Reaching the Quadruple Aim: Workforce and Service Delivery Within Certified Community Behavioral Health Clinics

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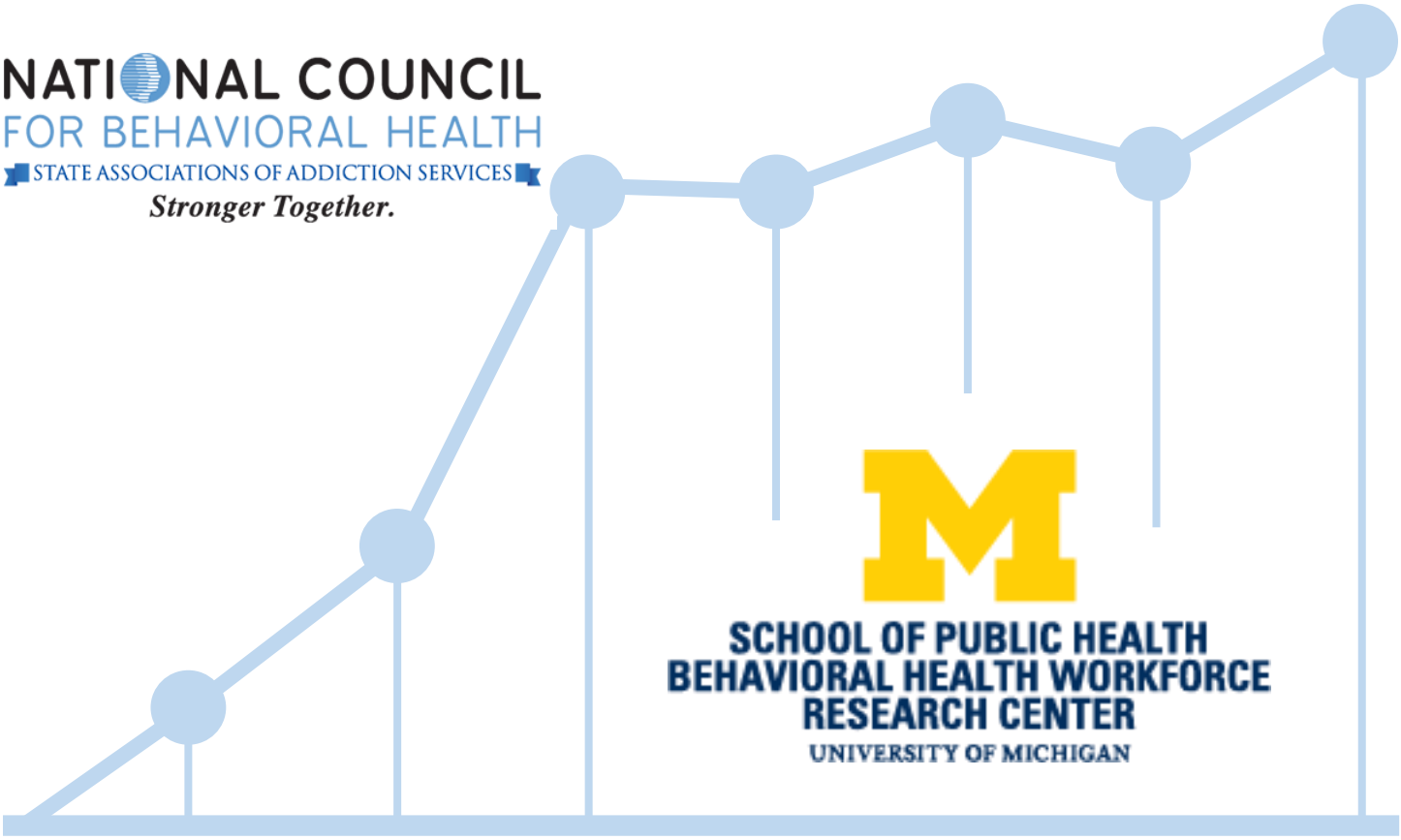

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Table of Contents

Key Highlights 4

Introduction and Background 4

- Overview of Certified Community Behavioral Health Clinics 4
- Certified Community Behavioral Health Clinic Required Services 5
- Certified Community Behavioral Health Clinic Financing 5
- Access to Behavioral Health Services and Treatment 5
- The Quadruple Aim 6

Methods 6

Findings 8

- Patient Access to and Engagement in Care 8
- Populations Served 8
- Outreach Strategies and Access Points 10
- Patient Barriers to Care 11
- Workforce Capacity 12
- Primary Care and Behavioral Healthcare Integration 14
- Certified Community Behavioral Health Clinic Support and Resource Needs 14

Discussion 16

Recommendations 16

- Increase and Enhance Financing and Reimbursement 16
- Strengthen the Behavioral Health Workforce 16
- Minimize Stigma 16

References 17

Key Highlights

The Certified Community Behavioral Health Clinic (CCBHC) model, established to provide integrated, comprehensive, and coordinated services to individuals with mental health and substance use disorder needs, is a promising care delivery model to improve the Quadruple Aim of improving the patient experience of care, improving the health of populations, reducing the per capita costs of care for populations, and improving the provider experience. Current peer-reviewed literature on CCBHCs is limited owing to the model's recent establishment; however, survey findings and provider results show that CCBHCs have had positive effects in domains related to the Quadruple Aim, including increasing patient access to care, increased behavioral health staff, and improved health information technologies. Further linkages between CCBHCs and the Quadruple Aim should be studied to inform practice and policy recommendations.

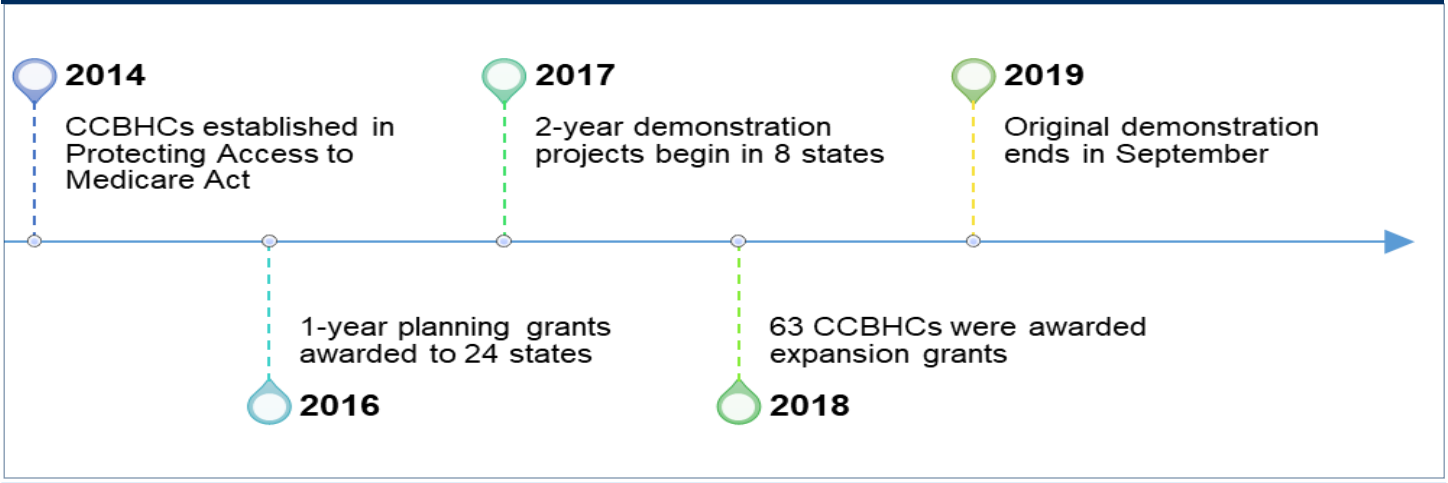
Introduction and Background

A new Medicaid provider type 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 known as Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC demonstration was expanded in 2018 following a recommendation to Congress by the Interdepartmental Serious Mental Illness Coordinating Committee. CCBHCs are a promising model to provide comprehensive services to improve the health of individuals with mental health and SUD challenges beyond the four walls of a clinic. To better understand behavioral health workforce factors and service delivery within CCBHCs and explore the "Quadruple Aim" in behavioral health care, 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. This report provides a summary of the quantitative and qualitative data collected and analyzed related to CCBHCs' impact on the behavioral health workforce and the Quadruple Aim.

Overview of Certified Community Behavioral Health Clinics

In 2014, the CCBHC demonstration project was established through the Protecting Access to Medicare Act. The demonstration involved two phases administered through the Substance Abuse and Mental Health Services Administration: (1) a 1-year planning grant awarded to 24 states and (2) a 2-year demonstration period awarded to eight states (chosen from the original 24 participants). As seen in Figure 1, the 1-year planning grants were awarded in 2016 and demonstration projects within the eight states began in 2017. In late 2018, the Substance Abuse and Mental Health Services Administration announced funding for CCBHC expansion projects that original participants were also permitted to apply.

Figure 1. Certified Community Behavioral Health Clinic Timeline



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). There were 66 clinics that participated in the original demonstration. Sixteen of the original participants also received expansion grant funds and 47 new CCBHCs have been created through expansion grant funds only.

Certified Community Behavioral Health Clinic Required Services

All 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 (Table 1).

Table 1. Certified Community Behavioral Health Clinic **Required Services**

	Required Service	Can be delivered by designated collaborating organization
1	Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization	No
2	Mental health screening, assessment, and diagnosis, including risk assessment	No
3	Patient-centered treatment planning or similar processes, including risk assessment and crisis planning	No
4	Outpatient mental health and substance use services	No
5	Outpatient clinic primary care screening and monitoring of key health indicators and risk	Yes
6	Targeted case management	Yes
7	Psychiatric rehabilitation services	Yes
8	Peer support and counselor services and family supports	Yes
9	Intensive, community-based mental health care for members of the armed forces and veterans	Yes

Certified Community Behavioral Health Clinic Financing

Similar to Federally Qualified Health Centers, the original CCBHC participants receive an enhanced Medicaid rate through a prospective payment system (PPS) that provides reimbursement based on the anticipated costs of serving the needs of complex populations.1 CCBHCs receiving an expansion grant do not receive a PPS rate for funding. Instead, these CCBHCs receive up to $2 million annually for a 2-year period.

Access to Behavioral Health Services and Treatment

Patients accessing needed behavioral health services remain a challenge across the U.S., increasing the demand for integrated, comprehensive care delivery that addresses access barriers. Among adults with any mental illness, only 43.1% received mental health care in 2016. Evidence-based treatment and services to prevent and treat SUDs are available, yet many individuals in need of services never receive SUD treatment.[2] Of the 20.7 million individuals who needed SUD treatment in 2017, only 2.5 million (12.2%) received it.2 Only 20% of adults with opioid use disorder (OUD) nationwide receive the treatment they need each year.[3] Recent studies show that more than 50% of adults and 35% of adolescents who received SUD treatment achieve sustained remission lasting at least 1 year.[3] Approximately 51% of individuals with any mental illness and SUD received SUD treatment **or** mental health care in 2016 and only 8.3% of adults with co-occurring disorders received SUD treatment **and** mental health care.[3]

The nationwide behavioral health workforce shortage has resulted in significant challenges in meeting the needs of individuals with OUD, other SUDs, and mental illness. Seventy-five percent of rural or frontier counties have no advanced behavioral health practitioners, impacting more than 45 million people.[4] Approximately, 30 million people in the U.S. live in counties without a single prescriber for addiction treatment.[5] The Health Resources and Services Administration estimates that by 2025, six behavioral health provider types (psychiatrists, psychologists, substance use and behavioral disorder counselors, social workers, mental health counselors, and school counselors) will have workforce shortages of more than 10,000 full-time equivalents.[6] The growing workforce crisis in the behavioral health field is due to high turnover rates, worker shortages, an aging workforce, stigma, and inadequate compensation.[7]

The Quadruple Aim

Dr. Don Berwick, former Administrator of the Centers for Medicare and Medicaid Services, defined the "Triple Aim" of healthcare as: (1) improving the individual experience of care, (2) improving the health of populations, and (3) reducing the per capita costs of care for populations.[8] The Triple Aim was the overarching goal of the Affordable Care Act's expansive provisions and continues to guide health reform efforts today. The Triple Aim, however, fails to address the need to improve the provider experience, which can have significant impacts on the ability to make improvements in the other three aims. The "Quadruple Aim" adds this fourth important goal: to improve care providers' experience. In 2014, Bodenheimer and Sinsky[9] called for the Quadruple Aim in response to the high rates of physician and staff burnout documented in the research. Bodenheimer and Sinsky found that 46% of U.S. physicians, 34% of hospital nurses, and 37% of nursing home nurses experience symptoms of burnout. Additionally, a 2013 survey of 508 healthcare employees found that 60% reported job burnout and 34% were looking for another job.[9]

Some of Bodenheimer and Sinsky's recommendations[9] for addressing the fourth aim include:

- implementing team documentation: nurses, medical assistants, or other staff present during the patient visit;
- expanding roles allowing nurses and medical assistants to assume responsibility for preventive care and chronic care health coaching;
- co-locating teams so that physicians and team members work together in the same space; and
- ensuring that new staff and staff who gain new responsibilities are well-trained.

The CCBHC model's certification requirements and PPS financing for the original demonstration grantees have the potential to improve the four goals of the Quadruple Aim.

Methods

To better understand the behavioral health workforce and service delivery needs, trends, and realities within CCBHCs, National Council research staff conducted a mixed methods study collecting quantitative and qualitative data from CCBHCs nationwide. Three phases of the study were conducted: (1) an environmental scan in February 2019, (2) the development and administration of an electronic survey in March 2019, and (3) key informant interviews that took place in July and August 2019.

The purpose of study was to answer the following questions:

1. What does patient engagement in care look like within the CCBHC model (e.g., populations served, service teams/caseload size, patient contact points)?
2. What are patient barriers to care and how are they mitigated?
3. In what ways are CCBHCs using services outside the four walls of a clinic and nontraditional service settings to improve outcomes and increase patient engagement?

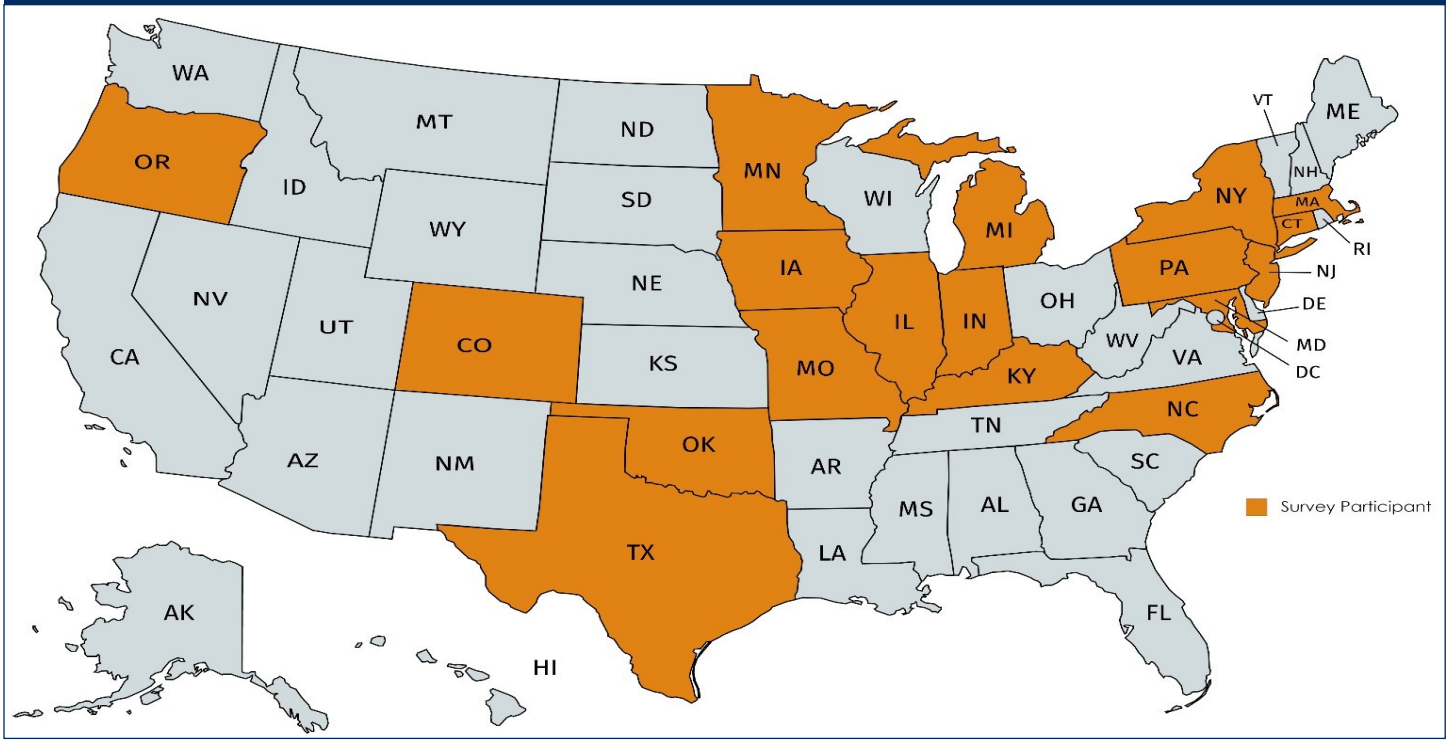
4. How has becoming a CCBHC impacted workforce capacity? How many and what types of behavioral health positions have been added with CCBHC implementation? How have CCBHCs recruited/retained behavioral health providers?
5. How is primary care and behavioral health integration occurring within CCBHCs?
6. What supports and resources are needed by CCBHCs?

In February 2019, National Council research staff conducted a scan of available online relevant peer-reviewed articles, white papers, briefs, public press, and guidance documents published in the last 3 years. To identify existing peer-reviewed publications, keyword searches for "certified community behavioral health clinics," within two academic library catalogues were conducted. White and gray literature including white papers, organizational reports, evaluation reports, governmental reports, and presentation slides from behavioral health organizations, government agencies, and CCBHC providers' webpages were also collected, analyzed, and synthesized.

To collect quantitative data from a representative sample of CCBHCs that received expansion grant funding (including original participants that received expansion funds and expansion grant–only CCBHCs), an electronic survey tool was designed and administered. National Council team members drafted a 14-item survey tool designed to be completed in ≤15 minutes. Prior to dissemination, the online survey was reviewed by Behavioral Health Workforce Research Center experts and pilot tested by three National Council team members not involved in the research project. Qualtrics, an electronic research platform, was used to securely collect data.

In March 2019, the survey tool was distributed via email to CCBHC administrators within each of the 21 states with CCBHCs. Participation in the survey was voluntary and respondents were offered a $25 MasterCard gift card to compensate the time needed to complete the survey. The survey was available online for 1 month with several electronic reminders sent to encourage participation. Quantitative data generated from the survey were analyzed with SPSS software. Univariate methods and frequencies were used to analyze the data and extract the most useful information. The survey was completed by 36 unique organizations, representing 18 states. The response rate was 68% and there was a 90% representation of sampled states (Figure 2).

Figure 2. Certified Community Behavioral Health Clinic Survey Respondent States



To gain a deeper understanding of workforce and service delivery trends among CCBHCs, qualitative data were collected through key informant interviews in July and August 2019. Interviews were recorded and transcribed and Microsoft Excel was used for data analysis. A thematic analysis was performed to identify common themes shared across respondents. Interviewees included representatives from original CCBHC participants that also received expansion grants and CCBHCs that received expansion grant funds only. Participation in the key informant interviews was voluntary and participants were offered a $25 gift card incentive. The same interview tool was used across participants. Eight qualitative interviews were conducted with key informants from CCBHCs representing eight different states (Table 2).

Table 2. Certified Community Behavioral Health Clinic Key Informant Participants

#	State	Expansion Grantee or Original and Expansion Grantee	Primary Geographic Areas Served	Estimated Number of People Served Annually
1	Maryland	Expansion	Urban	Not reported
2	Massachusetts	Expansion	Urban, Suburban	Not reported
3	Michigan	Expansion	Urban	6,500
4	Missouri	Original participant plus expansion grant	Rural, Urban	25,000
5	New Jersey	Original participant plus expansion grant	Not reported	Not reported
6	New York	Original participant plus expansion grant	Urban, Suburban, Rural	Not reported
7	Oregon	Original participant plus expansion grant	Rural	5,500
8	Texas	Expansion	Urban	28,000

Findings

Data gathered through the environmental scan, survey responses, and key informant interviews were analyzed and synthesized to better understand the patient and providers' experience of care within CCBHCs, including the opportunities and challenges CCBHCs have to meet the goals of the Quadruple Aim. Data were assessed related to five main domains: (1) patient access and engagement in care, (2) patient barriers to care, (3) workforce capacity, (4) primary care and behavioral health integration, and (5) supports and resources needed to improve workforce and services delivery.

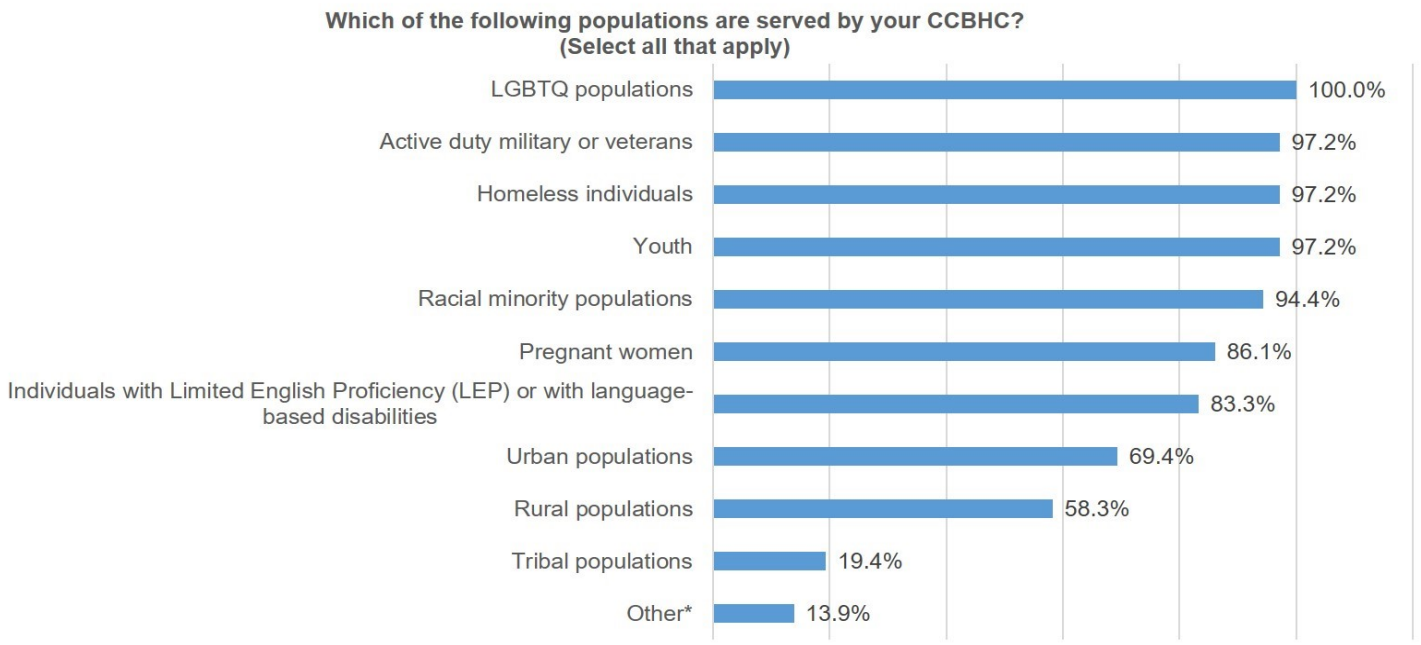
Patient Access to and Engagement in Care

Collected data supported that the surveyed and interviewed CCBHCs are serving a diverse population of patients in relation to demographic factors and types of behavioral health conditions. Most CCBHC survey respondents (91%) reported that they have increased the number of patients served since becoming a CCBHC, yet despite the increase in patient populations, the majority of CCBHCs have reduced wait time for services (73%) and no CCBHCs reported an increase in patient wait time. Thirty-five percent of survey respondents offer same-day access to behavioral health treatment and 41% offer treatment access within 7 days. Findings related to patient access to care and engagement are described below.

Populations Served

The CCBHCs serve a diverse patient population. All survey respondents indicated that they serve lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations; 97% serve active duty military or veterans, homeless individuals and/or youth; and 94% serve racial minority populations (Figure 3). One key informant noted that up to 30% of their patient population experience homelessness. Many CCBHCs serve several locations that include rural, urban, and suburban settings.

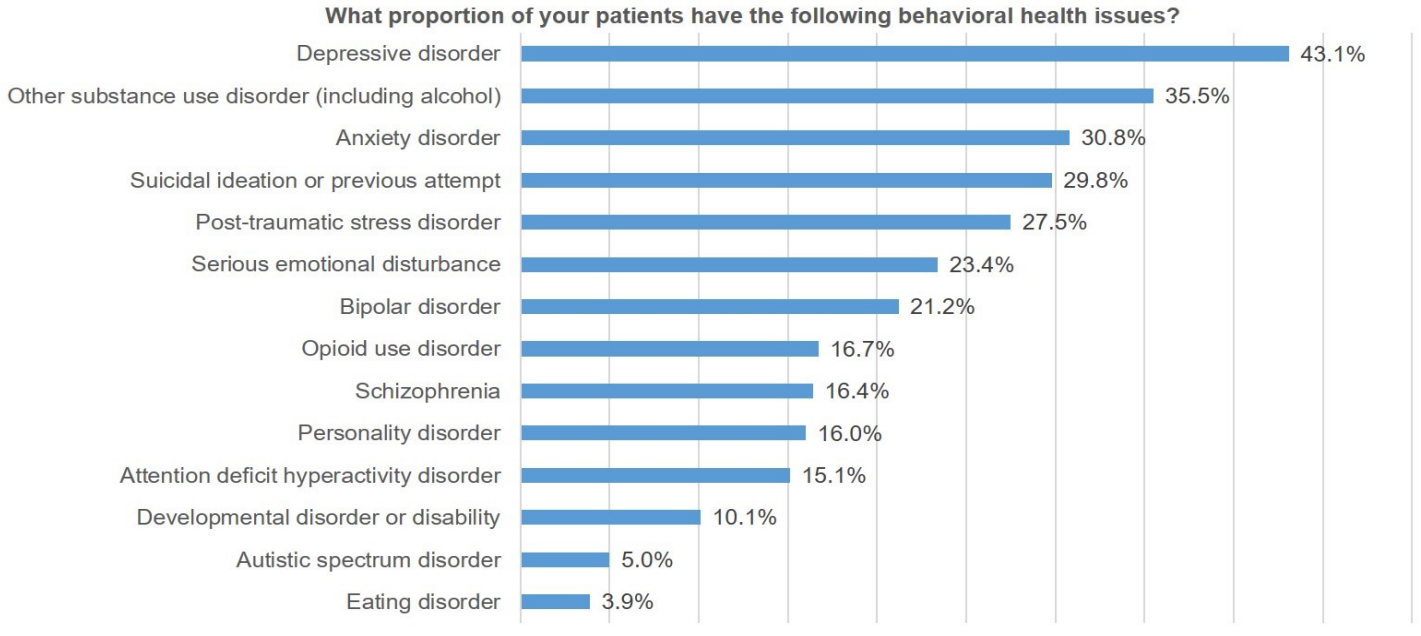
Figure 3. Populations Served by Respondent Certified Community Behavioral Health Clinics



*Other populations served include children and adults with serious mental illness/serious emotional disturbance, individuals with HIV, individuals with SUD, individuals with intellectual and developmental disabilities, and dual medical–behavioral complex individuals.

The CCBHCs also serve patients with diverse behavioral health conditions, the most common being depressive disorder (43%), followed by SUDs other than OUD (35.5%) (Figure 4). One hundred percent of survey respondents reported serving patients who have multiple behavioral health conditions. Key informant data supported the survey findings with reported >50% prevalence of co-occurring mental illness and SUD. 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.

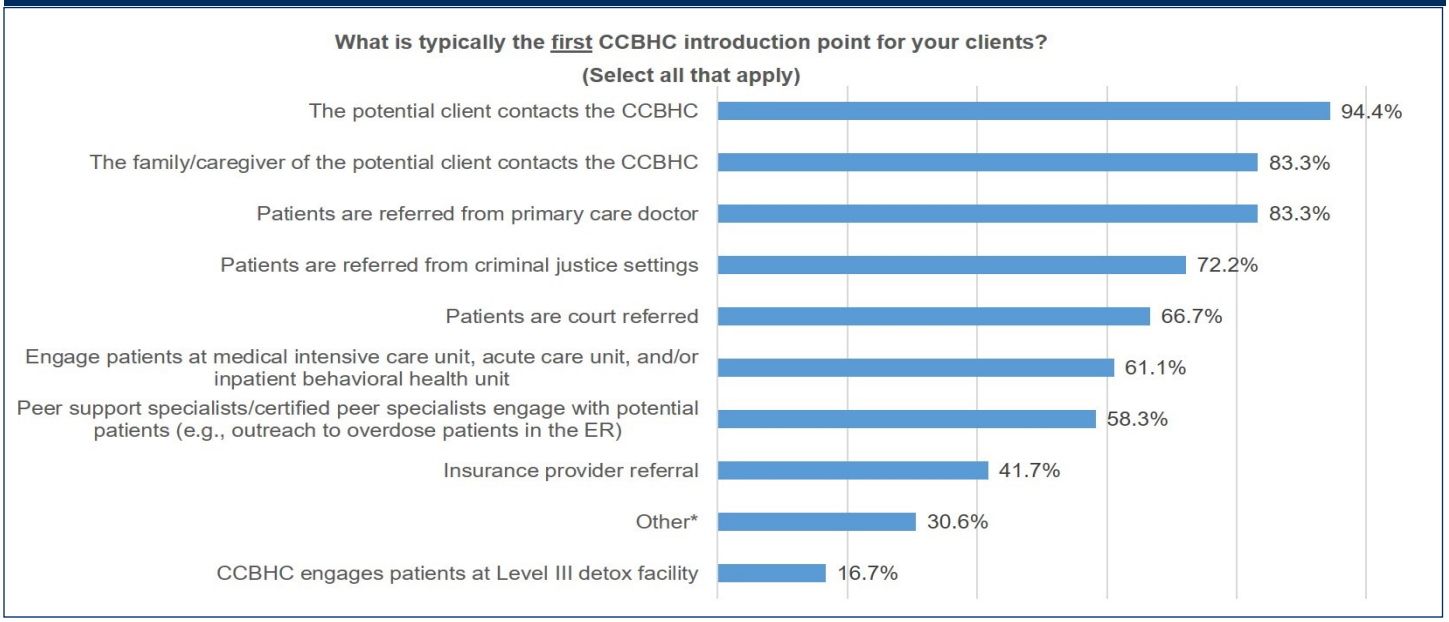
Figure 4. Prevalence of Behavioral Health Conditions Present Among Respondents' Patient Populations



Outreach Strategies and Access Points

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%); however, a large percentage of CCBHCs report receiving referrals from primary care providers (83%), criminal justice settings (72.2%), and peer support programs (58.3%) (Figure 5).

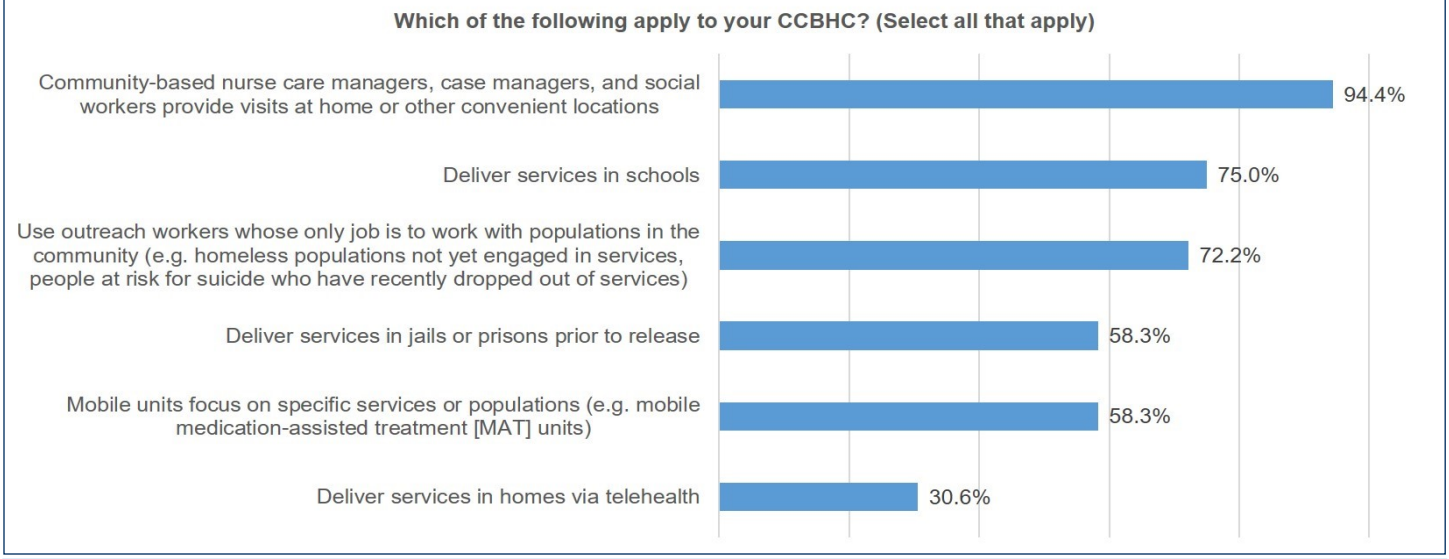
Figure 5. Initial Access Point for Clients of Respondent Certified Community Behavioral Health Clinics



*Other patient introduction points include outpatient crisis referrals, referrals from schools or mobile crisis teams, veterans choice referrals, homeless outreach, and emergency services program referrals.

Additionally, CCBHC 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%) (Figure 6).

Figure 6. Strategies Used to Engage Patients in Care by Respondent Certified Community Behavioral Health Clinics



All interviewed key informants described ways in which their organizations have developed partnerships outside of the four walls of the clinic to conduct outreach and engage patients in care. One key informant noted that one of the key areas of their practice that becoming a CCBHC has impacted is the way in which they conduct outreach and engage patients in care. She reported:

"The other area that the CCBHC has really impacted for people is that we're really trying to streamline our access in how people come through our front door and make it much easier for them to engage within our services."

Another key informant serving primarily rural populations reported that they have integrated staff into the area hospitals, emergency departments, 27 school districts, and the local Special Supplemental Nutrition Program for Women, Infants, and Children office to facilitate access to care. Additionally, most of the key informants reported that their organizations have developed partnerships with law enforcement and criminal justice settings. One informant described a partnership with the police, judiciary system, and department of corrections that is facilitated by CCBHC staff that help to link people with mental illness in these systems to care.

Patient Barriers to Care

Patient barriers to care were assessed through the survey and key informant interviews. 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) (Table 3). 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 access/data analysis, lack of residential treatment providers in rural setting, and low salaries for professional staff due to low reimbursement rates (3.0).

Table 3. Behavioral Health Treatment Barriers Reported by Respondent Certified Community Behavioral Health Clinics

Factor	Rating
Other*	**3.0**
Insufficient funding and resources	**2.7**
Insufficient number of behavioral health providers	**2.4**
Gaps within the transitions of patients between stages of care	**2.2**
Billing burdens	**2.2**
Insufficient number of DATA 2000–waivered providers to provide buprenorphine treatment	**2.0**
Inability to assess medication-assisted treatment access gaps in the most affected areas/counties	**1.9**
Lack of available partnerships	**1.9**
Mental health/SUD workforce is not ready to address patient needs (limited related knowledge, training, or experience in mental health/SUD treatment)	**1.9**
Current providers refuse to go through the DATA 2000 waiver process	**1.7**

*Other barriers include behavioral health providers with insufficient knowledge of information technology/data access/data analysis, future sustainability impacting staff recruitment, keeping up with growth rate of local communities and the needs associated with the growth rate, honoring culturally sensitive residents when English is not the first or second language in the family, lack of residential treatment providers in rural setting, low salaries for professional staff due to low reimbursement rates, staff turnover,

Key informants 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 to the lack of expansion has a major barrier to treatment.

One informant reported:

"The other issue is that a large proportion of our population is unfunded. 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"

Most key informants also identified stigma as a persistent challenge to individuals engaging in treatment. Many CCBHCs address stigma through education and outreach. For example, moving beyond the stigma of entering a "mental health clinic" was identified by several key informants as a successful strategy. By providing patients several access points to treatment, patients could potentially avoid negative consequences associated with being seen walking into a mental health clinic. One key informant reported that she felt co-location was the best way to address stigma and used a high school integration project as an example. She stated:

"Co-location really decreases the stigma. We had one project we worked on where we had embedded staff in the high school. . . . We've actually worked with them to become like coaches and different things at the school. So, it's not to go see that Options mental health person. It's oh, I'm going to go see Chris and making it normal."

Workforce Capacity

Data from CCBHC survey respondents and interviewees demonstrate that obtaining CCBHC status and funding has 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%. It appears that the bulk of the reported hiring was driven by the clinics that were original plus expansion CCBHCs (benefitting from the PPS rate). The majority of both groups reported staffing increases of up to 10%, but one quarter of the original plus expansion CCBHCs saw staffing increases between 26% and 50% (vs 5% of expansion-only CCBHCs) and 13% reported a +51% staffing increase since becoming a CCBHC (vs 0% of expansion-only CCBHCs).

As shown in Table 4, CCBHCs employ a variety of professionals on their service teams, including an average of 38 case managers on each service team and 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.

Key informants reported hiring significant numbers of staff supported by CCBHC funds. One informant organization hired 17 new positions and stated that they have a 90% retention rate within those positions. One key informant reported that they added an estimated 20 new physicians to their organization. Another key informant reported that their medical provider staff grew by 70% since 2017.

Workforce findings from the current study are supported by previous findings from a study conducted by the National Council with original CCBHC grantees in 2017. Findings from the 2017 survey found that 87% of respondents reported an increase in their patient caseloads.[10] In addition to increasing patient caseloads, the 2017 survey results showed that becoming a CCBHC expanded organizations' ability to implement evidence-based practices and new technologies. Relevant findings include:

- 78% of respondents reported that they were able to improve outreach;
- 75% reported that they expanded capacity to provide crisis care;
- 72% reported that they were able to implement new care delivery or outreach partnerships with hospitals;
- 64% reported that they improved or expanded services to veterans;
- 57% reported that they implemented same-day patient access protocols; and
- 72% reported that they adopted new technologies that support care delivery, including electronic health records, mobile apps, web platforms, and telehealth.[10]

Table 4. Certified Community Behavioral Health Clinic Service Team Professionals

Professional title	Average number on staff	Average number on referral (e.g., contracted employees; employees at collaborating organizations)	Current average caseload size
Psychologist	1.6	0.5	29.1
Psychiatrist	6.3	3.9	326.8
Nurse practitioner	5.6	2.3	329.1
Physician assistant	1.5	0.4	104.1
Certified peer support specialist/ Certified peer specialist	9.9	1.4	27.0
Licensed practical or vocational nurse or registered nurse	12.1	1.2	41.7
Marriage and family therapist	3.0	0.6	43.2
Licensed mental health counselor	15.0	2.7	64.0
Licensed clinical social worker	14.4	0.3	95.0
Licensed master social worker	19.6	5.8	91.4
In-training behavioral health provider	8.7	0.0	20.3
Alcohol and drug counselor	9.5	1.9	50.3
Primary care provider/physician	0.8	1.2	123.8
Health educator	2.0	0.0	51.1
Case manager	37.6	4.3	64.3
Rehabilitation worker	18.2	0.1	15.1
Other*	38.2	0.3	120.8

*Other professionals on CCBHC service teams include community support associates, family partners, pharmacists, recovery coaches, interpreters, certified addiction counselors, occupational therapists, and supported employment specialists.

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 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 for2 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?'"

Among key informants, a trend emerged related to engaging and retaining new staff with the CCBHC grant dollars. Larger organizations reported that they were not as concerned about retaining staff when grant funding ends because their systems were large enough to absorb the costs; however, smaller organizations with less room in their budgets expressed great concern about sustaining positions and services beyond the scope of the grant.

Primary Care and Behavioral Healthcare Integration

When asked about their current level of primary care and behavioral healthcare integration, CCBHC expansion grantees reported that clinics have close collaboration onsite with some system integration but have not yet achieved integrated care, as evidenced by full collaboration in a transformed/merged integrated practice (Table 5).

Table 5. Levels of Primary Care and Behavioral Healthcare Integration

Coordinated Care		Co-located Care		Integrated Care	
1 Minimal collaboration: In separate facilities.	2 Basic collaboration at a distance: In separate facilities.	3 Basic collaboration onsite: In same facility not necessarily same offices.	4 Close collaboration onsite with some system integration: In same space within the same facility.	5 Close collaboration approaching an integrated practice: In same space within the same facility (some shared space).	6 Full collaboration in a transformed integrated practice: In same space within the same facility, sharing all practice space.

All 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 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."

Certified Community Behavioral Health Clinic Support and Resource Needs

A range of resources and needs were identified by survey respondents and key informants 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; expanding Medicaid eligibility; addressing behavioral health workforce shortages and factors contributing to the shortages; increasing the number of peer services; securing transportation for clients; and other categories detailed in Table 6.

The greatest challenge to the long-term success of CCBHCs is the lack of sustainable funding. Other challenges include larger payment and reimbursement challenges (e.g., lack of Medicaid eligibility expansion), behavioral health workforce shortages, and barriers to collecting and sharing data, among others. The shift in funding mechanisms from the original CCBHC demonstration model (PPS rate) compared to the Expansion Grantees (no PPS rate) should be further studied to inform future policy and financing recommendations.

Table 6. Needs and Resources Identified to Support and Sustain Certified Community Behavioral Health Clinics

Funding and Expansion of the CCHBC Program	Behavioral Health Workforce	Data	Other Needs
Advocacy with commercial payers to cover necessary care and at a rate that covers cost	The overall shortage of psychiatrists and mental health providers in the community greatly affects behavioral health services	Data sharing opportunities	Expanding peer support services; perhaps using community partners
Stable positions that do not rely on Fee For Service	Issues with recruiting and retention; shortage of degreed candidates and inability to pay market salaries	Ongoing information on outcomes measures and how to achieve them	More partnerships and collaborations with resources to help efficiently and effectively provide services
Ongoing electronic health record adaptation	Lack of applicants for CCBHC positions in rural setting	Support for technology and data	Better integration with health information exchanges
Outcomes tracking	Additional licensed clinical staff and prescribers		Contracting with behavioral health organizations—better rates, reimbursement for care coordination
Support for integration care through technology and qualified staffing, specifically to address quality health indicators	More psychiatrists and more therapists		Residential treatment for SUD in the local area
A more flexible funding model for mental health, substance use, and primary care	Severe workforce shortage must be addressed		Transportation and housing resources
Ability to produce reimbursement to non-Medicaid population which is in great need for access to treatment	Trained staff with knowledge of resources in the community		Sufficient community and rehabilitation support for people with SUD who do not have severe mental illness; consultation about implementing primary care such as billing and coding
Ongoing long-term funding to support comprehensive services	Managing burnout with high needs and high volume of direct care necessary		Partnerships are remarkably available, but the financial risks associated with the need for sustainable systems of care result in missed opportunities to improve the health of communities
Consistency around the sustainability of the CCBHC model	Ongoing staff training		Client transportation and outreach/engagement
Continued PPS reimbursement that helps cover uncovered costs and makes pretreatment outreach and engagement much more possible	American Society of Addiction Medicine criteria staff training		
Permanent, stable funding that will allow us to increase staff pay in order to fill vacant positions, retain current staff, and recruit experienced staff			
Value-based payments that support non-billable care coordination, case management, and rehabilitation			
Payment methods that cover what it takes to provide intensive rehabilitative care and to cover prevention			

Discussion

The CCBHC demonstration is transforming clinics' ability to serve people in their communities. Although the current published literature related to CCBHCs' potential impact on the Quadruple Aim is limited, findings from this study show that CCBHCs positively impact patient care and outcomes and enhance the care provider experience. CCBHCs have expanded their workforce capacity significantly, increased the number of patients served, reduced wait times for services, established integrated care models, and established effective strategies and partnerships to move beyond the four walls of clinics to engage and retain patients in care.

Recommendations

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 demo in the original eight states for 2 years, while expanding the program to the other 11 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 OUD 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 OUD.

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