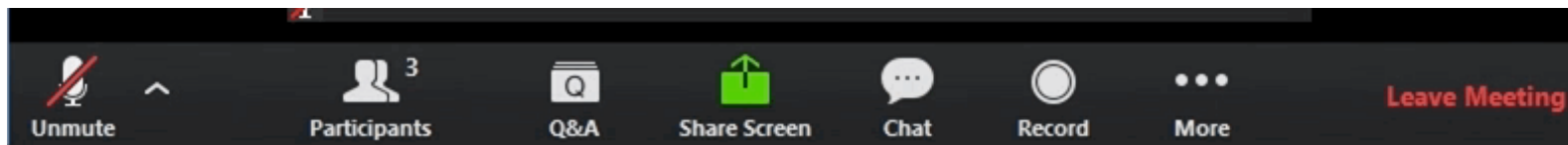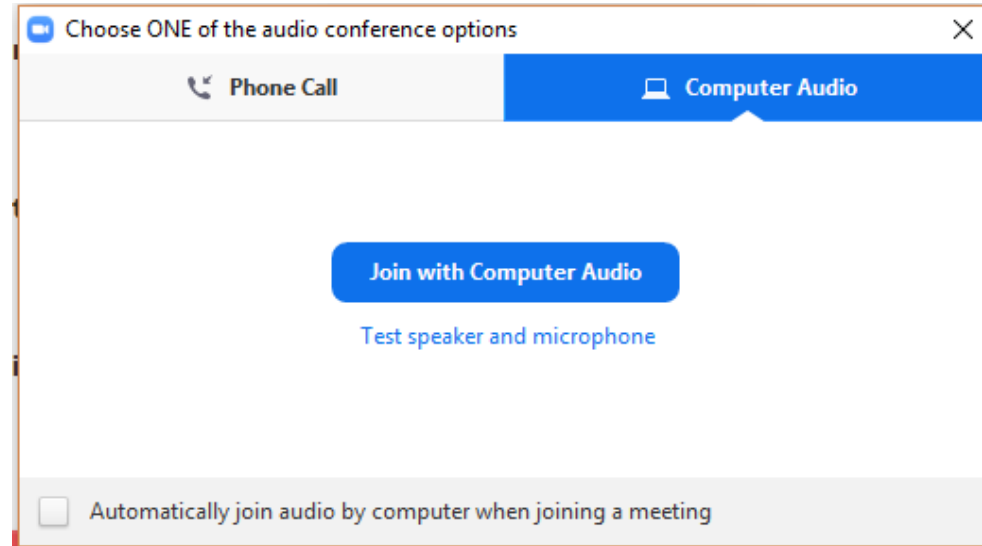# Take Your CCBHC Planning to the Next Level by Measuring Impact and Accessing Data

October 12, 2022

National Association of State Mental Health Program Directors
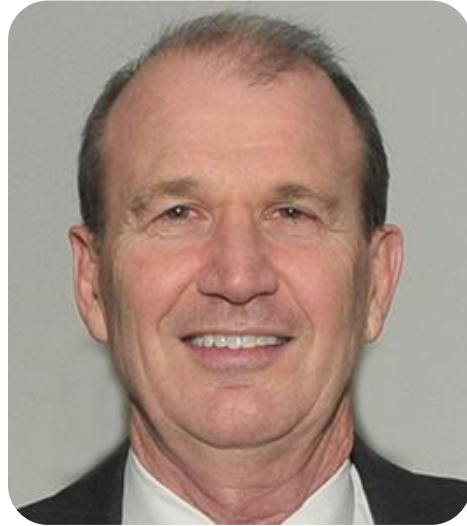**National Council for Mental Wellbeing**

Logistics & Housekeeping

- Call in on your telephone, or use your computer audio option
- If you are on the phone, enter your Audio PIN

Choose ONE of the audio conference options

Phone Call | Computer Audio

Join with Computer Audio

Test speaker and microphone

Automatically join audio by computer when joining a meeting

Type questions into the Q&A tab, located on your Zoom toolbar.
We'll answer as many questions as we can at the end of the presentation.

NATIONAL COUNCIL *for* Mental Wellbeing

Welcome

Brian Hepburn
Executive Director, NASMHPD

Rebecca Farley David
Senior Advisor, National Council

NASMHPD

NATIONAL COUNCIL *for* Mental Wellbeing

*To make mental **wellbeing**, including recovery from substance use challenges, **a reality for everyone**.*

TheNationalCouncil.org

Today's Presenters

Rachelle Glavin
VP Clinical
Operations,
Missouri Behavioral
Healthcare Council

Valerie Huhn
Director, Missouri
Department of
Mental Health

Brent McGinty
CEO/President,
Missouri Behavioral
Healthcare Council

Joe Parks
Medical Director,
National Council

NASMHPD

NATIONAL
COUNCIL
for Mental
Wellbeing

To make mental wellbeing, *including recovery from substance use challenges,* a reality for everyone.

TheNationalCouncil.org

What is a Certified Community Behavioral Health Clinic?

A CCBHC meets defined criteria for comprehensive service delivery and receives enhanced funding to support the costs of expanding access to care.

CCBHC Criteria

- Organizational Authority
- Staffing
- Access to Care
- Scope of Services
- Care Coordination
- Quality Reporting

For more: https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/

CCBHC Payment

- Cost-related Medicaid reimbursement rate (demonstration/SPA participants)

OR

- Grant funds: $2 million/year for 2 years (expansion grantees)

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Status of Participation in the CCBHC Model

Legend:

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Current (or working toward) independent statewide implementation
- No CCBHCs

There are **500+ CCBHCs** in the U.S., across 46 states, plus Washington, D.C. and Puerto Rico

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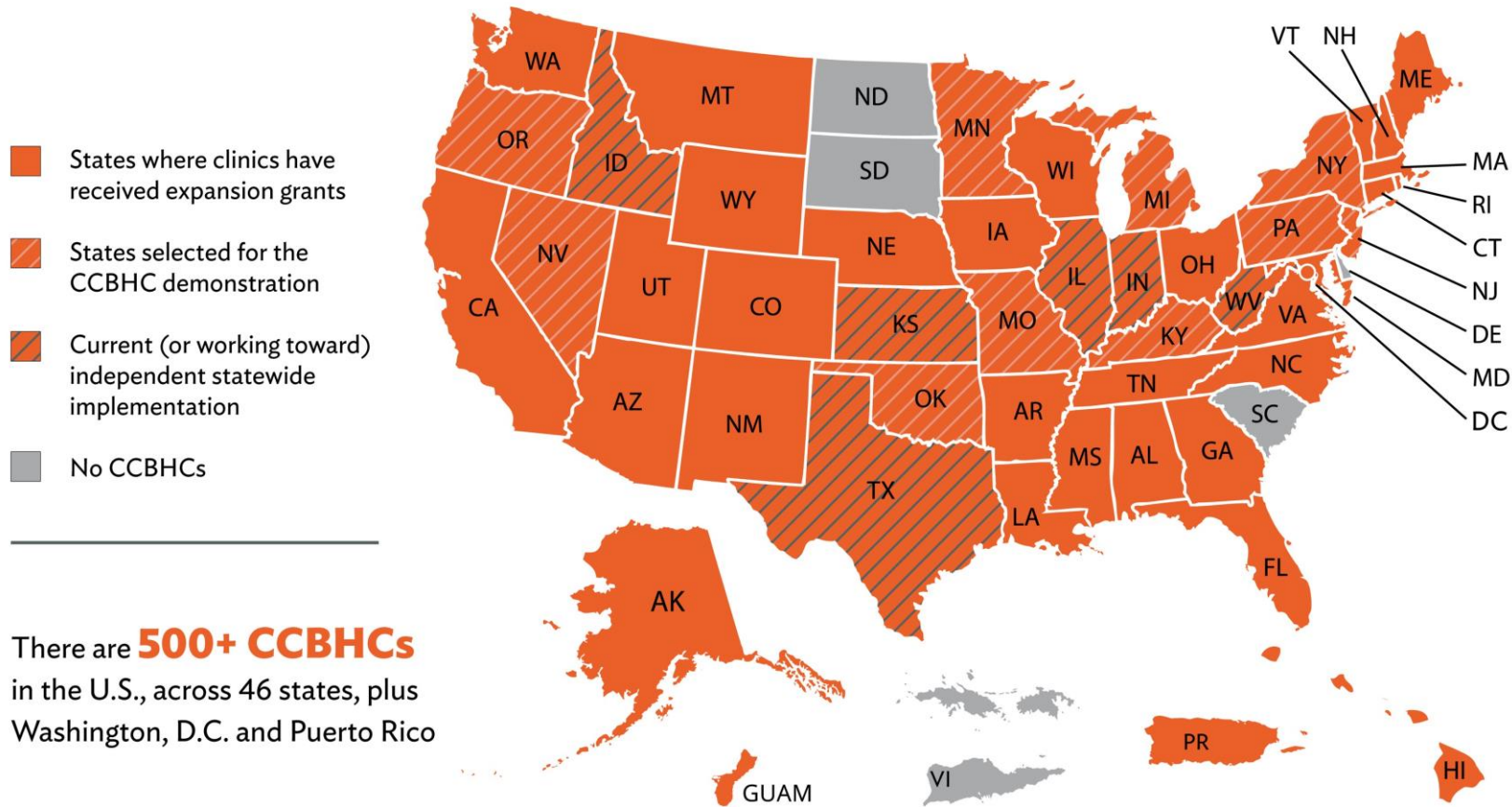
TheNationalCouncil.org

SAMHSA CCBHC Expansion Grants vs. Medicaid CCBHC Demonstration

Medicaid CCBHC Demonstration	SAMHSA CCBHC Expansion Grants
Open to 10 additional states every 2 years	Open to individual clinics in ALL states
Administered by state Medicaid and Behavioral Health authorities within guidelines set by SAMHSA/CMS	Administered by SAMHSA
States determine certification criteria using SAMHSA guidance as a baseline	Grantees must meet SAMHSA baseline CCBHC certification criteria
CCBHCs are certified by their states	CCBHCs are funded by SAMHSA; do not receive state certification
CCBHCs receive special Medicaid payment methodology (known as PPS)	CCBHCs receive up to $4M; continue to bill Medicaid and other payers per usual
Quality reporting includes 9 clinic-led and 12 state-led measures	Clinics report on clinic-led measures from the CCBHC demonstration

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Opportunities for enhancing data systems through the CCBHC model

For states that are not currently in the CCBHC demonstration:

- Demonstration expansion allows 10 more states to join every 2 years, beginning in July 2024
- Interested states apply for planning grants and conduct a planning process
- SAMHSA Notice of Funding Opportunity (NOFO) expected this month (Oct. 2022)
- In 2016, planning grant funds could be used to "develop or enhance data collection and reporting capacity" – details of the 2022 NOFO are TBA
- Other ongoing expenditures can be built into CCBHCs' cost reports/rates

For current demonstration states:

- Planning grant funding is not available, but states can implement enhanced data processes/platforms at any point
- For activities that require use of new platforms or staff, clinics can incorporate expenses in their cost report during the next rate rebase

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CCBHC presents an opportunity to reimagine service delivery

- Engaging in a wide range of services adapted to clients' and communities' needs

- Coordinating and engaging with partners in innovative ways
  - New partnerships for care delivery, including services and outreach delivered in new settings (e.g., schools, hospitals)
  - Electronic communication among partners

- Moving beyond care coordination to care management and population health
  - Understanding service utilization across health and social service systems
  - Risk stratification, registries, decision support tools
  - Addressing social determinants of health

- Tracking standardized measures within & across states; supporting clinical performance improvement; enabling evaluation of program outcomes

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Data and connectivity are the foundation for these efforts

- **For CCBHCs:** Real-time data can be used for care coordination, risk-stratified approaches to population health management, continuous quality improvement efforts, and demonstrating value to third-party payers when entering into value-based payment arrangements

- **For States:** Data can be used for assessing CCBHCs' impact, monitoring quality, and ensuring accountability (all critical for building buy-in across state agencies and legislatures)

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Uses of Shared Data to Support State Operations

- Collecting and reporting CCBHC required performance measures

- Monitoring compliance with CCBHC certification requirements

- Systemwide care coordination

- Managing transitions of care

- Supporting 988 crisis systems

- Cross provider benchmarking to improve performance

- Rapid response to governor and legislator inquiries

- Service system planning

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Financing to Align Interests

- Budget for the shared data capacity you need – software, training, staff

- Divide budget needed by your estimated # of PPS payments annually = shared data PPS add-on $

- Add CCBHC certification or contract requirement to participate in a statewide population management data system for accountability and quality improvement

- Each CCBHC must pay the shared data PPS add-on $ to the entity selected by the state to host and operate the state-wide population management data system.

- Options for the managing entity:
  - State CMHC Association
  - State University
  - Other?

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Missouri CCBHC Case Study

Building a data-driven culture in a world of CCBHCs and value-based care

"The time has come for a **bold new approach.**
–President John F Kennedy

CMHC

1963

community mental health act

2014

CCBHC

"Nothing will be more innovative than **treating behavioral health like all other health.**
–Senator Roy Blunt

excellence in mental health act

Certified Community Behavioral Health Clinics (CCBHCs)

- **Excellence in Mental Health Act** created a federal demonstration for CCBHCs

- Bipartisan legislation from U.S. Senators **Debbie Stabenow** (D-MI) and **Roy Blunt** (R-MO) in 2014

State Partnerships | Culture of Collaboration

» **Missouri Department of Mental Health**
Division of Behavioral Health

» **Missouri Department of Social Services**
MO HealthNet (Medicaid) Division

» **Missouri Department of Health & Senior Services**

» **Missouri Behavioral Health Council**

» **Missouri Primary Care Association**

» **Missouri Hospital Association**

" Furthermore, several key themes emerged from this study that are priority issues for state chief administrators and their staff, including **data governance, leading culture change, creating an agile workforce, and developing sustainable funding models for new initiatives**.

The Promise of Convergence:
Transforming Health Care Delivery in Missouri

A Case Study Developed for the 2015 NASCA
Institute on Management and Leadership

Denver, Colorado – October 7-9, 2015

LEADERSHIP FOR A NETWORKED WORLD

"The Promise of Convergence: Transforming Health Care Delivery in Missouri"

CCBH

Collaboration, Implementation & Development

» **CCBHC Leadership Team** DMH, DSS, MBHC, CCBHC providers

» **DMH & MBHC Liaison Meeting** DMH, MBHC, all providers

» **Practice Coaching** Missouri provider/state experts

» **CCBHC Learning Collaborative** DMH, MBHC, CCBHC providers

» **Quality Improvement Collaborative**

CCBHCs in Missouri

8 STATES	State Population (in millions)	CCBHC Organizations	CCBHC Service Locations	Year 1 Total to receive CCBHC services (all pay source)	Year 1 Projected CCBHC Consumers who are Medicaid Recipients
MINNESOTA	5.52	6	22	17,600	15,000
MISSOURI	**6.09**	**15**	**201**	**127,083**	**87,284**
NEVADA	2.94	4	5	7,305	5,844
NEW JERSEY	8.94	7	20	79,782	50,882
NEW YORK	19.75	13	77	40,000	32,000
OKLAHOMA	3.92	3	19	23,076	11,077
OREGON	4.09	12	21	61,700	50,000
PENNSYLVANIA	12.80	7	7	27,800	17,800
	64.05	67	372	381,346	269,887

Missouri CCBHC Growth

15 2017

21 Today

22 Projected by Jan 2023

Missouri CCBHC Service Area Map

CCBHC Outcome Measures & Value-Based Payments

⑨ Clinic-Led Measures

- » Time to Initial Evaluation
- » Adult BMI Screening/Follow Up
- » Youth Weight Assessment/ Counseling
- » Tobacco Use Screening/Cessation
- » Alcohol Use Screening/Counseling
- » **Youth MDD: Suicide Risk Assessment** $
- » **Adult MDD: Suicide Risk Assessment** $
- » Screening for Depression/Follow Up
- » Depression Remission at 12 months

$ = VBP measures
CCBHCs must meet all 9 measure goals, statewide benchmark, and/or show improvement over previous FY

⑬ State-Led Measures

- » Housing Status
- » Patient Experience of Care Survey (adult)
- » Youth/Family Experience of Care Survey
- » Follow-up after ED visit for MI
- » Follow-up after ED visit for AOD
- » **MI Hospitalization Follow-up (adult)** $
- » **MI Hospitalization Follow-up (youth)** $
- » All Cause Readmission Rate
- » Diabetes Screening
- » **Adherence to Antipsychotic Medication** $
- » Follow-up for Children ADHD Medication
- » Antidepressant Medication Management
- » **Initiation/Engagement of AOD Treatment** $

Missouri's Impact Report | Year 5
Improving Outcomes & Access to Care

Reducing Hospital & ED Utilization

174.0 ⭘——⭘——⭘——⭘——⭘——⭘ **145.5**
ED Visits

61.9 ⭘——⭘——⭘——⭘——⭘——⭘ **44.9**
Hospital

2016 2017 2018 2019 2020 2021

CCBHCs have shown a reduction in the number of ED and hospital encounters (per 1,000 member months)
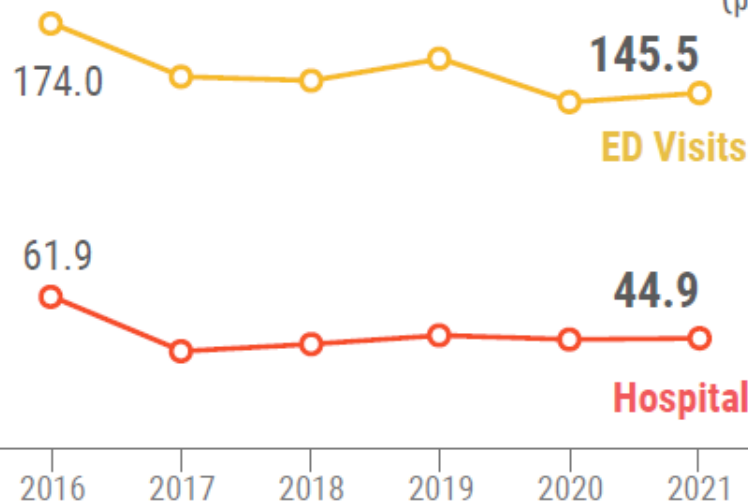
⬇ **16%**
Decrease in ED visits from baseline (2016) to 2021

⬇ **27%**
Decrease in hospitalizations from baseline (2016) to 2021

⬆ **35%**

Increase in patient access to care

Overall increase in patients served from baseline (2017) to Year 5 (2022)

Missourians Served by CCBHCs

119,022 123,963 140,963 146,944 152,382 160,568

Baseline Year 1 Year 2 Year 3 Year 4 Year 5
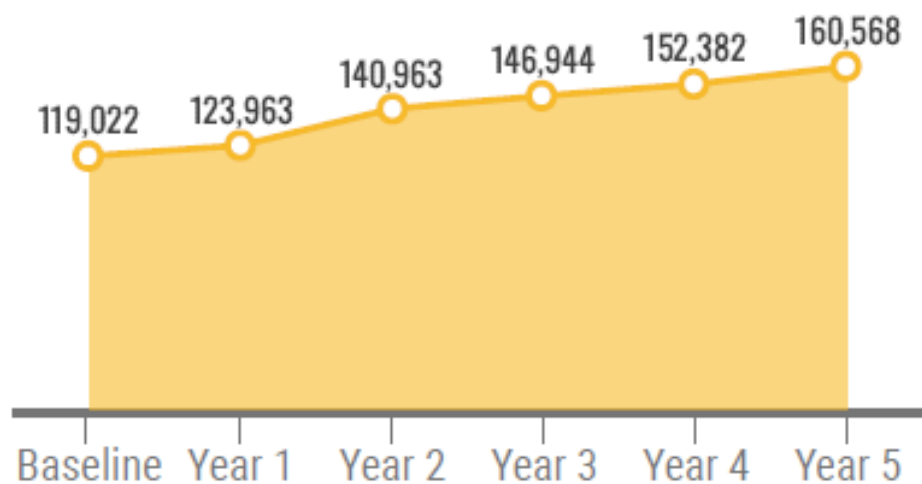
3,185

Veterans & active military served by CCBHCs

⬆ **26%** Overall increase in veterans and active military served from baseline to Year 5

Certified Community Behavioral Health Clinics > Missouri's Impact Report | Year 5

Workforce Recruitment

CCBHCs have seen growth in their care team positions from baseline (2017) to Year 4 (2021).

Family Support Providers
- '17: 14
- '21: 31

Peer Specialists
- '17: 36
- '21: 111

Psychiatrists (youth)
- '17: 14
- '21: 28

APRNs, PAs, APs
- '17: 45
- '21: 130

Cost Savings

CCBHC pre and post period hospital costs
- pre: $110,031,013.58
- post: $94,604,792.00

Costs per person pre and post
- pre: $3,449.90
- post: $2,966.23
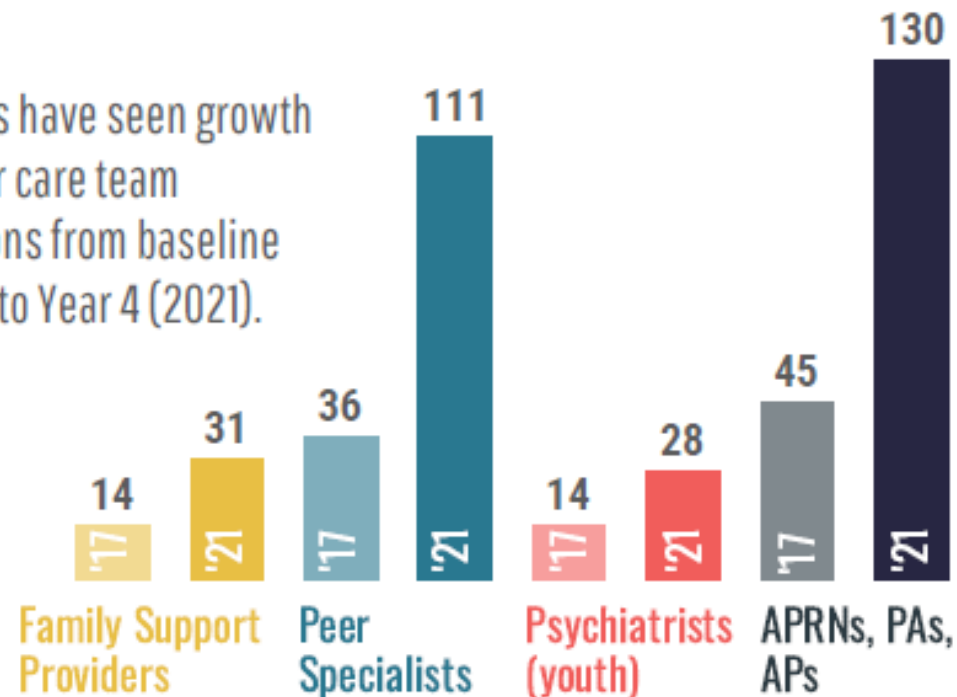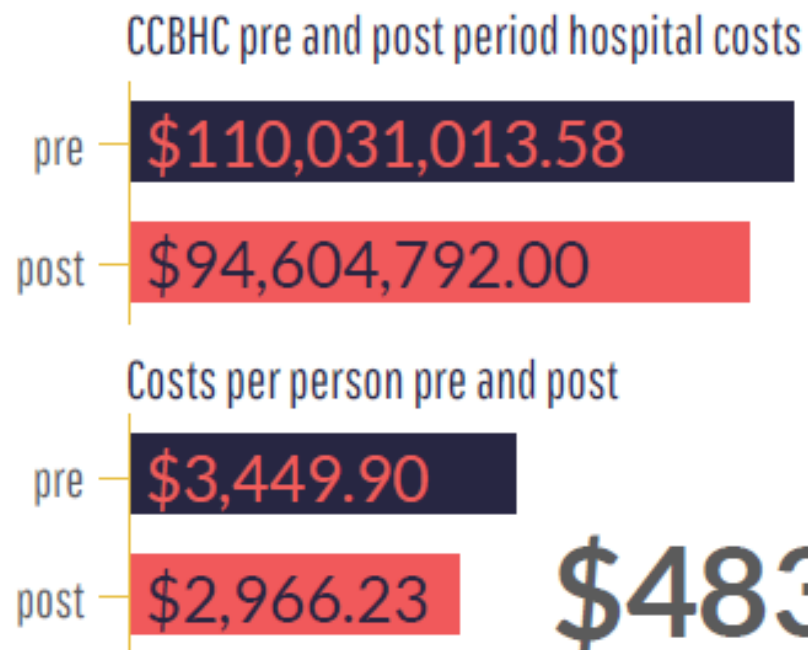
↓ **14%**

Decrease from pre to post period hospital costs totaling ⌄

$15.4 million in savings

$483.67 savings per person

The Data Journey

Evaluation of the workflow to gather information.
Conclusion: It's a hot mess – we need a one stop shop.

How can we eliminate the silos and integrate our data?

DMH sends hospitalization report/ED alerting

Tracking populations

Access to claims data

Access to clinical data

Data Entry to generate reports

Receive monthly reports* from reporting tool

CIMOR

Master Client Spreadsheet

Medicaid EHR
Medicaid Eligibility

Health Information Exchange

Provider Electronic Health Record

Reporting Tool
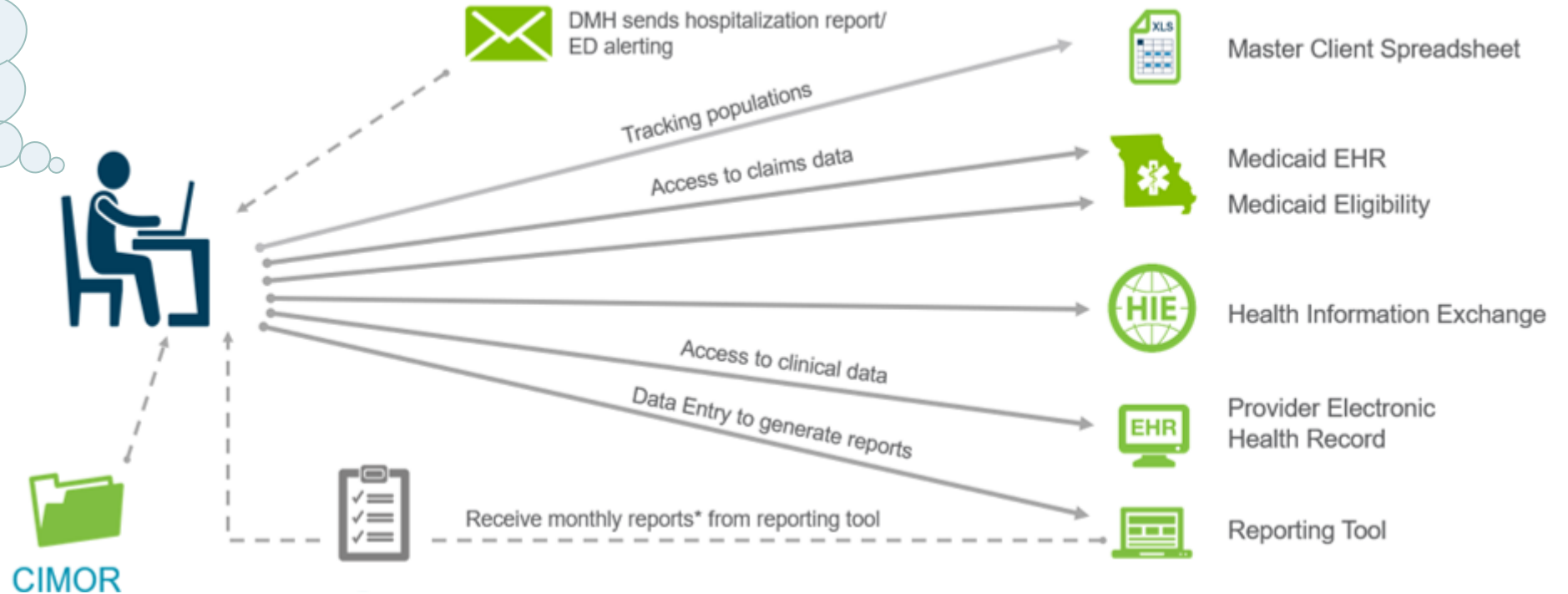
[1] Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

"Case Managers spend roughly 40% of their time searching for patient data"[1]

Please! No more spreadsheets.

» Has the spreadsheet been sorted by caseload?

» Is this spreadsheet the latest version? When was it last updated?

» You want me to log into another system?

» Check your email.

Data Needs Assessment | "Shopping List"

One Stop Shop | Aggregate and display meaningful data in one system for behavioral health providers to inform their day

(claims data, hospital and ER notifications, clinical data, assessment scores, demographics)

› Access to data in **near real-time** (daily)

› Eliminate double entry of clinical data - **interoperability with EHRs**

› **Custom reporting** from the aggregate data set at the state and provider level

› Automated **risk stratification** methodology

› Display data in a meaningful way to enable **population health** in team workflows

CareManager & Population Health

CareManager was selected as Missouri's new health technology tool for behavioral health providers to use in **care management** and **population health**.

>>> **34** providers

>>> **900+** end users

>>> **275,000** lives managed

CareManager combines **Medicaid claims** data + DMH **client detail** + **hospital** and **ER notification** + **clinical** data from providers to:

» **alert** the care team of ER and hospital events

» **assess** populations for risk

» **monitor** health outcomes

» **manage** interventions to address gaps in care

Missouri's Health Information

34 organizations

11 EHR vendors

Dept of Mental Health

MISSOURI DEPARTMENT OF **MENTAL HEALTH**

- Metabolic screening
- Status Reports
- Demographics
- SDoH
- Hospital follow up
- Functional assessment
- PHQ-9
- Suicide risk assessment

- Patient census
- Program assignment
- Demographics
- Medicaid claims
- Medicaid eligibility
- Hospital and ER notifications

Data Integration

CareManager

CareManager equips the Care Team on the ground to make informed, data-driven decisions with access to real-time, comprehensive health information.

Measures Reporting

Measures Reporting is integrated within CareManager and allows providers and the state to develop and standardize measures across the system for population health management.

MBHC

Health Risk Profile

Demographics

NAME | Blaine L Bambooson
DCN # | 5378434
NURSE CARE MANAGER ASSIGNMENT | Cecilia Rahardjo
DATE OF BIRTH / AGE | 06/06/1981   36 years   Adult
GENDER | Male
RACE | Caucasian

Risk Summary

Metabolic Screening		6.5
Physical Health Diagnosis		3
Medication Use		2.2
ER & Hospitalizations		3
TOTAL RISK SCORE	MODERATE-HIGH RISK	14.7

Program Enrollment
Primary Care Health Home - enrolled 1/3/2017

Health Plan
BCBS KC - enrolled 01/03/2017

Category Details

Metabolic Screening

Adult BMI 18.5 - 24.9 (Healthy Weight)	0
BP > 140/>90 mmHg (High)	1.7
No A1c or Blood Glucose, Unable to Calculate, or Opt Out in last 12 months	0.8
No LDL, Unable to Calculate, or Opt Out in last 12 months	0.8
HDL > 60 mg/dL (Normal)	0
Triglycerides 150 ? 199 mg/dL (Borderline)	0
No Total Cholesterol, Unable to Calculate, or Opt Out in last 12 months	1
Tobacco Use	2.2

Physical Health Diagnosis

Thyroid Disorders (Thyroid, Acquired Hypo; Thyroid, Goiter, Nodular; Thyroid Disorder, Other)	1
Blood Disorders (Anemia, NOS; Anemia, Other Deficiency; Anemia, Hemolytic, Hereditary; Sickle-cell Disease)	1
Other Physical Health Diagnosis- Not Cancer	1

Medication Use

Taking Aripiprazole (Abilify), Ziprasidone (Geodon), or first-generation antipsychotics	2.2

ER & Hospitalizations

1-2 ER Visits in last 6 months	3
No Hospitalizations in last 6 months	0

TOTAL RISK SCORE   MODERATE-HIGH RISK   14.7

Low Risk	< 7.5
Moderate Risk	7.5 – 11.5
Mod-High Risk	11.6 – 15
High Risk	> 15

Client Profile	› Demographics › Program Enrollment › Health Plan
Risk Factors	› Metabolic Screening Profile › Diagnosis: • Physical, Behavioral, Substance Use, Developmental Disability, Other Chronic Conditions › Medication Use › ER & Hospitalizations + Housing, Employment Status + PHQ-9, Suicide Risk + Functional Assessment Scores

CareManager

Russell, Marcus
Client ID: 3785772   DOB: 09/14/1959   Status: Enrolled

🔔 **Alerts** 2

⚙ **Coordination**

Episode: (06/19/2017 - ... ▼

| Claims | **Procedures** | Diagnosis | Drug Claims |

- 👤 Facesheet
- 📈 Metabolic Trends
- 🌐 Demographics
- ▦ Programs
- ▣ **Claims**
- ✳ Eligibility
- 📊 Assessments
- ⚙ Care Coordination
- ♁ Physical Health
- ♥ Health Factors
- 🏥 Hallmark Events
- 🗐 Documents
- rge

	Procedure	Code	Date	Count
▶	Free assay (FT-3)	84481	01/18/2018	2
▶	OFFICE/OUTPATIENT VISIT EST	99213	12/01/2017	3
▶	PPPS, SUBSEQ VISIT	G0439	10/19/2017	1
▶	Immunization admin	90471	10/19/2017	1
▶	REMOVE IMPACTED EAR WAX UNI	69210	10/10/2017	3
▶	OFFICE/OUTPATIENT VISIT EST	99214	08/28/2017	4
▼	X-ray exam of finger(s)	73140	07/24/2017	1

Service Date	Billing Provider	Rendering Provider	Place of Service ⇕	Claim Number
07/24/2017	MERCY CLINIC SPRINGFIELD COMMUNITIES		Urgent Care Facility	5555512021195

	Procedure	Code	Date	Count
▶	OFFICE/OUTPATIENT VISIT NEW	99203	07/24/2017	1
▶	CHEST X-RAY 2VW FRONTAL and LATL	71020	07/19/2017	1
▶	ELECTROCARDIOGRAM COMPLETE	93000	06/28/2017	2
▶	Iron binding test	83550	06/26/2017	1
▶	ASSAY OF FERRITIN	82728	06/26/2017	1
▶	ASSAY OF NATRIURETIC PEPTIDE	83880	06/26/2017	1

MB HC

Population Health

Dashboard | Agency Summary | Population Quality

Common Selectors

Populations

Agency

Common Selectors

Team Role

Staff Name

Payor Selectors

Payor Name

Medicaid/Medicare

Reporting Period

Reporting Period

Adult | Youth | Care Transitions

Number	Description	Percentage	Results	Goal
MoCo 0036 ⓘ	Asthma Medication Adherence (Adult)	0%	$\frac{0}{115}$	0% — Goal: 70%
MoCo 0059 ⓘ	Blood Pressure Control for Diabetes (Adult)	65%	$\frac{2248}{3458}$	65% — Goal: 65%
MoCo 0059 ⓘ	Hemoglobin HbA1c Control for Diabetes (Adult)	59%	$\frac{2031}{3458}$	59% — Goal: 60%

MB
HC

Population Health

| | Dashboard | Agency Summary | Population Quality |

Common Selectors

| Populations |
| Agency |

Common Selectors

| Team Role |
| Staff Name |

Payor Selectors

| Payor Name |
| Medicaid/Medicare |

Reporting Period

| Reporting Period |

Last Refresh: 2019/02/27 11:58:05

| Back | Hemoglobin HbA1c Control for Diabetes (Adult) Measure Details | Export Data |

Description	Persons Flagged	Eligible Population
% of patients 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) who had an HbA1c < 8.0%	Persons flagged have a documented HbA1c >= 8.0% OR have no HbA1c result reported in the previous 12 months	Persons identified as having diabetes during the current or prior year through pharmacy data OR two face to face encounters in an outpatient or non-acute inpatient setting with a diagnosis of diabetes or one face to face encounter in an acute inpatient or ED setting during the current or prior year with a diagnosis of diabetes. Metformin is excluded from pharmacy data since it is used for numerous other conditions.

| Managed - (62) | Intervention - (48) | Population - (110) |

Client DCN ID	Client DMH ID	Last Name	First Name	Gender	Age	County of Residence	Nurse Care Manager	Lab Date	A1c Result
								-	-
								2018-09-12	8.7
								2018-11-09	8.3
								2018-04-05	10
								2018-07-05	10
								2018-12-28	11.6
								-	-
								2018-10-09	10.5
								-	

The new and improved workflow with integrated data that is near real-time and actionable.

That's better! ☺

Provider
Electronic Health
Record

EHR

CareManager &
Population Health
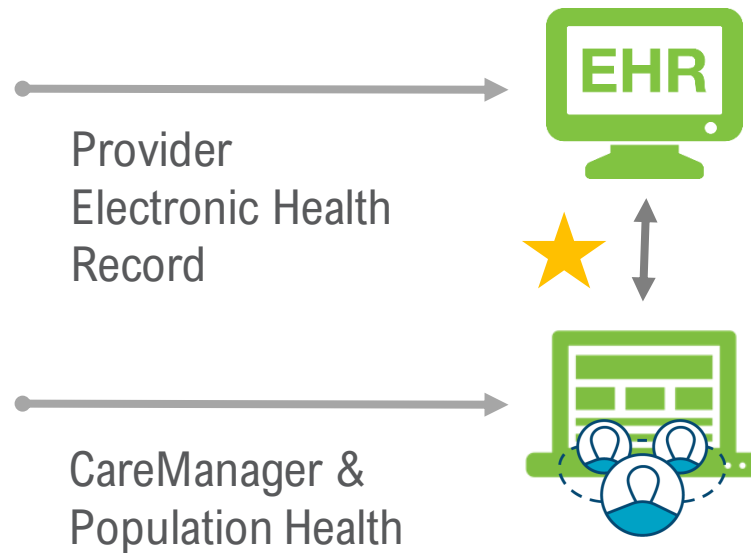
Front Line Operations
Care Management/Coordination
View

Quality Measures and Reporting
Population Health Data View

State Outcomes
Analytics and Compliance View

» Daily **alerts** of hospital and ER encounters
» Access to claims data + Medicaid eligibility
» **Assess** populations for risk
» **Monitor** health outcomes
» **Manage** interventions to address gaps in care
» DIY Reports
» State Reporting Requirements

MB
HC

Building a Data-Driven Culture
to thrive in a Value-Based World

CareManager
Provider

Care Management
Risk Stratification
Custom Reporting

Population Health
Provider, State, Association, Payors

Measures
Outcomes

Data Warehouse
Provider Admin, State, Association, Payors

Evaluations
Advocacy
Social Factors of Health

MBHC

Missouri's Health Information

34 organizations

Dept of Mental Health

Data Integration

MBHC CLIVE
Data Warehouse
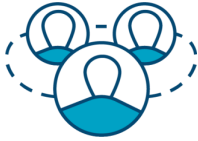
CareManager
Driving quality care in the field.

CareManager combines **Medicaid claims** data + DMH **client detail** + **hospital** and **ER notifications** + **clinical** data from providers to:

- ⚙ Alert the Care Team of ER and hospital events
- ⚙ Assess populations for risk
- ⚙ Monitor health outcomes
- ⚙ Identify gaps in care

Measures Reporting
Measuring quality real-time.

Population

Managed

Intervention Needed

populations can be further stratified by:

- › Medicaid Coverage or MCO
- › Program Enrollment
- › CCBHO-specific or State Totals
- › Team Role or Staff Name

OPPORTUNITIES

IPA / Payor Access

Primary Care / Community Health Centers

State Reporting

HIE / CareQuality

START WHERE YOU ARE.

USE WHAT YOU HAVE.

DO WHAT YOU CAN.

- Arthur Ashe

MB
HC

Questions & discussion

Brian Hepburn, NASMHPD
brian.hepburn@nasmhpd.org

Rebecca Farley David, National Council
rebeccad@thenationalcouncil.org

Joe Parks, National Council
joep@thenationalcouncil.org

Valerie Huhn, MO Dept of Mental Health
Valerie.Huhn@dmh.mo.gov

Rachelle Glavin, MO Behavioral Healthcare Council
rglavin@mobhc.org

Brent McGinty, MO Behavioral Healthcare Council
bmcginty@mobhc.org

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To make mental wellbeing, including recovery from substance use challenges, a reality for everyone.