The CCBHC: An Innovative Model of Care for Behavioral Health

BRENDA GOGGINS, JD VICE PRESIDENT
OAKS INTEGRATED CARE

MICHAEL D’AMICO, LCSW DIRECTOR
OAKS INTEGRATED CARE

REBECCA FARLEY, MPH VICE PRESIDENT POLICY & ADVOCACY
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
Overview of the CCBHC

• The Certified Community Behavioral Health Clinic is authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) (PL 113-93) and was established from the Excellence in Mental Health Care S.264
• Program objectives are to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, improve access to high-quality care and demonstrate cost efficiencies.
• States selected will participate will initiate a two year demonstration project utilizing a Prospective Payment Rate system.
History of the CCBHC

• 2015 – HHS awarded planning grants to 24 states to support certification of community behavioral health clinics

• Fall of 2015, 7 providers selected to participate in application process with New Jersey Department of Human Services and Division of Mental Health and Addiction Services

• From Fall 2015 to Fall 2016, the provider agencies independently completed 6 separate assessments for certification and prepared structured cost reports.

• October 2016 New Jersey submitted its application to the federal evaluation planning team.

• 19 of the initial 24 states submitted applications to participate in the demonstration program.

• New Jersey was one of 8 states selected for the demonstration program.
NJ CCBHC Providers

AtlantiCare
BEHAVIORAL HEALTH
A MEMBER OF GESINGER HEALTH SYSTEM

Oaks
INTEGRATED CARE

Catholic Charities
DIOCESE OF TRENTON

Northwest Essex
Community Healthcare Network

CarePlus
NEW JERSEY

Rutgers
University Behavioral Health Care

CPC Behavioral Healthcare
The Mission and Purpose

1. Improve overall health and wellness by expanding and improving community mental health care
2. Implement a model that provides integration of behavioral health, physical health and addictions treatment; serving the whole person
3. Enhance services provided through implementation of Evidenced Based Practices endorsed by the model
CCBHC and the Pillars of Program Success

The CCBHC Model gives us the framework to bolster the key pillars upon which our programs rest:

1. Access to services: 24/7 access to care; integrated health care; crisis response; care coordination
2. Quality Care: Making services Evidence Based and data driven
3. Outcomes: Improved wellness and client satisfaction
Components of the CCBHC System

Screening, assessment and diagnosis
Psychiatric Care and MAT
Outpatient MH/SA
Veterans Services
Patient Centered Treatment Planning
Crisis Services
Psych Rehab
Peer Supports
Primary Health Screening and Monitoring
Care Coordination
Targeted Case Management
Ambulatory Detox Services
Screening, assessment and diagnosis
Ambulatory Detox Services
Core Services

Core Service must be provided by CCBHC directly:

- Behavioral Health Crisis Services
- Comprehensive Behavioral Health Screening, Assessment, Diagnosis and Risk Assessment
- Comprehensive Outpatient MH and SA Services
- Patient Centered Treatment Planning
- Care Coordination
- ASAM Level 1 of Withdrawal Management for adults
Other Required Services

The services listed below are also required, but can be provided by a CCBHC directly, through a Designated Collaborating Organization, referral or other partnership.

- Outpatient primary care screening and monitoring of key health indicators and risk
- Psych Rehab Services
- Community Wellness and Recovery Centers
- Targeted Case Management
- Peer and family supports
- Community based MH and SA services for Armed Forces and Veterans
- ASAM Levels of Withdrawal Management for Adults 2WM, 3.2WM, 3.7WM
The CCBHC seeks to make an impact in five (5) diagnostic categories:

1. Children w/Serious Emotional Disturbances (SED)
2. Adults with Severe and Persistent Mental Illness (SPMI)
3. Adults w/Substance Use Disorders (SUD)
4. Veterans w/PTSD (VETS)
5. General Population w/any other Mental Health of Substance Use Diagnosis
<table>
<thead>
<tr>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness and Management Recovery (IMR)</td>
</tr>
<tr>
<td>Motivational Interviewing (MI)</td>
</tr>
<tr>
<td>Medication Management and Education</td>
</tr>
<tr>
<td>Trauma Informed Care (TIC)</td>
</tr>
<tr>
<td>Medication Assisted Treatment (MAT)</td>
</tr>
<tr>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>Integrated Dual Diagnosis Treatment (IDDT)</td>
</tr>
</tbody>
</table>
Payment and reimbursement structures in CCBHC

CCBHC utilizes a prospective payment system, the PPS2 model

- Payment Relates to Cost
  - Reimbursement based on cost of serving consumers, not on fee schedule
  - PPS rate is unique to each CCBHC
  - Same rate is paid for each qualifying unit of service regardless of the intensity of services provided
  - PPS rate is stratified based on specialty populations-SMI, SUD, PTSD, & General (as determined by population and diagnosis)

- Providers are “at-risk” in this model
  - May not equal costs for a given year and is not subject to cost settlement
  - Unanticipated costs as it related to retro fitting space, start up costs, specialty staff, etc.
  - Agencies can submit for outlier reimbursement for services provided beyond the state defined threshold
Partnerships in the CCBHC model

- Partnerships are an important component of the model
- NJ CCBHC Provider Collaboration
- There are a number of ways that providers can partner with a CCBHC:
  - Designated Collaborating Organizations (DCO)
  - Care Coordination Partnerships
Working with CCBHCs

- Designated Collaborating Organization
  - Not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements at the CCBHC

- Fee Agreements with the CCBHC

- Care Coordination
  - Various opportunities for CCBHCs to make referrals to other organizations for services not required to be provided as Core or Required services through DCO’s
The “Linch-Pin” of program success….

- Coordinates Care across the spectrum of services internally and externally
- Care coordination for ongoing treatment and aftercare services
- Helps to establish the “Treatment Team”
- Fosters relationships and collaboration with:
  - Schools
  - Justice and Legal System
  - Hospital System; Psych and Medical
  - DCPP
  - Veterans Affairs
  - FQHCs
  - Residential Substance Abuse Treatment
  - Methadone Treatment
  - Other Community Providers
- Done through electronic exchange of information (e.g. HIE) as well as through connecting via telephone, e-mail and in-person
- All staff are involved with the care coordination process
Care Coordination Partnerships Cont.

- Differs from CCBHC-DCO relationships in that they are referral relationships.
- Each entity maintains full clinical and financial responsibility for its own services.
- CCBHC does not bill for services provided by its care coordination partners.
Designated Collaborating Organizations (DCO)

- CCBHC organizations that were not able to provide all nine required CCBHC services directly were permitted to contract with external providers for the provision of some services. Ex. Emergency Psychiatric Screening Services
- SAMHSA designated these entities as DCOs and established guidelines for the CCBHC-DCO relationship.
- CCBHC is clinically and financially responsible for the provision of services through a DCO. This means the CCBHC is the billing provider for the service and must ensure the DCO meets all relevant requirements in the statute and guidance.
- Relationships with DCOs are optional; if a CCBHC directly provides all nine required services, it is not required to establish a relationship with a DCO.
Quality measures are tools that help measure or quantify healthcare processes, outcomes, patient perceptions and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

-CMS DEFINITION-
National Quality Strategy

3 Aims
- Better Care,
- Smarter Spending,
- Healthier People

6 Domains (to be measured)
- Engagement
- Clinical Process/Effectiveness
- Efficient Use of Healthcare Resources
- Patient Safety
- Care Coordination
- Population/Public Health
CCBHCs are required to report on CCBHC Behavioral Health Clinic Measures

32 measures in total – structured data from EHRs, Assessments, Surveys

Federal CCBHC measures – 14

State led measures – 18

DY1 = July 1, 2017 to June 30th 2018
### Examples of Measures

<table>
<thead>
<tr>
<th>Potential Source of Data</th>
<th>Measure or Other Reporting Requirement</th>
<th>NQF Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR, Patient records, Electronic scheduler</td>
<td>Time to Initial Evaluation</td>
<td>N/A</td>
</tr>
<tr>
<td>EHR, Patient records</td>
<td>Adult Body Mass Index (BMI) Screening and Follow-Up</td>
<td>0421</td>
</tr>
<tr>
<td>EHR, Encounter data</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
<td>0024</td>
</tr>
<tr>
<td>EHR, Encounter data</td>
<td>Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>0028</td>
</tr>
<tr>
<td>EHR, Patient records</td>
<td>Unhealthy Alcohol Use: Screening and Brief Counseling</td>
<td>2152</td>
</tr>
<tr>
<td>EHR, Patient records</td>
<td>Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment</td>
<td>1365</td>
</tr>
<tr>
<td>EHR, Patient records</td>
<td>Adult major depressive disorder (MDD): Suicide risk assessment</td>
<td>0104</td>
</tr>
<tr>
<td>EHR, Patient records</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>0418</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Source of Data</th>
<th>Measure or Other Reporting Requirement</th>
<th>NQF Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>URS</td>
<td>Housing Status</td>
<td>N/A</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Follow-Up After Emergency Department for Mental Health all ages and hospitalization</td>
<td>2605, 0576</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Follow-Up After Emergency Department for Alcohol or Other Dependence</td>
<td>2605</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Plan All-Cause Readmission Rate</td>
<td>1768</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications</td>
<td>1932</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
<td>N/A</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Follow-up care for children prescribed ADHD medication</td>
<td>0108</td>
</tr>
<tr>
<td>Claims data/ encounter data</td>
<td>Antidepressant Medication Management</td>
<td>0105</td>
</tr>
<tr>
<td>MHSIP Survey</td>
<td>Patient experience of care survey; Family experience of care survey</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Aggregating the Data

Administrative
- Claims/ encounter data

Medical Records – CCBHC medical records or other clinical data sources such as:
- Electronic health records
- Paper medical records
- Clinic registries
- Scheduling software

Hybrid – The numerator combines
- Administrative data sources
- Medical record data
HIE and CCBHC

- Local Level - Trenton Health Team HIE
- State Level - New Jersey Innovation Institute
- (NJII) New Jersey Health Information Network (NJHIN) team

**HIE will allow CCBHCs broader information on hospital admissions and discharges**

- Manage connections with DCOs
- Eliminates redundant services/Reduced costs
- Improves public health reporting and monitoring
- Provides a basic level of interoperability among electronic health records (EHRs) maintained by individual physicians and organizations
- Supports right level of care at the right time
Improving Overall Health and Wellness

- Improved Access to Care
- A Wraparound model of service delivery that is seamless
- How does this change the experience for the individuals we serve?
- The Journey toward health and wellness...
How are the CCBHC providers doing so far?
New Jersey CCBHC Successes to Date

The following data reflects responses from six of the seven CCBHCs in New Jersey, an 85% response rate. Responses were collected in November 2017.
Since Implementation...

1,160 new CCBHC positions were created nationally

New Jersey

97 new positions

NJ new positions include:
- 11 psychiatrists
- 39 staff members with an addiction specialty or focus
Since Implementation Began…

100% of New Jersey CCBHCs report an increased number of patients served, representing up to a 25% increase in total patient caseloads for most clinics.
NEW JERSEY CCBHC ACTIVITIES TO EXPAND OPIOID TREATMENT CAPACITY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hired staff with addiction specialty/trained staff in addiction-focused competencies</td>
<td>100%</td>
</tr>
<tr>
<td>Launched other opioid treatment or recovery initiatives</td>
<td>83%</td>
</tr>
<tr>
<td>Expanded existing Medication-Assisted Treatment (MAT) program</td>
<td>67%</td>
</tr>
<tr>
<td>Trained staff or community partners in naloxone administration</td>
<td>67%</td>
</tr>
<tr>
<td>Implemented screening protocols for opioid use disorder</td>
<td>67%</td>
</tr>
<tr>
<td>Began offering Medication-Assisted Treatment (MAT)</td>
<td>50%</td>
</tr>
<tr>
<td>Hired peer recovery specialists to provide recovery support</td>
<td>50%</td>
</tr>
</tbody>
</table>
“We are now licensed for Ambulatory Withdrawal Management. We will be hiring peer specialists specifically for that program. We are moving towards having a specific service line for Addictions, which is a result of CCBHC expansion into substance use disorder treatment.”

-NJ CCBHC comment from survey
Implement same-day access protocols so that every client can be seen on the same day they are referred for services

Initiate new programs, service lines or locations

Improve or expand services to veterans

Implement new care delivery or outreach partnerships with hospitals

Adopt new technologies that support care delivery, such as EHR upgrades, mobile apps, web platforms, telehealth, etc.

Expand capacity to provide crisis care

Implement new care delivery or outreach partnerships with criminal justice agencies, jails, prisons, or courts

Implement remote monitoring technologies

Implement new care delivery or outreach partnerships with schools

Implement same-day access protocols so that every client can be seen on the same day they are referred for services

NEW JERSEY CCBHC ACTIVITIES TO EXPAND SERVICES, TECHNOLOGY, AND TREATMENT INNOVATIONS

Improve outreach (e.g. hiring outreach workers or care coordinators, implementing protocols to reduce no-shows via... 100%
“CCBHC has expanded our reach in the community and provided for much needed care coordination. Through CCBHC, we have been able to increase capacity and become a full data partner with the HIE [health information exchange] and area hospitals.”

-NJ CCBHC comment from survey
Looking to the Future

- Implications of Federal & State policy on the viability of CCBHC in differing scenarios
  - ACA changes
  - Medicaid Expansion
  - Excellence in Mental Health Act
  - 1115 Waiver
  - DMHAS transition to DOH
  - Quality Measures in the move to Managed Care/Population Health
  - Advocacy efforts
  - Creating Partnerships with other Community Providers
Questions?

- Brenda Goggins: brenda.goggins@oaksintcare.org
- Michael D’Amico: michael.damico@oaksintcare.org
- Rebecca Farley David: rebeccad@thenationalcouncil.org
Thank you!