

# POLICY BRIEF

## Certified Community Behavioral Health Clinic Workforce and Service Delivery Trends



### Background

The Certified Community Behavioral Health Clinic (CCBHC) model was established through the [Protecting Access to Medicare Act of 2014](#) to expand access to mental health and substance use disorder (SUD) care in community-based settings. The original demonstration project, administered through the Substance Abuse and Mental Health Services Administration in 2016, provided 1-year planning grants awarded to 24 states followed by 2-year demonstration grants awarded to eight states. Funding for the original demonstration period was set to expire in June 2019, but a recent bill passed by Congress provides short-term extension funding until September 13, 2019.<sup>1</sup> Building off the original demonstration, in late 2018, the Substance Abuse and Mental Health Services Administration announced funding for CCBHC expansion projects that organizations from the original 24 states were permitted to apply.<sup>2</sup>

At the time of data collection, there were 113 CCBHCs in 20 states; New York, Missouri, and Oregon had the greatest number of CCBHCs (16, 15, and 12 respectively). To meet certification criteria, CCBHCs must provide care to all individuals in need of services, regardless of ability to pay, and comply with established staffing, governance, and data reporting requirements. Additionally, CCBHCs must provide a range of comprehensive services either directly or through a designated collaborating organization to meet certification requirements.<sup>3</sup> The nine required services include:

1. crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention, 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.<sup>4</sup>

To better understand behavioral health workforce factors and service delivery within CCBHCs, the National Council for Behavioral Health (National Council), in partnership with the University of Michigan Behavioral Health Workforce Research Center, conducted a mixed methods study between February and August 2019. Results from the study informed the policy and practice recommendations discussed in this report.

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## Methods

A mixed methods approach was used to investigate the behavioral health workforce and service delivery needs, trends, and realities within CCBHCs, including:

1. an environmental scan of existing literature and publications;
2. an electronic survey disseminated via email to CCBHC administrators, including original grantees that received expansion funds and new expansion grantees within each the 21 states with CCBHCs. The survey was completed by 36 unique organizations, representing 18 states (response rate: 68%; 90% representation of sampled states); and
3. key informant interviews with representatives from CCBHCs across eight different states (Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, Oregon, and Texas). Key informants were conducted by telephone.

## Key Findings

### Patient Access and Engagement in Care

Surveyed and interviewed CCBHCs are serving a diverse population of patients related to demographic factors and behavioral health needs. The most common diagnosis prevalent among CCBHC patients is depressive disorder (43%), followed by SUDs other than opioid use disorder (36%). One hundred percent of survey respondents reported serving patients who have multiple behavioral health conditions. Key informant data supported the survey findings with reported prevalence of co-occurring mental illness and SUD >50%. One key informant serving an urban population reported that approximately 80% of their patient population has more than one mental health diagnoses and 60% has co-occurring mental health and SUD diagnoses.

Most CCBHC survey respondents (91%) reported that they have increased the number of patients served since becoming a CCBHC. The majority of CCBHCs have reduced wait time for services (73%) and no CCBHCs reported an increase in wait time. Thirty-five percent of survey respondents offer same-day access to behavioral health treatment and 41% offer treatment access within seven days.

Surveyed and interviewed CCBHCs use a wide range of strategies to conduct outreach and increase access to and engagement in care for patients, including beyond the “four walls” of the clinic. The most common first introduction point for CCBHC survey respondents is when potential patients contact the clinic (94%), followed by families/caregivers contacting the clinic (83%). Additionally, a large percentage of CCBHCs reported receiving referrals from primary care providers (83%), criminal justice settings (72.2%), and peer support programs (58.3%). CCBHCs service teams rely on a variety of outreach and engagement strategies to retain patients in care, including providing home visits and visits at convenient locations (94%), delivering services in schools (75%), and employing outreach workers (72%).

All interviewed key informants described ways in which their organizations have developed partnerships to conduct outreach and engage patients in care. One key informant noted: *“We’re really trying to streamline our access in how people come through our front door to make it much easier for them to engage within our services.”* Another key informant reported that they have integrated CCBHC staff into hospitals, emergency departments, 27 school districts, and the Special Supplemental Nutrition

Program for Women, Infants, and Children office to facilitate patient access to care. Additionally, most key informants reported that their organizations have developed partnerships with law enforcement and criminal justice settings.

### Patient Barriers to Care

The CCBHC survey respondents rated factors that potentially impact their ability to offer behavioral health services on a 3-point scale (3=large impact, 2=minimal impact, and 1=no impact). Respondents indicated that the top three behavioral health treatment barriers were insufficient funding and resources (2.7); insufficient number of behavioral health providers (2.4); and other factors such as behavioral health providers with insufficient knowledge of information technology/data analysis, lack of residential treatment providers in rural setting, and low salaries for professional staff due to low reimbursement rates (3.0).

Key informants also identified several barriers to care that supported the survey findings, including funding, number of behavioral health providers, and workforce readiness concerns, specifically related to providing medication-assisted treatment. Additionally, informants from states that have not expanded Medicaid eligibility cited the lack of expansion as a major treatment barrier. One informant reported: *“A large proportion of our population is unfunded and through state funding, prescribers are allowed to see individuals every 3 months. But when you are putting someone under opioid treatment you would want to see them more on a weekly basis. So there is also the issue of funding and what you can provide in terms of services.”*

## Workforce Capacity

Survey and interview data demonstrate that obtaining CCBHC status and funding has had a significant impact on organizations' ability to increase workforce capacity. Since becoming a CCBHC, 100% of survey respondents have added new staff to their clinics, with half reporting an average staffing increase of up to 10%. CCBHC expansion grantees employ a variety of professionals on their service teams, including an average of 38 case managers on each service team and an average of four case managers on referral. Psychiatrists and nurse practitioners have the highest patient caseloads, with an average current caseload size of 327 and 329 patients, respectively. CCBHC funding has enabled organizations to hire staff that they otherwise would not have been able to fund. One informant reported her organization hired 17 new positions and stated that they have a 90% retention rate within those positions. Another key informant reported that they added an estimated 20 new physicians to their organization. A third key informant reported that their medical provider staff grew by 70% since 2017.

Key informants also identified workforce challenges, including recruitment and retention of staff. One workforce recruitment challenge noted by a key informant was the issue of recruiting for a position funded by unsustainable grant dollars. When asked about how that issue is addressed during interviews, the informant reported: *“We're very open and upfront to people when they're applying for a grant position and the grant funding that we're receiving is for 2 years. When we're bringing people in for interviews, what we really do is [talk] a lot about our overall benefits package: our benefits, our offering competitive salaries, and being expressive about some of the additional trainings that will help them advance their clinical skills that they can receive through us. So, that's what's helped. But there's still always, as we're going through this, they'll come in with questions of like, 'Have we figured out how to sustain this? Are we going to be ready? What's going to happen with my position?’”*

## Primary and Behavioral Healthcare Integration

All of the interviewed key informants reported that their CCBHCs offer some level of onsite integrated primary and behavioral healthcare integration. Moreover, beyond primary care and behavioral healthcare integration, several key informants described other types of service integration their organizations provide. One key informant described a patient “success story” that involved accessing onsite dental care: *“She [the patient] was really utilizing services pretty strongly. She was in the ER probably every other day. She was in our buildings a lot. She was in crisis a lot. And one day we started asking a question about dental care. And she goes yes, I have dental problems. And we accept walk-ins in our dental [clinic] right now so, there's a dental hygienist. And it turns out she had multiple abscessed teeth and was absolutely miserable. She couldn't eat, she couldn't—it was horrible. Once she got that taken care of, she stopped going to the ER. I mean we truly looked at the whole person. And, what do you know, her mental health got better because she could concentrate again. She could start going to supportive appointments. She could start getting better because she wasn't in constant pain.”*

## Support and Resource Needs

Informants and survey respondents identified a range of resources and needs related to improving, supporting, and sustaining CCBHCs. Funding for CCBHCs was identified as a major need. Other categories of needs included: collecting, sharing, and using data to inform practice; addressing behavioral health workforce shortages and factors contributing to the shortages; increasing the number of peer services; and securing transportation for clients; among others.

## Conclusions

By obtaining CCBHC status and funding, organizations are able to increase patient access to and engagement in care, decrease wait times for services, expand workforce capacity, and deliver a wider range of integrated and comprehensive services. CCBHCs face challenges in light of these successes however, including a lack of long-term funding, behavioral health workforce gaps, and stigma related to mental illness and SUD. To address these challenges, the following policy and practice changes are recommended:

- 1. Increase and Enhance Financing and Reimbursement.** CCBHCs have shown promising preliminary results related to improvements in workforce and service delivery for individuals with behavioral health needs in the first few years of the demonstration project and expansion period. CCBHCs operating in states that did not expand Medicaid eligibility and serving a greater proportion of individuals without health insurance coverage expressed concerns about meeting the CCBHC requirement of serving everyone regardless of insurance status without sustainable funding. Legislation should be passed to expand the project providing adequate time to study the impacts CCBHCs have on provider and patient outcomes. For example, the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 824/H.R. 1767) would extend the demonstration in the original eight states for 2 years, while expanding the program to the other 11 states that applied but were not originally selected. Additionally, the original CCBHC grantees are funded through the PPS mechanism, similar to Federally Qualified Health Centers. Through the PPS reimbursement model, CCBHCs receive payment based on the anticipated costs of providing comprehensive services to a complex population. Unlike the original CCBHC grantees, expansion grantees receive grant funds to support program costs, but must rely on existing reimbursement mechanisms for services. Compared with the PPS rate, grant funding is less sustainable.
- 2. Strengthen the Behavioral Health Workforce.** A robust and competent behavioral health workforce is critical to providing individuals with essential behavioral health services. Recommendations include identifying systems-level factors that influence behavioral health workforce capacity and identifying the education and training needs of behavioral health professionals including the use of behavioral telehealth. Behavioral health organizations and providers continue to lag far behind physical health providers' adoption, implementation, and utilization of health information technology, including electronic health records, data analytic software, and health information exchanges. CCBHC respondents reported increased uptake of health information technology supported by grant funding and the PPS reimbursement structure; however, there is a persistent need for additional funding and technical assistance to bring CCBHCs more in alignment with the capabilities of physical health providers to facilitate improved data exchange to inform the improvement of individual and population health outcomes.
- 3. Minimize Stigma.** Stigmatizing attitudes and behaviors have been shown to impact patient access to care, undertreatment, social marginalization, and the patient-provider relationship. Furthermore, stigma related to medications for opioid use disorder among providers may prevent the adoption of evidence-based treatment. Recommendations include creating multi-layered activities and technical assistance programming to address stigma (e.g., assist states in developing resources to address stigma at the community and provider level) and increasing education and training to overcome stigma related with providing medication for opioid use disorder.

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