

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

HOPE FOR THE FUTURE

CCBHCs EXPANDING
MENTAL HEALTH
AND ADDICTION
TREATMENT

▶ AN IMPACT REPORT

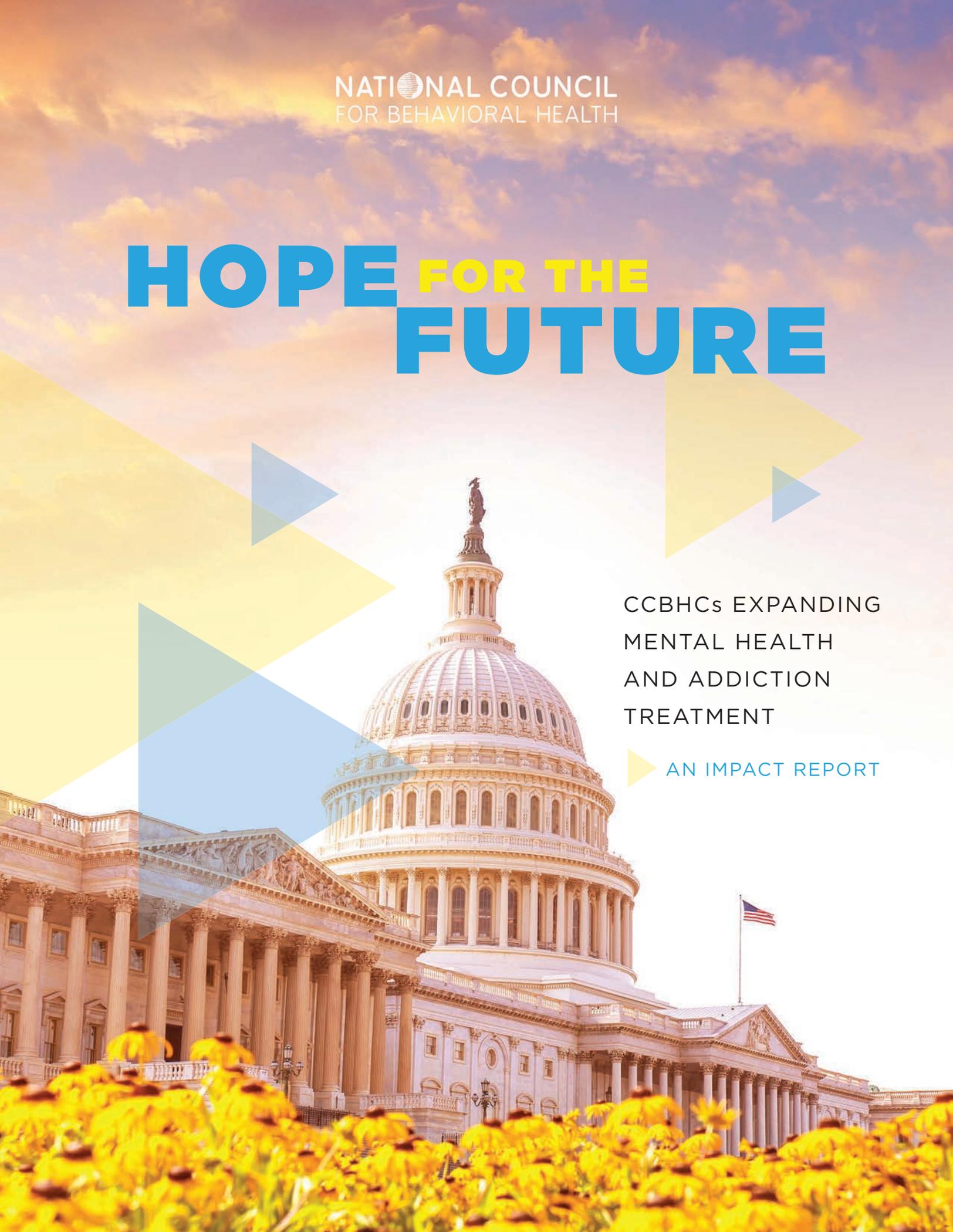


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EXECUTIVE SUMMARY

Lack of access to timely, high-quality mental health and addiction treatment is the greatest barrier to a healthier America.

The numbers are staggering. A mere 12% of Americans with a substance use disorder receive specialty treatment in any given year. Only 43% of all people living with mental illness receive treatment for their condition. Although the numbers increase to 67% for serious mental illnesses like schizophrenia, bipolar disorder and major depression, unacceptable gaps in access remain.ⁱ

It is all too easy to forget that these statistics have real life consequences — they represent lives claimed by mental illness and addictions. In 2017 alone, 47,173 Americans died by suicideⁱⁱ and since 2016, suicide has been the second leading cause of death for ages 10-34.ⁱⁱⁱ In 2016, there were 70,237 drug overdose deaths in the U.S., a 9.6% increase over the prior year.^{iv}

But, in the midst of those devastating numbers, we see signs of hope and progress.

Thanks to bipartisan leadership in the U.S. Congress, **Certified Community Behavioral Health Clinics** (CCBHCs) are leading a bold shift to increase access to high-quality mental health and addiction treatment that is making a difference in the lives of thousands of individuals and communities across the nation. The National Council for Behavioral Health is committed to creating 500 CCBHCs nationwide by 2025. When that happens, 2.9 million individuals will receive high-quality mental health and addiction treatment — when they seek it, where they live, tailored to their needs.

We are fortunate to have been among the first clinics to become a CCBHC. We know firsthand that it is possible to implement meaningful changes, to expect more from ourselves and, most importantly, to bring health and hope to people living with mental illness and addiction. We are proud of what we have accomplished in the very early stages of this bold experiment. And we know that this is just the beginning.

CCBHCs are the model for the future. Our accomplishments in the first year, captured in this report, provide a glimpse of what's possible and provide a roadmap forward. We are hopeful that soon, individuals in every state will have access to CCBHCs. When that happens, we will have created the greatest opportunity to improve the health and well-being of the entire nation.

We know how to get there and we are confident we have already begun this important journey.

Randy Tate, CEO
NorthCare, Oklahoma City, Oklahoma

Frank A. Ghinassi, Ph.D., President and CEO
Rutgers University Behavioral Health Care
Piscataway, New Jersey

OVERVIEW OF THE CCBHC PROGRAM

After decades of declining federal funding for mental health and addiction treatment services, the bipartisan Protecting Access to Medicare Act of 2014 established a new provider type in Medicaid designed to expand access to treatment for all Americans. Certified Community Behavioral Health Clinics (CCBHCs) provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals, including 24/7 crisis response.

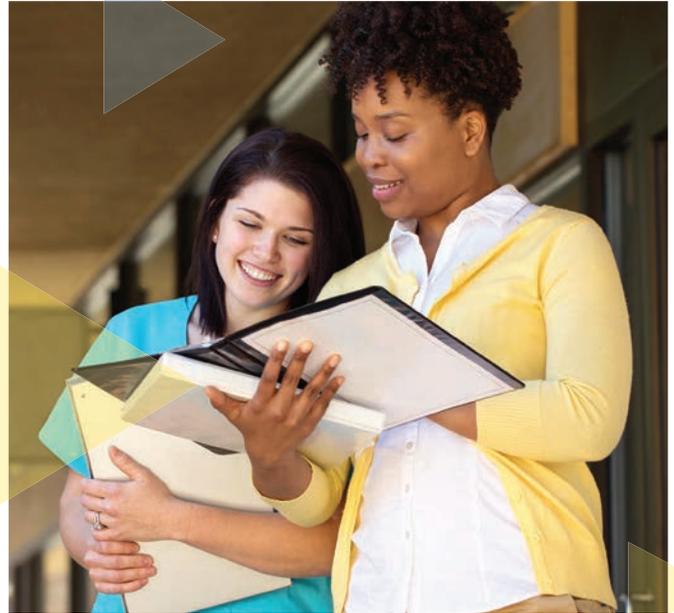
In order to qualify as a CCBHC, clinics had to expand their service array in required categories, such as tailored care for active duty military and veterans, 24/7 crisis services and rapid access for non-crisiscare and guarantee that their clinics would serve everyone, regardless of their ability to pay. It is worth noting that these rigorous requirements do not apply to non-CCBHC clinics and this array of services are only required of CCBHCs.

Clinics in 24 states took steps to qualify for the two-year Medicaid demonstration program. In 2017, 66 CCBHCs began operations in eight states selected: **Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon** and **Pennsylvania**.

Since launching, CCBHCs have dramatically increased access to mental health and addiction treatment, expanded capacity to address the opioid crisis and established innovative partnerships with law enforcement and hospitals to improve care and reduce recidivism and readmissions. In exchange, they receive Medicaid payment that covers the actual costs of providing these comprehensive services.

Recognizing the promise of the CCBHC demonstration, Congress enacted a grant fund to support clinics as they prepared to become CCBHCs. Since 2018, Congress has appropriated yearly funds for two-year CCBHC Expansion Grants. As of 2020, these grants are open to clinics in all 50 states. While these grantee organizations do not receive the full benefits of the Medicaid demonstration reimbursement rate, the grant funds have launched CCBHC activities in states that otherwise would not have benefitted from the program. Today, a total of 113 CCBHCs are operating in 21 states: the eight demonstration states **plus Colorado, Connecticut, Indiana, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, North Carolina, Rhode Island, Texas** and **Virginia**.

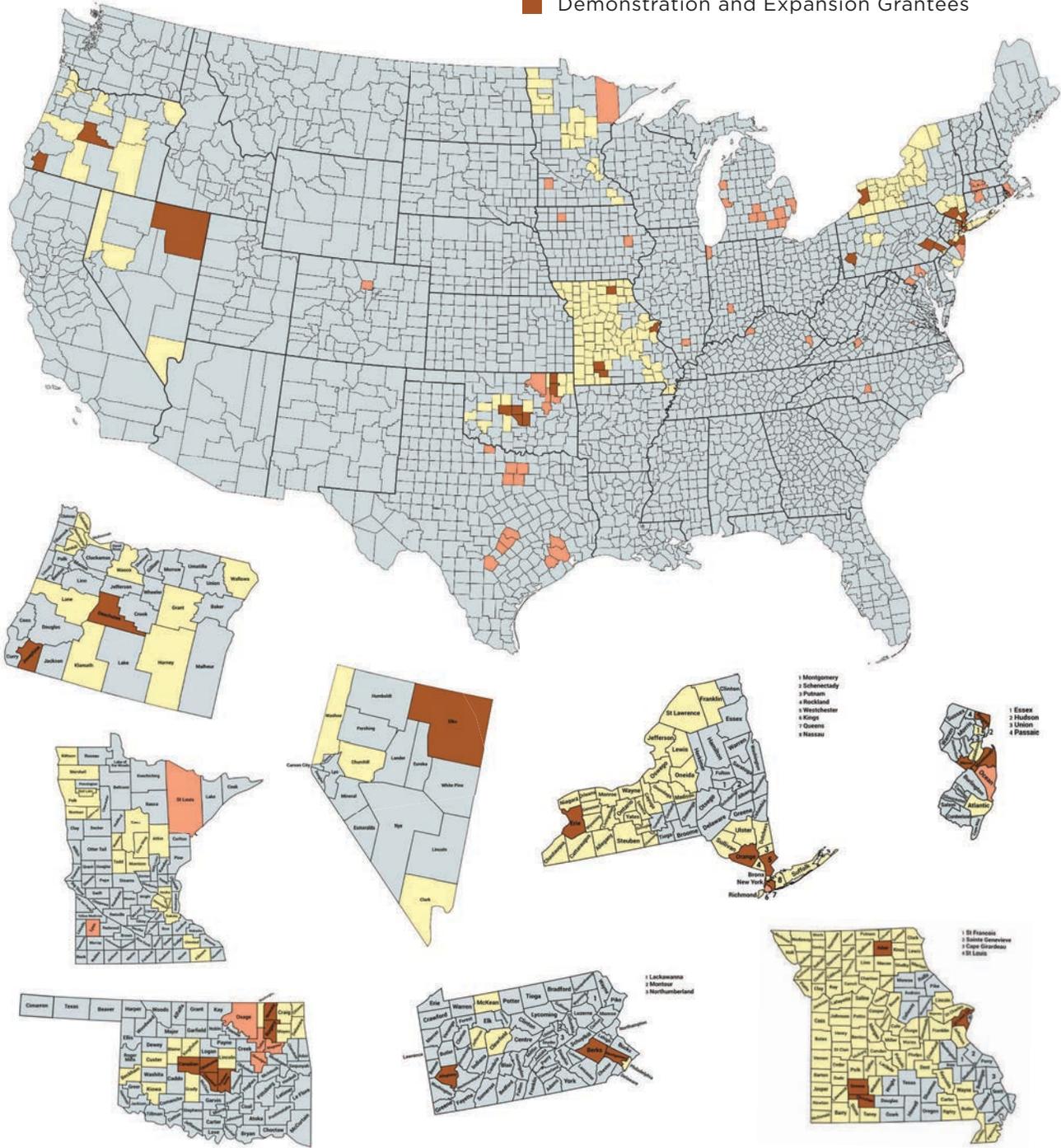
This report highlights accomplishments of the initial cohort of 66 CCBHCs in the Medicaid demonstration, as they are furthest along in this process.

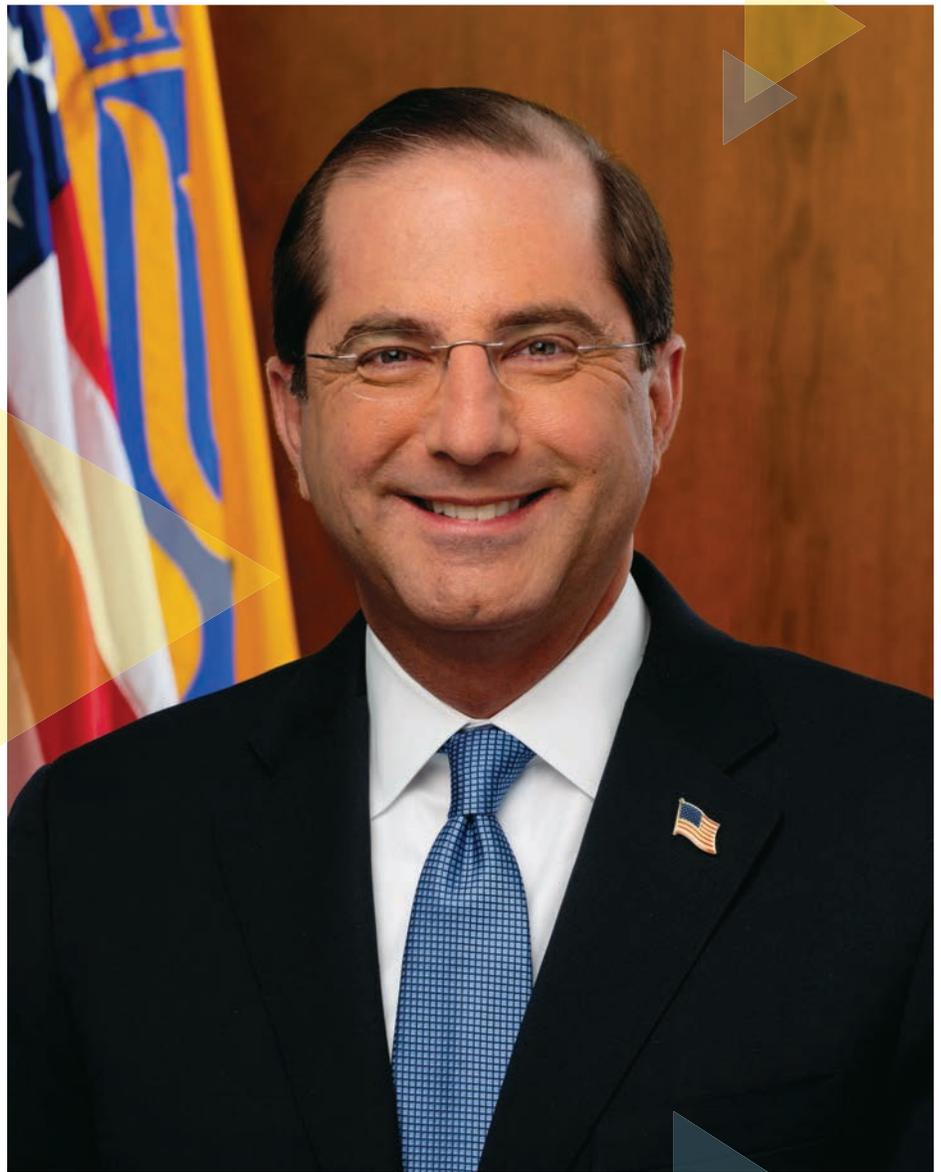


113 CCBHCs OPERATING IN 21 STATES

NCBH CCBHC MAPPING

- Demonstration Grantees
- Expansion Grantees
- Demonstration and Expansion Grantees





**“The CERTIFIED
COMMUNITY BEHAVIORAL
HEALTH CLINICS
PROGRAM... [is] making**

services more convenient. They’re introducing more frequent appointments, tailoring services offered to diverse populations such as school-aged youth and veterans, and they’re expanding access to care in our communities. So, in our budget, we proposed to extend this program through FY2021 for the eight current participating hospitals because we are believers in this program and obviously happy to continue working with you as we think about expansion to other states.”

— **Alex M. Azar II**, Secretary of the Department of Health and Human Services responding to a question from Sen. Debbie Stabenow (D-Mich.) at a Senate Finance Committee hearing on February 13, 2020

THE **CHALLENGES** CCBHCs WERE DESIGNED TO ADDRESS

- **Suicide Crisis:** In 2017 alone, 47,173 Americans died by suicide^v and as of 2016, suicide is the second leading cause of death for ages 10–34.^{vi}
- **Overdose Epidemic:** In 2017, there were 70,237 drug overdose deaths in the U.S., a 9.6% increase over the prior year.^{vii}
- **Lack of Access to Addiction Treatment:** Nearly 20 million people need substance use treatment, but only 12.2% are able to receive it.^{viii}
- **Lack of Access Mental Health Services:** Among the 46.6 million adults with a mental illness, less than half (42.6%) received mental health services in 2017.^{ix}
- **Inadequate Care for Veterans:** Approximately 18.5% of U.S. service members who have returned from Afghanistan and Iraq have post-traumatic stress disorder or depression; roughly half who need treatment seek it, but many receive minimally adequate care.^x
- **Limited Use of MAT:** Only an estimated one-third of substance use treatment facilities offer access to medication-assisted treatment (MAT).^{xi}
- **Workforce Shortage:** 113 million Americans live in mental health “deserts” — areas that lack sufficient numbers of health professionals to meet the needs of the population.^{xii}
- **Delayed Care:** Nationwide, wait times from referral to first appointment average 48 days.
- **Overburdened Jails and Emergency Departments (ED):** One in eight ED visits involves a mental health or substance use concern^{xiii} and nationwide, 2 million individuals with a serious mental illness are in jail.^{xiv}
- **Funding:** Decades of funding cuts have left treatment providers struggling to hire staff and expand programs to meet the needs in their communities.
- **No Standardization of Services:** Local and state funding currently drives availability of services, often leading to a nationwide patchwork of covered services.



CCBHCs — A NEW AND BETTER WAY TO DELIVER CARE

CCBHCs adopt a standard model to improve the quality and availability of addiction and mental health care and, in doing so, address some of the nation's most urgent challenges. They provide care to people regardless of ability to pay — those who are underserved; have low incomes; are insured, uninsured or on Medicaid; and active duty military or veterans. CCBHCs are different than other federally funded mental health providers: they must, by statute, provide a comprehensive range of addiction and mental health services, including:

- **24/7/365 mobile crisis team services** to help stabilize people in the most clinically appropriate, least restrictive or traumatizing and most cost-effective settings.
- **Immediate screening and risk assessment** for mental health, addictions and basic primary care needs.
- **Easy access to care** to ensure people receive needed services without lengthy wait times and that every person can receive care regardless of ability to pay.
- **Tailored care for active duty military and veterans** to ensure they receive the unique health support essential to their treatment.
- **Expanded care coordination** with local primary care providers, hospitals, other health care providers, social service providers and law enforcement.
- **Commitment to peers and family**, recognizing that their involvement is essential for recovery.

Unlike traditional service organizations that operate differently in each state or community, CCBHCs must also meet uniform federal requirements related to quality reporting, governance and staffing. In exchange for meeting these additional criteria, CCBHCs qualify for a Medicaid payment rate that covers the real costs of delivering enhanced services to an increased number of patients and represents an important transformation in the sustainability of clinics, eliminating the uncertainty of time-limited grant funding.

BEFORE CCBHCs

Mary is hearing voices and doesn't know where to get help, so she turns to opioids to help dull the problem.

- ▶ Mary develops an opioid addiction and overdoses. Emergency responders are called.
- ▶ Mary is revived with naloxone and discharged from the hospital with a referral to a community provider.
- ▶ Mary attends the appointment, but the provider cannot issue a prescription for MAT and makes a referral to a MAT clinic two hours away where she can receive the needed prescription.
- ▶ Mary gets worse and never makes it to the MAT clinic. She resumes opioid use and begins drinking alcohol.
- ▶ Mary causes a public disturbance while intoxicated and experiencing a mental health crisis. The police are called and Mary spends the night in jail detoxing.
- ▶ Mary is released from jail the next day and referred for substance use disorder (SUD) services, but there is a six-week wait for an appointment.
- ▶ Mary continues a dangerous downward spiral, prompting continued interaction with law enforcement and ED professionals.

AFTER CCBHCs

Mary is hearing voices and doesn't know where to get help, so she turns to opioids to help dull the problem.

- ▶ Mary is contacted by a care coordinator working with the hospital and the local CCBHC as part of routine community outreach to opioid users.
- ▶ Outreach worker schedules a same day appointment for Mary at the CCBHC.
- ▶ Mary is transported to the CCBHC, where MAT is prescribed and administered immediately.
- ▶ The CCBHC also conducts a mental health screening, which determines Mary is experiencing a first episode of psychosis. A psychiatric treatment plan is developed and a care team is assembled with follow-up plan in place.
- ▶ Mary's outreach manager ensures she has what she needs to attend appointments (transportation, access at convenient times, etc.) and maintain her treatment plan.
- ▶ Mary is stabilized and maintains her treatment plan and no longer requires urgent or high intensity services.

CCBHCs ARE MAKING A DIFFERENCE WHERE IT MATTERS MOST

ADDRESSING THE SUICIDE CRISIS

In response to rising suicide rates across the nation, CCBHCs have developed tools to screen for suicide risk, respond immediately to people experiencing suicidal thoughts and partner with schools and other community institutions for suicide prevention. Quality reporting requirements hold CCBHCs accountable for conducting suicide risk screenings for all patients who come into their care. CCBHCs have been able to hire staff to offer services at times that are convenient for their patients, including clinical staff with pediatric specialties to help school-age youth and families, a significant challenge for most community behavioral health organizations. Additionally, CCBHCs must provide 24/7 crisis care, mobile crisis teams and work in partnerships with local law enforcement and hospitals to provide services designed to intervene with and support individuals contemplating suicide.

COMPREHENSIVE MH SERVICES (MISSOURI)

“Prior to becoming a CCBHC, we were working to implement a Zero Suicide initiative. Since becoming a CCBHC, we are able to screen all clients who come for therapy or medication services. We also added two

new positions. The suicide prevention liaison oversees our services, reviewing risk assessments working with treatment teams to ensure supportive care plans are in place. The Hospital Discharge Specialist ensures timely client follow-up after discharge and collaborates with the treatment team to ensure services are provided throughout the process. Through this approach, we are reducing psychiatric hospitalizations and making tremendous progress toward our goal of zero suicides.”

In the first year of operations:^{xv}

93%

of CCBHCs provided staff training in suicide prevention and response.

81%

of CCBHCs targeted outreach to school-age youth.

97%

of CCBHCs created a formal referral relationship with local schools, with 55% providing mental health services on-site in schools.

ADDRESSING THE OPIOID EPIDEMIC AND EXPANDING ACCESS TO MEDICATION-ASSISTED TREATMENT

Despite the surging opioid crisis and the deaths of more than 70,000 Americans by drug overdose in 2017, only one in 10 Americans with an addiction receives treatment in a given year.^{xvi} Across the nation, access to addiction treatment services is spotty, with wide variation in available services and only an estimated one-third of substance use treatment facilities offer access to MAT.^{xvii}

Addiction treatment is a core component of CCBHCs' required service array. Because of the CCBHC program, participating clinics have implemented major expansions of the addiction treatment services available to all community members. As a result, nearly all CCBHCs have increased the number of patients with addictions they serve, either by taking on new patients, improving screening protocols to identify at risk use and addiction among existing patients or both. Nearly all CCBHCs have adopted MAT, a highly effective addiction treatment method that combines the use of medications with cognitive and behavioral therapies. MAT is the gold standard for opioid addiction treatment.

SWOPE HEALTH SERVICES (MISSOURI)

"Prior to becoming a CCBHC, one of our clients who received psychiatric care at Swope Health Services would drive a 250-mile round trip for Suboxone treatment for his opioid addiction. During this time, he was struggling to maintain a job and attend other treatment services. Now that we are CCBHC, he can get this MAT service at Swope, much closer to home."

In the first year of operations:

94%

of CCBHCs reported an increase in the number of patients treated for addiction.

84%

Nearly all CCBHCs (84%) offered MAT and 46% added MAT because of the CCBHC requirements compared to 36% of all treatment facilities nationwide.

9,144

An estimated 9,144 patients were engaged in MAT at a CCBHC as of November 2018.

SPECTRUM HUMAN SERVICES (NEW YORK)

After becoming a CCBHC, Spectrum developed a plan to incorporate MAT into its services, conducting MAT trainings with its providers, redesigning its intake process and using community outreach teams to address "no-shows." As a result, 77% of clients with a substance use disorder began treatment within 14 days of diagnosis and 97% attended at least two appointments within the first 34 days of entering the program. Through a collaboration with local ERs, individuals with an opioid or alcohol use disorder received rapid assessment and initiation of MAT within 24 to 48 hours.

FILLING THE GAPS — MAKING CARE AVAILABLE WHEN AND WHERE PEOPLE NEED IT

Lengthy wait times for services reduce the likelihood that patients will initiate and fully engage in care. And when it comes to addiction treatment, long wait times also increase the risk of an overdose. Fortunately, CCBHCs are serving more people — and more quickly — than before.

CCBHC requirements ensure that crisis care is provided immediately or within three hours at the latest. Urgent need must be addressed within one business day, while services for routine needs must be provided within 10 business days. In addition, CCBHCs are coordinating with hospitals, other addiction treatment providers, organizations serving homeless individuals and local correctional facilities to provide crisis intervention and chronic disease management services.

BIKUR CHOLIM (NEW YORK)

Prior to becoming a CCBHC, Bikur Cholim had a waitlist of 140 patients. By hiring new staff, expanding treatment programs and implementing rapid access protocols, Bikur Cholim has completely eliminated its waitlist while simultaneously expanding its total patient caseload.

ESTER QUILICI, CEO

VITALITY UNLIMITED (NEVADA)

“We live in a county with more jackrabbits than people. Nevada’s at the bottom of the mental health world, in terms of delivery and treatment. I think that what we’ve offered is a way out for so many people in our area. In just a short time, since July 1, 2017, we have treated more than 1,900 people and delivered more than 20,000 units of service. Could we have done that before becoming a CCBHC? No, we could not. I think the area and the people we have supported are better for it.”

87%

In the first six months of implementation, 87% of CCBHC reported an increased number of patients served, with the majority reporting an increase of up to 25% in total patient caseload.^{xviii}

68%

of CCBHCs decreased patient wait times in the first year, 46% provided same day access to care and 30% kept wait times consistent despite increases in patient caseloads.^{xix}

78%

After an initial call or referral, 78% of CCBHCs can offer a follow-up appointment within a week or less.^{xx}

CARING FOR ACTIVE DUTY MILITARY AND VETERANS

About 20 veterans a day die by suicide and fewer than 50% of our returning service members who need mental health care receive it. Many veterans live too far from their local VA health care facility, cannot access services there in a timely way or prefer to seek services in their own communities.

CCBHCs have taken a variety of steps to improve outreach and access to care for veterans, including building and strengthening relationships with local VAs, providing veteran peer navigators and looking creatively for opportunities to connect with veterans in social settings.

CATHOLIC CHARITIES, DIOCESE OF TRENTON (NEW JERSEY)

Many of the more than 40,000 veterans in Burlington County live far from the closest VA facility. After becoming a CCBHC, Catholic Charities began working more closely with the VA to build crisis capacity and rapid access to a full continuum of behavioral health services, including psychiatric rehabilitation, peer support, supported employment and transportation to and from appointments.

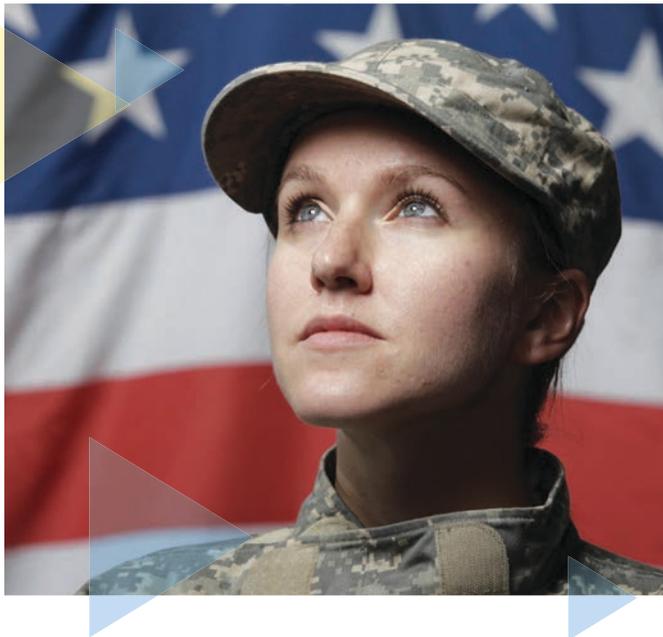
In the first year of operations:

72%

of CCBHCs provide services to veterans.

64%

of CCBHCs expanded services to veterans.



BERKS COUNSELING CENTER (PENNSYLVANIA)

Building and maintaining trust is one of the most significant steps health care providers need to take when working with veterans. Berks Counseling Center knows successful care starts when patients have confidence in their providers and Berks found a creative way to cultivate relationships with the veterans in their community — an annual veterans' dinner dance. The event opened doors with potential patients and helped highlight the unique needs of veterans, which led to service members coming to the center for treatment.

IMPROVING COORDINATION WITH LAW ENFORCEMENT

A disproportionate number of individuals with serious mental illness (SMI) and/or SUD encounter the criminal justice system each year. In 2012, jails and prisons housed 10 times more people with SMI than state hospitals. Community-based treatment reduces the chances of reincarceration, decreases the burden on jails and prisons to provide mental health services and improves outcomes by providing evidence-based treatment that can help individuals avoid arrest.

CCBHCs are improving access and collaboration with law enforcement and the cornerstone of that effort is the availability of 24/7 crisis response. CCBHCs have strengthened relationships with local courts, law enforcement, probation officers, jails and prisons to enhance sharing information that improves care and reduces recidivism. Furthermore, CCBHCs are reducing the time spent by police officers responding to mental health and substance use disorder incidents, increasing the diversion of individuals from jails to treatment and, ultimately, saving local governments money.

DANIEL ENGERT, DEPUTY CHIEF AND JAIL ADMINISTRATOR, **NIAGARA COUNTY, N.Y., SHERIFF'S DEPARTMENT**

"Almost 70% of the inmates in our county jail have a serious mental illness or substance use disorder, many times both. Historically, when we released people into the community, there was no direct linkage to community treatment.... Their condition deteriorates, they re-offend and they end up back in jail or worse, they end up dead.

"That situation has started to change recently. [We work with] a local [CCBHC] clinic, BestSelf, to provide counseling and education services in our jail, along with medication-assisted treatment. BestSelf was [also] able to launch a mobile unit staffed by a counselor, a peer support specialist and access to a doctor and nurse via telemedicine. The mobile unit meets our inmates upon their release from incarceration [and] ... can immediately transport individuals with opioid addiction to their first medication-assisted treatment appointment."

KLAMATH BASIN BEHAVIORAL HEALTH (OREGON)

In partnership with the local jail, this CCBHC provides on-site services, beginning with daily copies of booking reports, following up with clients who have a treatment history and conducting check-ins with anyone who has been incarcerated. This CCBHC works to link individuals to services in the community, complete behavioral health assessments and develop or adjust treatment plans. Klamath County now has the lowest recidivism rate in Southern Oregon, resulting in an estimated \$2.5 million in savings for the state due to reduced prison costs.

In the first year of operations:

96%

of CCBHCs had a relationship with law enforcement.

97%

of CCBHCs were working with adult criminal justice agencies/courts and 90% with juvenile justice agencies.

93%

of CCBHCs were working with mental health/drug courts.

JOSH CANTWELL, CHIEF CLINICAL OFFICER OF SPECIAL PROGRAMS, **GRAND LAKE MENTAL HEALTH CENTER** (OKLAHOMA)

“Since becoming a CCBHC we’ve been able to get many mobile devices, iPads, into the communities. Law enforcement officers are able to reach out to us seven days a week, 24 hours a day. Through these partnerships, we have been able to save law enforcement officers in Northern Oklahoma 275 days of continuous driving – the equivalent of 15 trips around the world – because we can identify the best, most appropriate level of care.”

CREATING JOBS AND ALLEVIATING THE EFFECTS OF THE WORKFORCE SHORTAGE

In the first year of operations:

99%

of CCBHCs employed a medical director.^{xxi}

91%

of CCBHCs employed psychiatrists.^{xxii}

76%

of CCBHCs employed child/adolescent psychiatrists.^{xxiii}

3,000

CCBHCs added more than 3,000 staff.^{xxiv}

The current mental health care workforce is only able to meet 26% of the need for services, and the gaps are much higher in rural areas. If this trend is not reversed, a shortage of more than 250,000 behavioral health professionals is projected by 2025. In the midst of this workforce crisis, a key goal of the CCBHC initiative is to expand clinics’ capacity to serve more people via an expanded workforce. CCBHCs must have adequate numbers of Medicaid-enrolled providers to meet the needs of the communities they serve. Specific staffing requirements include: a psychiatrist serving as medical director, providers eligible to prescribe and manage medications and credentialed SUD specialists.

Prior to becoming a CCBHC, few clinics had the financial resources to add this capacity and, for those that had psychiatrists on staff, the range of services they were able to provide was constrained by inadequate reimbursement, resulting in a shortage of access to psychiatric care. As part of the CCBHC model, clinics are able to fill vacancies and redesign care teams to put a greater focus on patient needs rather than financial pressures.

AMHERST WILDER (MINNESOTA)

“The CCBHC model enabled us to hire 26 additional full-time employees. Our focus on client-centered care and our ability to provide the full-spectrum services has made us more attractive to prospective employees. As a result, we have successfully filled more than 90% of positions posted since becoming a CCBHC.”

REDUCING HOSPITALIZATIONS AND EMERGENCY DEPARTMENT VISITS

In the first year of operations:

- 99% of CCBHCs were working with EDs.^{xxv}
- 90% worked with the discharged patients to establish emergency plans to prevent future hospitalizations.^{xxvi}
- 88% received notification when patients receive treatment in a hospital and 72% receive notification when patients are treated in an ED.^{xxvii}

According to SAMHSA data released as part of President Trump's FY 2021 budget:

- CCBHC patients report a 61.6% reduction in hospitalization and a 62.1% reduction in ED visits.
- 15.2% of patients had an increase in employment or started going to school and 30.4% reported increased mental health functioning in everyday life.^{xxviii}

People living with mental illness or addiction have high rates of hospitalization and ED visits. Fortunately, this is a critical intervention period when an assertive care transition strategy can help patients initiate or re-engage in treatment with the goal of reducing future hospitalizations. Unfortunately, traditional funding streams provide little support for this type of care coordination.

CCBHCs must develop or strengthen relationships with other providers and social service agencies in the community and coordinate care across a specific spectrum of safety-net services, including inpatient care, primary care and housing access. CCBHCs have used their payment model, which covers care coordination, to support reduce hospitalizations and improve care transitions for CCBHC patients discharged from the hospital.

FAMILY GUIDANCE CENTER BEHAVIORAL HEALTH (MISSOURI)

Family Guidance Center created a full-time position in their local jail to complete assessments, connect individuals to behavioral health treatment and provide crisis services or mental health services on-site. In addition, the clinic worked closely with law enforcement to reduce inpatient psychiatric admissions. Together, they were able to achieve a 66% reduction in requests for crisis intervention services

while diverting 85% of those referred for inpatient hospitalization to care in the community.^{xxix}

Family Guidance Center also provides on-site services, including a school-based crisis clinician, to the largest local school district, which does not employ behavioral health professionals. Prior to that, 41% of ED admissions were children believed to be in need of inpatient behavioral health care. In fact, most did not require inpatient care, but the school district was not equipped to address the student's needs. As a result of these efforts, the number of children requiring hospitalization has dropped dramatically.

CASCADIA BEHAVIORAL HEALTHCARE (OREGON)

Through a data-driven effort to identify and intervene early with patients at high risk of ED utilization, Cascadia Behavioral Healthcare found that 16% of its patients accounted for 54% of ED and hospital costs, largely driven by alcohol use, chronic pain and hypertension. By implementing preventive efforts, enhancing the availability of substance use treatment (including MAT for opioid use disorder) and engaging patients in chronic pain management, Cascadia achieved an 18% reduction in ED visits, a 20% reduction in hospital admissions and an estimated \$1.65 million in savings.

**CCBHCs ARE THE GOLD STANDARD,
SETTING THE WAY FORWARD**

Community behavioral health safety-net providers have long been doing the best they can with limited resources. One persistent challenge they face is that they lack a definition in federal law, in contrast to other provider types that are federally defined, such as Federally Qualified Health Centers or Rural Health Centers. For organizations with a federal definition, reporting requirements enable insights into their quality and operations, while payment models can be developed to enable them to fully meet the need for care in their communities. The same is not true of the community behavioral health sector, where there is no federal definition.



CCBHCs are different, and part of a national movement to improve behavioral health service delivery. They are required to meet established criteria and be evaluated by a common set of quality measures. Furthermore, CCBHCs establish a sustainable payment model that more accurately covers the true cost of expanding services and reaching new populations. The traditional system, funded by time-limited grants, do not support these innovative efforts.

CCBHCs also advance states' efforts to move toward value-based purchasing and improved integration, offering a payment model that incentivizes performance through quality

bonus payments and provides support for critical activities to coordinate care. Simultaneously establishing a new national standard for comprehensive behavioral health care while still affording state flexibility in community-based requirements and prioritized quality measures, CCBHCs improve access, improve quality and manage costs in the health care system, keeping vulnerable populations in the community, rather than in the hospital.

KEY DIFFERENCES – CCBHCS VS. TRADITIONAL DELIVERY MODELS

	CCBHCS	TRADITIONAL MODELS
Evidence-based Practices	CCBHCS must provide nine types of services grounded in evidence-based practices.	No standard definition of services that requires evidence-based practices; availability driven by grants.
Quality Measures	Clinics must report on standardized quality metrics, while states report on additional quality and cost measures.	Quality measures are inconsistent across states, communities and grant programs.
Access to Care	CCBHCS have increased staff in order to meet requirements to serve everyone, regardless of ability to pay.	Low reimbursement rates contribute to workforce shortages, long waiting lists and patients turned away.
Wait Times	CCBHCS must provide immediate screening and risk assessment for mental health and addictions. They offer basic primary care needs within 10 days or less.	Wait times from referral to first appointment average 48 days nationally at community-based behavioral health clinics.
MAT Access	Nearly all CCBHCS (84%) offered MAT and 46% added MAT because of the CCBHC requirements (ASPE p. 21) compared to 36% of all treatment facilities nationwide (business as usual).	Only an estimated one-third of substance use treatment facilities offer access to one or more types of MAT.
Services	All CCBHCS offer 24/7 access to crisis care, including mobile crisis teams.	Crisis services vary nationally due to limited reimbursement.
Payment	CCBHCS receive a sustainable payment rate that supports expansion of services.	Services are supported by grant funding that is limited in scope and not sustainable.

CCBHCs — THE BEST HOPE FOR THE FUTURE

CCBHCs represent an essential and long-overdue shift in the way mental health and addiction treatment services are funded and provided. What began as a bold experiment is proving to be a compelling roadmap for the future — a future that promises to ensure more Americans have access to the health care they need.

Today, CCBHCs are leading a bold shift to integrate physical, mental health and substance use treatment, address social determinants of health, provide 24/7 crisis care, collaborate with law enforcement and schools and coordinate with hospitals to reduce emergency department visits and readmissions.

Bipartisan congressional leadership has made this important progress possible. And bipartisan congressional leadership will be essential if we are to achieve the goal of creating 500 CCBHCs nationwide by 2025 and, in doing so, providing high-quality mental health and addiction treatment services to 2.9 million people.

As a nation, it is in our common best interest to further invest in mental health and addiction prevention, treatment and recovery services — to take care of each other. Only then can our nation be truly healthy and strong. CCBHCs are truly one of the best hopes for a future that ensures those in need of mental health and addiction treatment are able to access it and get well.

Based on the early success of the CCBHC program, we know how to move forward. Now is the time to be bold. Let's not miss the opportunity before us to truly make a difference.



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