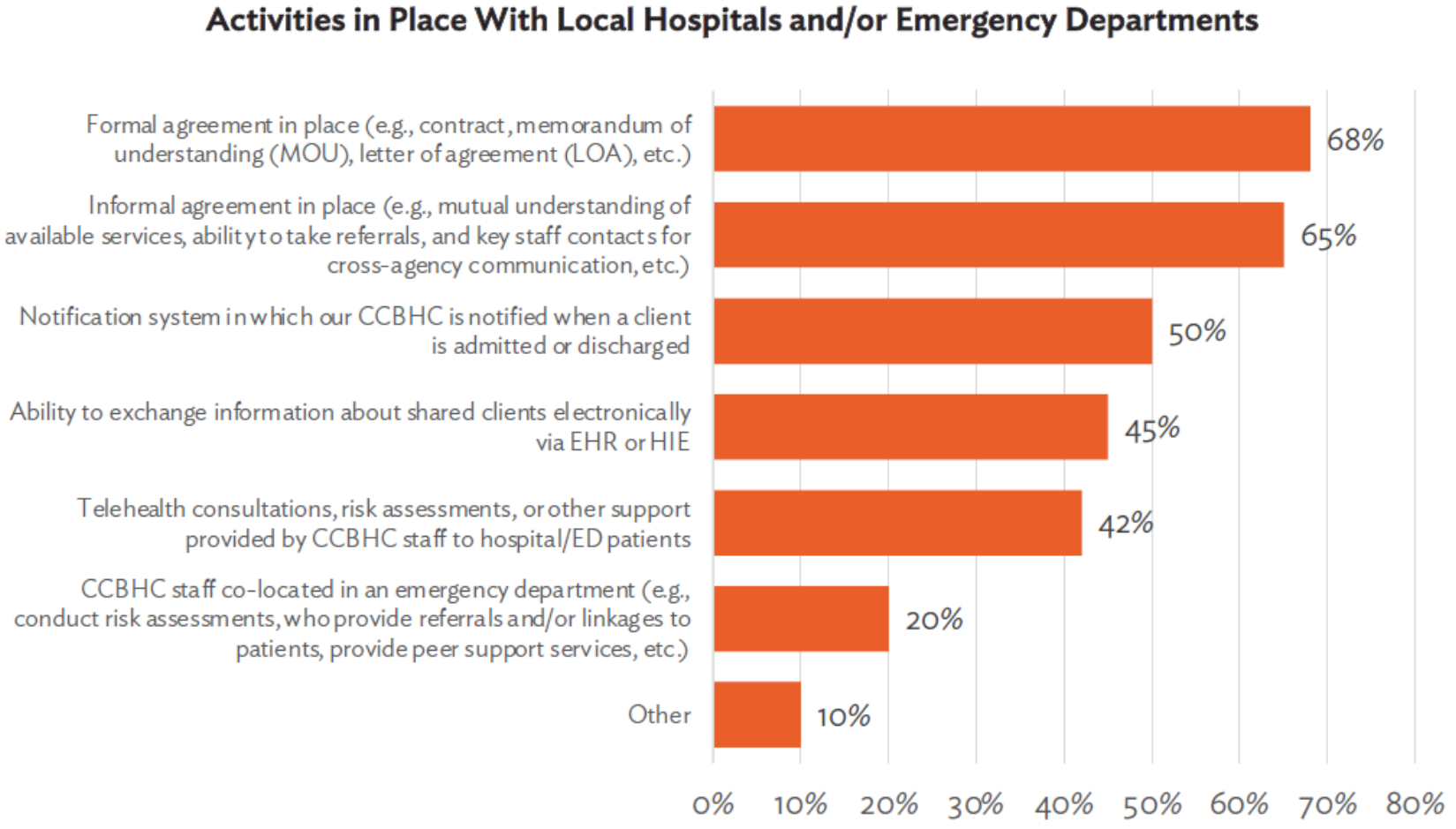


Other Crisis Response Activities

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%

Partnerships with Hospitals & EDs

Nearly all (**98%**) CCBHCs and grantees are also working to improve collaboration with local hospitals and/or emergency departments. While more than two-thirds of respondents (**68%**) have formal agreements in place with their hospital/ED partners, the near-universal adoption of these activities indicates that enhanced collaboration does not have to wait for establishment of a formal agreement.



Needs for Support Related to Crisis Care

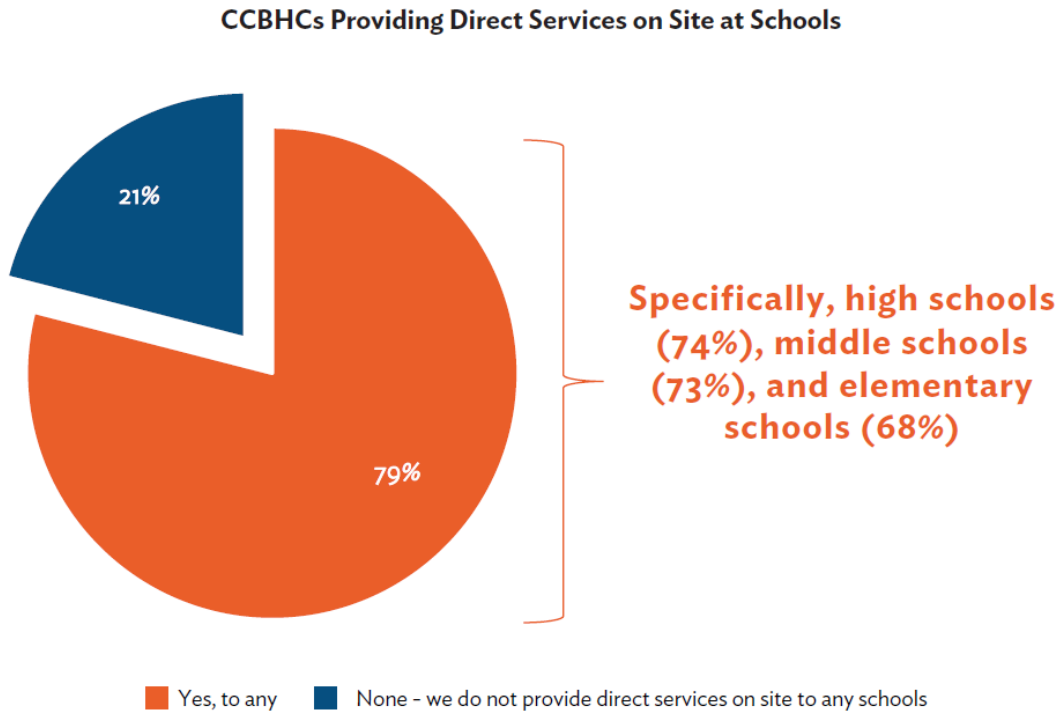
When thinking about your organization's ability to participate in or coordinate with local/state crisis systems (including efforts emerging from 988 implementation), which of the following types of support would be most helpful to you?

	All respondents
Securing additional financing to support hiring, technology, or other needs	79%
Staff training (e.g., training for crisis responders or clinic leadership, etc.)	64%
Stakeholder alignment (e.g., cross-sector workgroups, local/state/national level convenings, etc.)	55%
Building tools and staff capacity to leverage data	53%
Learning and/or sharing high-impact innovations	53%
Changing state laws or regulations to reduce barriers in accessing services	46%
Building a research base to adapt existing models/tools to meet the needs of specific groups or improve interventions	42%
Support with launching or strengthening direct service lines	37%
Other, please specify	3%
Nothing	1%

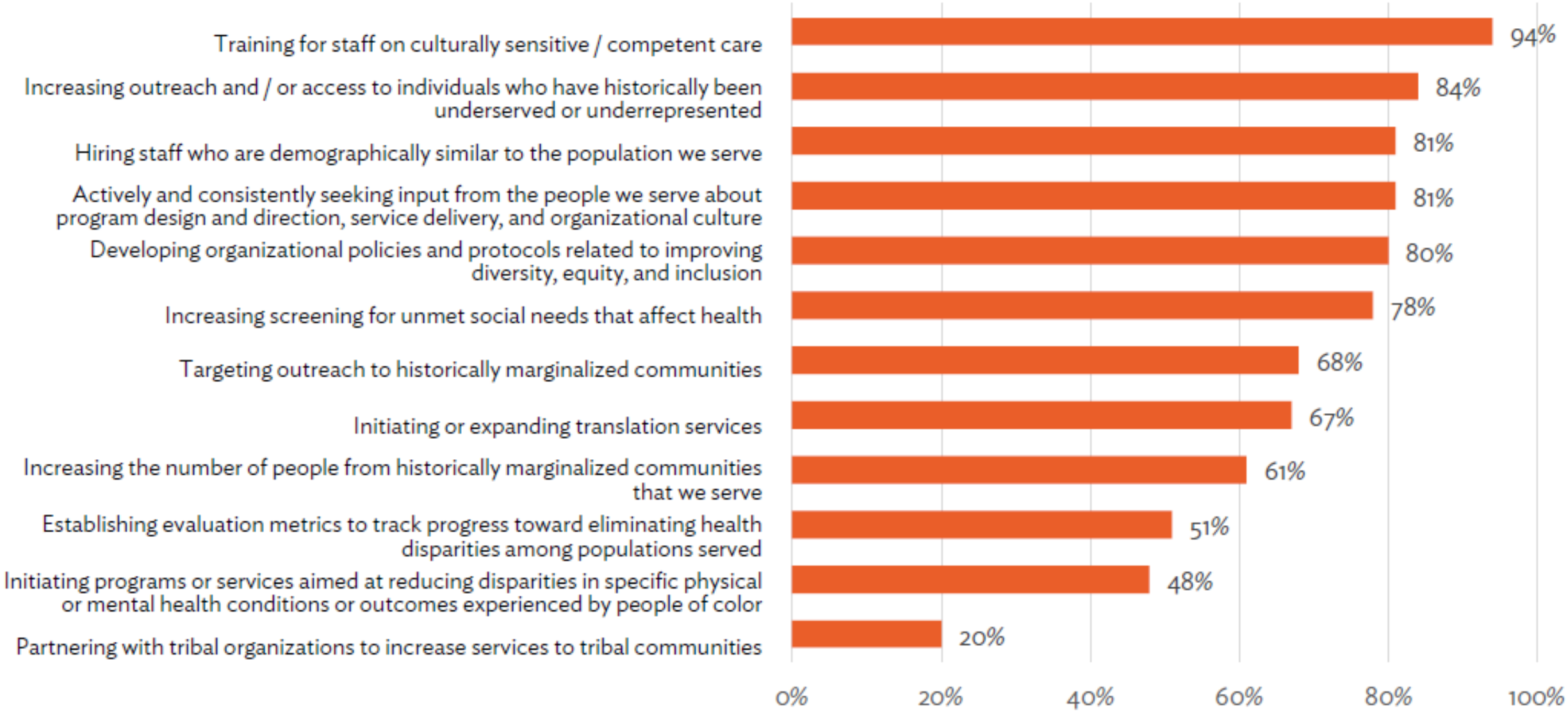
Activities Conducted in Partnership With Criminal Justice Agencies to Improve Outcomes for People who Have Criminal Legal System Involvement or are at Risk of Being Involved With the Criminal Legal System	Percentage of participating CCBHCs
Collaboration with court systems: Provide services or take referrals in partnership with courts	86%
Outreach and engagement: Increase outreach and / or access to individuals who have criminal legal system involvement or are at risk of being involved with the criminal legal system	77%
Training: Train law enforcement or corrections officers in Mental Health First Aid, CIT, or other mental health / SUD awareness training	65%
Re-entry support: Provide pre-release screening / referrals or engage in related activities to ensure continuity of care upon re-entry to the community from jail or prison	64%
Community supervision support: Embed services within parole / probation agencies or coordinate with these agencies	41%
Data-sharing: Initiated data or information sharing with law enforcement or local jails / prisons to support improved collaboration	36%
Technology: Provide telehealth support to law enforcement officers responding to mental health / SUD calls	33%

Child & Youth Services

Most respondents (**94%**) directly deliver services to children and youth; others (**8%**) collaborate with a DCO for child/youth services.



Activities to Improve Access to Care, Reduce Health Disparities Among, and Serve People of Color or Other Historically Marginalized Populations



What is next for Indiana?

Establish Indiana-specific Goals.

Conduct State & Community Needs Assessments.

Craft CCBHC certification criteria with Indiana's needs in mind

Establish a CCBHC prospective payment methodology.

Develop data collection and reporting capacities..

Request CMS Permission to establish the CCBHC model in Medicaid

Questions?