Screening and Monitoring for Primary Care as a CCBHC:

A Case Study

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Introduction

Certified Community Behavioral Health Clinics (CCBHCs) increasingly play a vital role in facilitating access to care, improving outcomes and addressing community needs. A hallmark of the model is whole-person care, as CCBHCs provide or coordinate access to primary health screenings, monitoring of co-morbid health conditions, and connections to primary care and other providers who specialize in chronic disease prevention and management.

To assist Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC grantees in implementing high-quality outpatient primary care screening and monitoring services, the following guidance was developed. Contracted by the National Council for Mental Wellbeing's CCBHC Expansion National Training and Technical Assistance Center (CCBHC-E NTTAC), Third Horizon Strategies (THS), a strategic health care advisory firm with a deep bench of behavioral health expertise, developed the following guide.

THS' methodology included a detailed review of the SAMHSA criteria, a literature review of publicly available sources, a series of five case study interviews with CCBHCs around the country and tapping the firm's extensive experience and subject matter expertise in community behavioral health and integrated and coordinated care.

This guide:

- Describes why primary care screening and monitoring are critical components of CCBHCs.
- Highlights the specific requirements of CCBHC Criterion 4G: Outpatient Clinic Primary Care Screening and Monitoring, and the relevant required quality measures.
- Identifies best practices and assists grantees in determining appropriate staffing, workflows and data-collection processes to fully implement Criterion 4G.
- Provides case studies highlighting CCBHCs nationwide that have successfully implemented primary care screening and monitoring using various approaches. Some have more fully integrated primary care services that exceed what is required. The case study interviewees are:
  - Compass Health Network, Missouri
  - Ohel Children's Home and Family Services, New York
  - SummitStone Health Partners, Colorado
  - Wallowa Valley Center for Wellness, Oregon
  - Zumbro Valley Health Center, Minnesota

Why Outpatient Primary Care Screening and Monitoring Are Critical CCBHC Components

There is ample evidence that people with behavioral health conditions are at increased risk of morbidity and mortality from chronic health conditions. Yet, many lack or are not routinely engaged with their primary care provider (PCP), or a regular source of care. The high rate of physical comorbidity may reduce life expectancy for people with mental health and substance use disorders while increasing the personal, social and economic cost of these conditions across the lifespan.

According to a September 2022 study, people with serious mental illness (SMI), including schizophrenia, bipolar disorder and severe major depressive disorder, tend to have higher rates of comorbid physical disease than the general population (Grudniewicz et al., 2022). For example, people living with schizophrenia have higher rates of cardiovascular disease, hyperthyroidism, chronic obstructive pulmonary disease, tuberculosis and obesity.

Additionally, a study released in December 2023 found a significant association between four chronic diseases (cholesterol disease, kidney disease, coronary heart disease and asthma) and mental health challenges (Huang et al., 2023)

Research published in the Journal of the American Heart Association in March 2022 found that 30-year cardiovascular risk was significantly higher in those with SMI (**25% of patients with SMI compared to 11% of patients without**) (Rossom et al., 2022). The individual factors contributing most to increased cardiovascular risk among those with SMI were elevated body mass index (BMI) and smoking, which indicates there are some modifiable risk factors. CCBHCs are well positioned to support people in developing healthier lifestyles through behavioral health interventions and wellness services, such as smoking cessation.

The use of psychotropic medication (antipsychotics, antidepressants and mood stabilizers) can further increase the risk of metabolic disorders in people with SMI. In particular, antipsychotics are associated with weight gain after prolonged use (Mazereel et al., 2020). This makes it even more critical that CCBHCs ensure people receiving services are connected to primary care and participate in regular screening and monitoring.

Individuals with behavioral health conditions often face barriers to accessing primary care, including socioeconomic and environmental factors. Behavioral health-related stigma, including that which exists in the health care system and among health care providers, has also been identified as a major barrier to accessing treatment and recovery. It is also attributed to health challenges for people with mental illness. An example is the roughly 37 million people in the U.S. with diabetes, who are 2 to 3 times more likely to develop depression. Moreover, people with diabetes who have depressive symptoms have a 46% increased risk for all-cause mortality than those without depressive symptoms. However, only 25%-50% of people with diabetes with depression are diagnosed and treated (Knaak et al., 2017).

Another recent study published in JAMA found that many physicians face challenges in screening for or treating substance use disorders (SUDs) due to lack of perceived institutional support, knowledge, skills or training on working with SUD, along with difficulties in managing higher levels of care. This reticence may leave people with an SUD without a regular source of primary care (Campopiano von Klimo et al., 2024).

This body of research points to the critical need for CCBHCs to engage in primary care screening and monitoring services. Providing whole-health-oriented services within behavioral health settings can reduce disparities and ensure people receiving services are connected to preventive and routine care that can address ongoing health care needs (Mangurian et al., 2013). Early and regular screening can detect conditions more prevalent in individuals with mental illness, such as hypertension and obesity, sooner (Romain et al., 2019). CCBHCs are often the primary source of care for people with behavioral health conditions, making it imperative that they detect and address the needs of people with chronic health conditions.

By providing primary care screening and monitoring, CCBHCs help connect individuals with services they otherwise might not access while promoting chronic disease self-management and improving overall health and functioning.

Criterion 4G: Outpatient Clinic Primary Care Screening and Monitoring Requirements

CCBHCs are responsible for screening for and monitoring key health indicators such as vitals (e.g., weight, height, temperature, pulse rate, blood pressure) and blood work (e.g., hemoglobin A1C control for people with diabetes, lipid panel), while establishing strong partnerships and coordinating with PCPs to meet the whole health needs of people receiving services. The CCBHC Certification Criteria updated by SAMHSA in March 2023 define expectations for clinics.

A CCBHC's medical director is expected to define protocols that meet the needs of the populations being served and adhere to the CCBHC requirements. This is an opportunity for the CCBHC's clinical, operational and administrative leadership to collaborate with medical leadership to establish workflows and organizational protocols that meet the needs of people with behavioral health and other chronic health conditions.

Obtaining periodic health assessments and using standard screening tools allow CCBHC care teams to get a snapshot of the health status and risks of people served and connect them with appropriate care. Routine screenings also allow CCBHCs to compare results over time, increasing the chances that interventions like medications or lifestyle changes can prevent a potential problem.

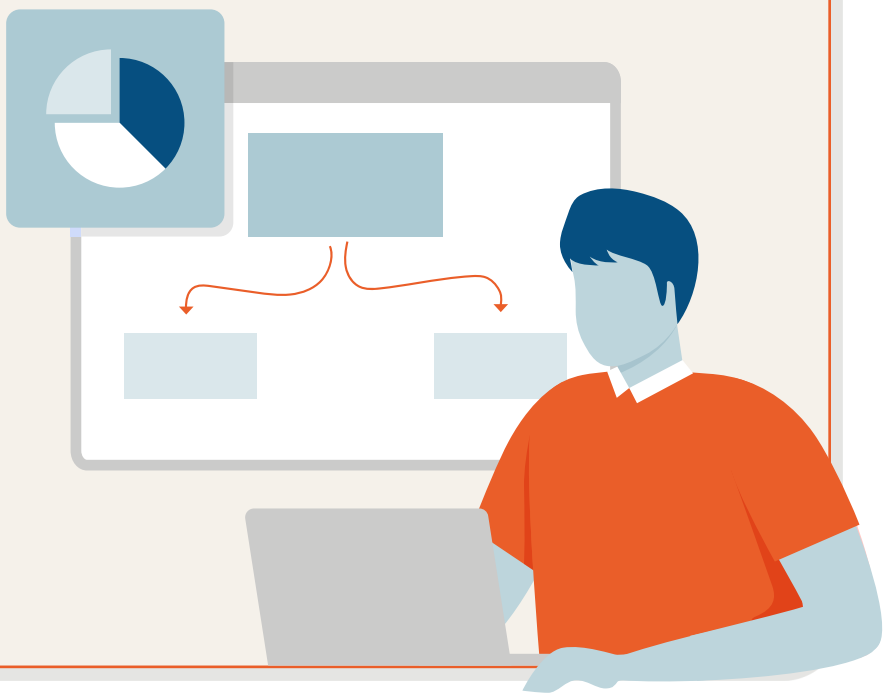
4.G.1: The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a [contracted entity, known as a Designated Collaborating Organization (DCO)], the CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The medical director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions:

- HIV and viral hepatitis
- Primary care screening pursuant to CCBHC Program Requirement 5: Quality and Other Reporting and Appendix B
- Other clinically indicated primary care key health indicators of children, adults and older adults receiving services (e.g., blood pressure, BMI, hemoglobin A1C), as determined by the CCBHC medical director and based on environmental factors, social determinants of health and common physical health conditions experienced by the population receiving services.

4.G.2: The medical director will develop organizational protocols to ensure screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan (e.g., diabetes, obesity, hypertension, asthma). Protocols will include:

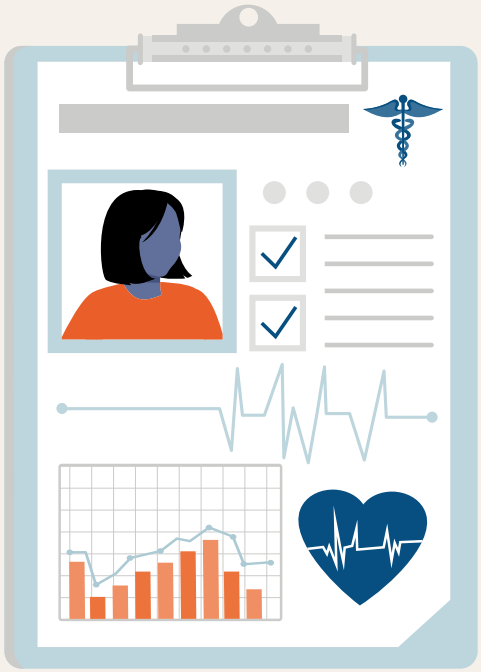
- Identifying people receiving services with chronic diseases.
- Ensuring that people receiving services are asked about physical health symptoms.
- Establishing systems for the collection and analysis of laboratory samples, fulfilling the requirements of 4.G.

In order to fulfill the requirements under 4.g.1 and 4.g.2, the CCBHC should have the ability to collect biologic samples (e.g., blood, urine) directly, through a DCO or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the PCP to ensure that screenings occur for the identified conditions. If the person receiving services' PCP conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHC's screening and monitoring protocols developed under 4.G.



4.G.3: The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following:

- Ensuring individuals have access to primary care services.
- Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions.
- Coordinating care with primary care and specialty health providers (e.g., cardiologists, endocrinologists), including tracking attendance at needed physical health care appointments.
- Promoting a healthy behavior lifestyle (e.g., wellness goal setting, nutrition, exercise, tobacco cessation groups, or classes).



Essential Steps and Best Practices

In meeting the criteria, CCBHC grantees may experience some common challenges if they're modifying workflows, staffing appropriately to deliver the new services, strengthening relationships with primary care to ensure timely information and data exchange, ensuring robust data collection, and using comprehensive data to support practice transformation and improve treatment outcomes. Fortunately, there are some proven practices for clinics to mitigate these challenges and use primary care screening and monitoring to support better behavioral and physical health outcomes, as well as the overall recovery and wellbeing of people receiving services. The implementation of primary care screening and monitoring can also improve the experience of care for people with behavioral health conditions as it helps them to recognize the interplay between their physical and mental health, while ensuring stronger coordination among members of their care team.

1 *Select a program model.*

The CCBHC Certification Criteria specify what clinics must do regarding primary care screening and monitoring but leave clinics with significant flexibility in meeting these requirements. The first step for organizations adding these services is determining a program model or overall approach, such as providing services directly by hiring medical assistants or nursing staff, working with a DCO, or coordinating with one or multiple primary care clinics (without a DCO relationship). These services may or may not be co-located with the other CCBHC services.

The best approach for an individual CCBHC depends on multiple factors such as findings from its local community needs assessment, organizational capacity and expertise, the strength of its existing relationships with PCPs, workforce availability, preferences of people receiving services and local health care market factors. According to the National Council's 2024 CCBHC Impact Report, of the Medicaid CCBHCs and expansion grantees surveyed, the vast majority provide primary care screening and monitoring directly; only 43 (12%) reported contracting with a PCP as a DCO.

It is important to note that providing more extensive primary care services outside the screening and monitoring requirements defined in 4.G is not within the scope of the nine required CCBHC services. While CCBHCs may provide primary care services, these cannot be reimbursed through the SAMHSA grant program or Section 223 CCBHC Demonstration Prospective Payment System. Nonetheless, half of the CCBHC Impact Report (2024, July) respondents exceed minimum requirements by making comprehensive primary care available on-site. Nearly 3 in 10 (28%) Medicaid CCBHCs and established grantees reported their CCBHC is a fully integrated primary care and behavioral health provider with all services available in the same location. With an additional 22% reporting a co-location arrangement with a PCP, that means a total of 50% make comprehensive primary and behavioral health care available to all people being served in the same location. The most frequently cited type of primary care partner for CCBHCs is a Federally Qualified Health Center (FQHC).

2 *Support change management and build an organizational culture of whole-person care.*

For many CCBHCs, primary care screening and monitoring account for one of the nine required services that are newer to the organization as they have not been part of historical behavioral health service delivery. As with any significant change, integrating these new services requires an intentional approach to creating internal buy-in. According to case study interviewee SummitStone Health Partners, staff flexibility and willingness to adapt, as well as support from the leadership to incorporate staff input, are instrumental in supporting change management.

Recommended change management strategies include proactive communication about the importance of primary care screening and monitoring — and how they align with the organization's mission — engaging staff in designing new workflows, celebrating early wins or accomplishments of goals, and widely sharing outcome data and success stories.

A common theme among the CCBHCs interviewed was the importance of training, engaging and including feedback from staff to support change management. The clinics offer training on topics such as developing wellness or whole-health-related treatment plan goals, collecting vitals, and best practices in coordinating with PCPs. According to Zumbro Valley Health Center, coordinating with local work groups, statewide associations and other external collaboratives to encourage knowledge-sharing on best practices and implementation helps with staff buy-in, engagement and training as well.

3 *Determine staffing needs.*

Beyond meeting the CCBHC staffing criteria (1A-1D), clinics must determine the ideal staffing plan and team-based approach to fulfilling the primary care screening and monitoring requirements. The staffing plan may differ based on the program model (i.e., whether the CCBHC is meeting the requirements internally or with a DCO) and the findings of the CCBHC community needs assessment.

Another common theme among the case study interviewees was the value of recruiting and hiring clinicians with experience and background in primary or specialty care. These can include chief medical officers, addiction medical specialists, nursing directors, medical assistants, physician assistants or integrated care directors.

Compass Health described the value of community support workers in helping people receiving services with severe behavioral health challenges. These professionals have a college education in any human services field. They may help with several areas of support, such as assisting individuals in accessing services, activities of daily living (ADLs), healing and treatment needs and scheduling care appointments.

SummitStone Health Partners has a medical director who previously worked for an FQHC and is dual-certified in addiction medicine. Ohel Children's Home and Family Services hired a registered nurse who has primary responsibility for conducting the routine screenings required under the CCBHC criteria, while Zumbro Valley Health Center hired tobacco specialists.

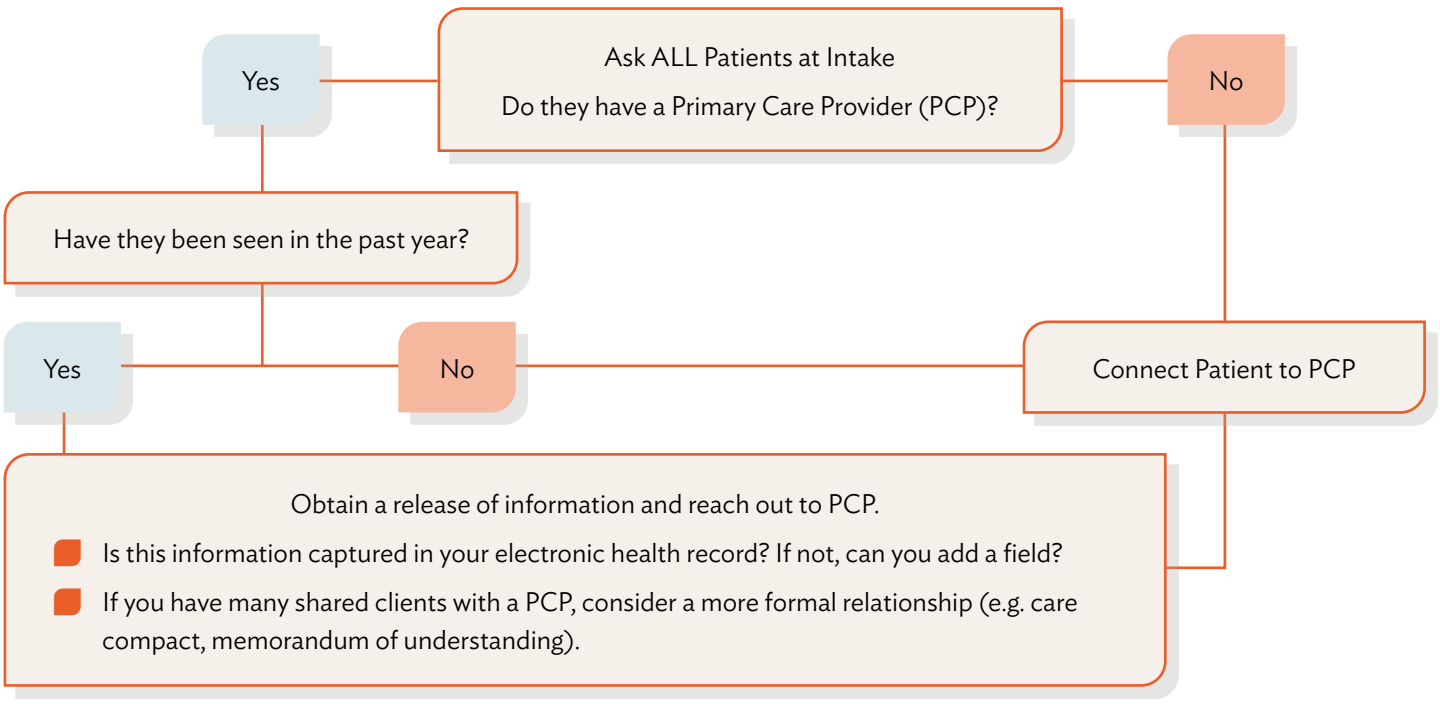
Beyond clinical staffing, CCBHCs should consider staffing needs related to clinical quality improvement and reporting. Many clinics find that they need additional data analysts and population health management capabilities since, historically, many behavioral health providers have not collected physical health data or worked to address comorbid conditions. These specialists can help ensure CCBHCs not only collect the necessary data but also use it to support whole-person care.

4 *Develop standardized organizational protocols and workflows that support primary care screening and monitoring and population health.*

The CCBHC criteria require the medical director to develop organizational protocols to ensure appropriate screening is implemented for clients who are at risk for common comorbid physical health conditions, such as diabetes, HIV and other infectious diseases, hypertension, chronic pain, cardiovascular concerns, or obesity. This includes screening that conforms to the U.S. Preventive Services Task Force recommendations. Some CCBHCs integrate a standardized primary medical screening into their initial assessment process, while others combine the screening, vitals and blood draws with prescriber visits.

One best practice is to collect information at intake on whether the person receiving services has a PCP and has been seen in the past year. If the answer is yes, the CCBHC should implement comprehensive efforts to obtain a release of information and work to coordinate care with the providers. Some CCBHCs may also seek to have case conferences or additional, regular communication with primary care practices that see a large volume of shared clients. If the answer is no, the CCBHC should connect the client with a PCP through a warm handoff or coordinated referral process. This seemingly basic step can make a huge difference in improving overall health outcomes. Case study interviewees stressed the importance of ensuring there is a place for this information to live. Ideally, the data can be entered into discrete fields within an electronic health record (EHR) so that reports can be generated. Alternatively, some CCBHCs augment their behavioral health-focused EHR with a disease registry, care management software, or even a basic spreadsheet or client database.

A Starting Point: Where Do your Clients Go for Primary Care?



For example, at Compass Health, the client is asked if they have access to a PCP and if they need behavioral health service providers as part of their initial screening questionnaire. The team then connects the client to the appropriate services as needed. Compass Health has strong partnerships with multiple FQHCs in their region. It has shared access to scheduling portals or a direct liaison that assists its staff in seamlessly navigating appointments. "Looking at all gaps in care and making it a part of our checklist and care management approach has helped us achieve successful patient outcomes," the team at Compass Health shared.

Developing and implementing medical profiles, as well as detailed decision trees and risk stratification processes, help inform clinical decision-making to guide primary care screening and monitoring and successful care coordination. For example, Wallowa Valley Center for Wellness has 13 "high-risk criteria" that help determine service gaps and needs. The criteria consider both behavioral health needs and other comorbid chronic health conditions. The organization tracks the risk stratification process manually but is developing more robust systems. Risk stratification uses a mix of objective and subjective data to assign risk levels to patients. CCBHCs can systematically use patient risk levels to make care management decisions, such as providing greater access and more intensive resources to patients in higher risk levels.

5 *Coordinate care with external providers.*

CCBHCs may face challenges coordinating care with external PCPs, tracking external referrals and obtaining records in a timely manner. Common barriers include capacity issues, staffing shortages, lack of digitalized records or a lack of understanding about the importance of integrated or coordinated care. Some best practices to mitigate this include developing memorandums of understanding, care compacts or other written agreements, and business associate agreements. CCBHCs with DCO relationships should define expectations for timely data sharing in their contractual arrangements. It is also helpful to identify primary points of contact who can serve as liaisons between the partner organizations, troubleshoot as needed, and assist with scheduling and communication.

More best practices around care coordination can be found in the National Council's CCBHC Care Coordination Toolkit (2024).

6 *Promote wellness and a healthy lifestyle.*

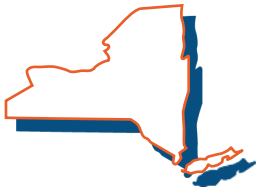
The CCBHC criteria for primary care screening and monitoring call for "promoting a healthy behavior lifestyle." It is essential that CCBHCs screen for modifiable risk factors and unhealthy behaviors that contribute to morbidity and mortality, such as smoking, obesity and sleep disorders, and then offer services that promote wellness and educate clients about health risks.

CCBHCs approach this in diverse and innovative ways, such as incorporating individual wellness goals as part of the treatment plan. They may also offer classes on nutrition or eating healthy on a budget, health coaching, smoking cessation, mindfulness activities, yoga and other wellness-related services. For example, Compass Health has wellness coaches to meet clients' physical goals and needs, specifically helping with prevention outcomes. Wallowa Valley Center for Wellness partnered with its local FQHC to form a limited liability company and fundraise to operate a shared space for cooking classes, walking groups, etc. At Ohel, all CCBHC clients have a health monitoring session with the nurse to assess a range of needs and ensure a whole-person care delivery approach.

Case Studies

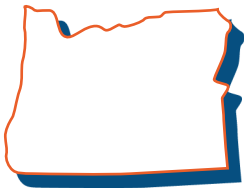
THS interviewed five CCBHCs that have successfully implemented primary care screening and monitoring using different approaches. The case study interview guide included questions about the program model, successes and challenges, lessons learned, outcomes to date and next steps. Clinics were selected based on recommendations from National Council staff and THS, and attention was paid to ensuring geographic diversity. The CCBHCs interviewed were:

Compass Health Network, Missouri



Ohel Children's Home and Family Services, New York

SummitStone Health Partners, Colorado



Wallowa Valley Center for Wellness, Oregon

Zumbro Valley Health Center, Minnesota

Common Themes from Interviews

Successfully implementing the CCBHC model and meeting the requirements related to primary care screening and monitoring involves a multifaceted approach. One of the common themes that emerged across the case studies was the importance of having strong and positive connections within their respective communities as well as with key state and local government agencies. These partnerships require cross-collaboration and robust communication with stakeholders.

Organizations can enhance resource mobilization and integrated service delivery by establishing collaborations with FQHCs and other PCPs. These partnerships, both formal and informal, ensure seamless care coordination and consistent access to health screenings for clients. While some CCBHCs use DCOs, others have created limited legal partnerships to form a new entity (known as limited liability companies, or LLCs), or have coordinated care simply by obtaining signed releases of information.

Sometimes, a business associate agreement (BAA) is necessary. A BAA establishes a legally binding relationship between HIPAA-covered entities and business associates to ensure complete protection of protected health information. These arrangements can facilitate whole-person care, data-sharing practices and improved screening and scheduling processes. For instance, Compass Health gained read-only access to scheduling portals with its partner FQHCs to improve service scheduling efficiency. Using shared EHRs is another effective strategy to enhance communication and streamline client information management across different care providers.

Strategic hiring and deployment of specialized staff is critical for successful implementation. Case study participants emphasized the importance of hiring staff with primary care backgrounds, such as physicians, integrated services directors, nurse practitioners and registered nurses. Expanding roles to include other specialists, such as data analysts, care support workers and wellness coaches, is essential for managing integrated care complexities. Investing in staff training and development also fosters a symbiotic relationship between behavioral health and primary care staff, creating a holistic service delivery ecosystem. Regular training and engagement ensure all team members align with and understand the significance of integrated care objectives.

Furthermore, utilizing evidence-based screening guidelines and creating and tailoring standardized implementation protocols, fidelity measures and other risk stratification tools may also help ensure that the care provided is comprehensive and aligned with best practices. Additionally, collaborating with other local and state-level initiatives and working groups in robust knowledge-sharing helps develop standardized approaches.

Almost all participants reported that implementing CCBHC primary care screening and monitoring services came with certain challenges. Some indicated difficulty navigating coordinating care between behavioral health providers and PCPs, managing external referrals, and ensuring consistent access to screening. To address these challenges, successful programs have employed strategies such as optimizing EHR systems for better tracking of referrals and screenings and developing standardized protocols for care coordination.

One key challenge participants described pertained to data collection, analysis and reporting. While each clinic noted the ongoing development of their own trajectories within this area, almost all described challenges with managing the administrative burden associated with comprehensive reporting, identifying and developing outcomes frameworks, and using data to inform practice improvement and quality assurance internally. Hiring specialized staff such as data analysts may be essential to mitigate some of these challenges and implement robust systems for data collection and reporting. Data analysts should have expertise in data collection, analysis and processing, quality assurance, developing outcomes frameworks, and utilizing data to inform and improve practice improvement efforts.

Additionally, case study participants noted that the additional screenings and data-collection procedures can impact the experience of care for people with behavioral health conditions. A best practice for CCBHCs is to "piggyback" or streamline appointments to help reduce the number of times a client needs to come to the clinic. This can help mitigate barriers such as transportation, childcare or time away from school or work.

The successful implementation of CCBHC primary care screening and monitoring relies on a coordinated approach that leverages community partnerships, specialized staff and advanced data management systems. By addressing challenges proactively and continuously refining processes based on data and feedback, CCBHCs can effectively meet the complex needs of their clients and improve overall health outcomes. The featured case studies not only highlight some of these aforementioned best practices but also specific mitigation strategies that CCBHCs have used to address the challenges.

Compass Health Network

Compass Health Network (CHN) is a nonprofit health care organization that provides a comprehensive range of behavioral health services, as well as primary care and dental health services, throughout Missouri. In 2022, Compass Health Inc. was awarded a SAMHSA CCBHC Improvement and Advancement Grant (CCBHC-IA). The program commenced Sept. 30, 2022, and will conclude Sept. 29, 2026, with Compass Health Inc. being awarded $4 million to be distributed evenly across the four-year term.

Even before receiving the grant, CHN was one of the original eight clinics selected by the state of Missouri for its CCBHC Medicaid Demonstration in 2016 and is now the largest CCBHC in Missouri. The organization serves urban, rural and suburban areas across the state. The primary focus is to increase service accessibility and reach a broader population. This has been achieved through conducting comprehensive community needs assessments to identify and address gaps in care. A critical aspect of its model includes ensuring clients have access to a PCP from the get-go. CHN noted that having a preexisting statewide health home model immensely helped with its transition to a CCBHC.

Historically, CHN operated as a large community mental health center and an FQHC in some, but not all, service areas. In areas where CHN is a CCBHC, internal collaboration and formal partnerships with FQHCs have been essential. The state's encouragement of such partnerships led to their successful implementation.

CHN adopted a population health management approach by using data to pinpoint service gaps and needs, performing thorough screenings, and regularly following up to ensure a seamless pathway to care. It has developed standardized decision-making tools called "care pathways" to enhance efficiency. Ensuring that clients in behavioral health have access to a PCP and dental services is a vital part of its individualized care planning.

CHN believes that establishing care with a PCP at the entry point is crucial, especially since some individuals with behavioral health conditions use urgent care services in lieu of primary care. For this reason, formal partnerships with FQHCs aid in navigating the processes. Through these partnerships, CHN has also facilitated on-demand scheduling processes. As this level of scheduling coordination had previously been challenging, CHN now works either with a liaison or uses read-only access to scheduling portals to coordinate necessary services. On-site lab testing is conducted, and additional bloodwork or testing can be performed during psychiatric appointments. Guidelines for diabetes and hepatitis screenings that are provided by the state-specific medical council and the medical director assist in overcoming challenges and developing best practices.

"We have a statewide behavioral health council that establishes specific guidelines for implementation and best practices. Having these guidelines and the council's leadership has helped us navigate challenges and develop comprehensive, easily replicated best practices over time."

CHN uses data to support and sustain service provision. For example, using claims and historical client data helps identify service gaps during the screening and intake process. With value-based measures, outcome metrics and data dashboards for each program, CHN ensures robust data-informed practices and whole-person health. Additionally, reviewing data monthly, quarterly and annually continues to help address service gaps and overall program trends and performance. CHN reported that its youth hospital follow-up within seven days increased to 89.74%, adult hospital follow-up increased to 82.34%, adherence to antipsychotic meds increased to 67%, youth suicide risk assessment increased to 98.7%, and adult suicide risk assessment increased to 98.9%. CHN also uses two separate EHRs (NextGen for primary care and dental, and Netsmart's MyAvatar for behavioral health) to further streamline service coordination.

Its current staffing structure entails community support workers (CSWs), medical directors, licensed qualified mental health professionals, peer support specialists, and regional nursing directors who manage care coordination and data-informed service facilitation. CSWs play a crucial role in primary care screening and linkage. CSWs are unique to Missouri and function similarly to community health workers. They must have a college education in the human services field and/or equivalent years of work experience in the field. They can assist with ADLs and other areas of healing and treatment, such as linking to additional service appointments and ensuring attendance, as well as ensuring an individual applies for all possible resources to lead an independent life. They typically check in two to three times a week, facilitating access to services. Additional peer support may also complement CSW efforts. CHN also has wellness coaches who address physical goals and needs, particularly aiding prevention efforts.

CHN emphasized that its growth did not stem from mergers or acquisitions but from conducting thorough assessments and understanding community needs (90% organic growth). The organization's strategic focus on identifying gaps in rural areas and creating new access points while expanding hours at existing ones has been integral to developing a robust CCBHC model. CHN highlighted that strong community partnerships and state support remain vital for sustaining these practices.

CHN recommends that grantees not affiliated with FQHCs seek small grants and work with state agencies to secure additional funding for FQHC partnerships. Government agencies, payers and philanthropy may share an interest in fostering these successful partnerships. Most importantly, approaching partnership development through the lens of mental health parity and a whole-person approach, particularly in primary care, has been key to the organization's ongoing success in serving communities.

Wallowa Valley Center for Wellness

Wallowa Valley Center for Wellness (WVCW) is Wallowa County's community-based mental health program, county program for developmental disabilities and a CCBHC. It offers a range of community-based services including mental health, SUD, crisis intervention, early intervention and residential living. WVCW became a CCBHC in April 2017. Through this expansion, it was able to add over a dozen new positions and increase access to services. While it was certified as a CCBHC in the state of Oregon, participating in the Medicaid Demonstration, it also was awarded an expansion grant through SAMHSA in 2021.

WVCW has partnered and is co-located with a local FQHC. It shares an EHR to streamline screening and service coordination. To aid this process, it has established specific BAAs and a memorandum of understanding between the two entities. If a current client does not have an existing PCP, that can be established at the FQHC which only requires a request of information for any SUD services. Currently, 65% of WVCW's clients receive care at the FQHC. For clients who have external PCPs, it uses external messaging platforms and a health information exchange (HIE) called Care Everywhere to collaborate. It leans heavily on the primary care arm to conduct bloodwork, which can also be requested by its psychiatrist if need be. WVCW noted that having an EHR is extremely helpful in having easy access to reliable client-level data.

The staff utilizes a "high-risk registry," a 13-criteria-based tool to aid risk stratification which helps in identifying specific service trajectories and needs for all clients. These categories include:

- Age
- Sex
- Access to PCP
- 90-180-day emergency department (ED) visit history
- Pain reported during ED visit
- Risky substance use
- Other impulsive behaviors
- History of head injury
- A positive response to question 9 in the Patient Health Questionnaire-9 (PHQ-9) (regarding suicidal/homicidal ideation) in the last three months
- High needs in social determinants of health
- History of COVID-19
- Dental concerns
- Any history of losses (parents, loved ones, etc.)

If clients meet 7 of the 13 criteria, they are added to the registry and a flag is added to their chart. This information is reviewed quarterly. While WVCW currently does not have hepatitis screening fully implemented, it relies on its FQHC to do that screening and have systems built in to initiate it. The organization focuses on clients with SUDs and helps educate and connect them to a PCP and continues to implement overdose prevention strategies.

WVCW shared that it continues to refine processes to determine how to best use data for whole-health planning. It has a dedicated staff member who helps review data and facilitates using it to inform treatment planning. All clinicians also have an integrated behavioral wellness goal in their treatment plans. This aids the clinicians in working closely and being in constant communication with the PCP.

The WVCW team noted that hiring support staff, including a medical assistant, was vital to expanding service capacity and aiding clinicians as they continue to do the primary care screening and monitoring work. The medical assistant is tasked with rooming the client and conducting the PHQ-9, collecting vitals and helping identify any other health concerns and gaps that further support prevention strategies.

WVCW recommended that to truly support whole health, optimizing and augmenting other existing resources in the community is crucial. This is exemplified by the aforementioned LLC it created with Winding Waters Clinic, the FQHC it is co-located with, to fundraise and build a space to offer more community-based recreation and wellness services. These include cooking classes and walking groups, along with the primary care, mental health, massage therapy, acupuncture, physical therapy and other services the Winding Waters Clinic provides. WVCW shared that under this LLC, it was able to create a unique partnership with its FQHC to focus on delivering specific community services (not including health-based services) for its clients.

Zumbro Valley Health Center

Zumbro Valley Health Center (ZVHC) is a nonprofit organization serving southeast Minnesota and offers a range of community-based services including mental health, substance use treatment, residential care and mobile crisis stabilization. ZVHC adopted a whole-person approach and is committed to delivering integrated care services to the communities it serves. It is a state-certified CCBHC and participates in the federal Medicaid Demonstration.

ZVHC uses standardized screening protocols starting at intake, and in regular intervals throughout treatment, to identify any gaps in care to determine needed resources and referrals. A comprehensive and integrated treatment plan is developed that gets an initial review and then again every six months to assess if client needs are being adequately met. Data is collected in the EHR (CareLogic) and reviewed in dashboards and reports by the treatment team to provide appropriate intervention and follow-up.

ZVHC has a multidisciplinary staffing structure that provides a holistic health care approach. The staffing structure comprises psychiatric prescribers, an internist, behavioral health clinicians and practitioners, peers, care coordinators, and some specialty roles, such as certified tobacco treatment specialists. Designated care coordinators use a comprehensive report for their caseloads to monitor and provide interventions related to primary care screening, engagement and outreach, hospital and ED utilization, prescriber coordination for medications for opioid use disorder, and other CCBHC measures.

> ***"We have certified tobacco treatment specialists attend departmental meetings to discuss with staff and attend substance use groups to allow clients to blow into the carbon monoxide monitor and offer education/resources at that time."***

Clients at ZVHC are also supported with provided resources and training on specific wellness goals. If clients have external PCPs, the team uses standardized templates to plan and communicate with external providers, specifically to gather information on tobacco screening, BMI, A1C levels, dental care and primary care. When available, ZVHC will access a client's health portal to obtain needed information versus duplicating services. It is currently in the planning phase to create a protocol for hepatitis screening and monitoring and anticipates the phased implementation initiation starting in 2025.

ZVHC also has formal partnerships with two local hospital systems and several rural clinics to facilitate access to primary care for clients who currently do not have PCPs. Staff members consistently engage in the scheduling processes for their clients as well as other levels of care coordination as needed. A challenge working with external providers can often emerge when they do not have HIE or EHR systems established, which makes obtaining some of this information burdensome.

ZVHC shared that transitioning into the CCBHC model came with a few challenges, including acquiring initial support from staff. Engaging with staff on an ongoing basis and facilitating open dialogue through robust training programs on the significance of primary care screenings enabled a smooth transition.

At ZVHC, the staff regularly engages in comprehensive data reporting and continuous quality improvement and is now working on developing an outcome module. The team also noted that through the CCBHC's primary care screening and monitoring work, it successfully closed over 1,000 "preventative screening gaps." Gaps are defined as members eligible for a preventative health screening/appointment based on a defined criteria through the Healthcare Effectiveness Data and Information Set who have not yet completed that visit. ZVHC is provided with a monthly claims-based registry of CCBHC clients to identify those who have a gap. ZVHC has successfully completed 77% adult and 100% child BMI screenings, and 100% tobacco use screenings. Most notably, 75 clients were referred to ZVHC for tobacco use services, with five clients quitting fully and several reporting reduced use in 2023 alone.

"We really start with understanding the right level of care at the right time to meet our clients' needs. We engage in continual assessment and reassessment throughout to make sure that we are meeting our clients' needs. [Training] staff in that ideology and instilling the 'why' in them helps to ensure quality assurance."

ZVHC found that being involved in local and external work groups, collaboratives and associations, such as the Minnesota Association of Community Mental Health Programs, to facilitate knowledge-sharing has been one of the most vital factors for its success. Through these partnerships, it has tailored and customized general CCBHC guidelines to meet its own community and client needs more accurately. Additionally, partnering with dental care service providers and having an on-site pharmacy has significantly helped improve outcomes and meet client needs more seamlessly.

"We had a client come in starting with a BMI of 43 and facing severe challenges, including substance use, an abusive relationship, unemployment and cognitive difficulties. She benefited greatly from our wrap-around support. Our care coordination team helped her secure employment, which provided purpose and led to significant weight loss through increased activity. She also overcame the trauma related to her past abuse, achieved sobriety, underwent bariatric surgery and mended relationships with her daughter and sister. Now financially stable and smoke-free, she no longer needs our services and has reintegrated positive relationships into her life."

SummitStone Health Partners

SummitStone Health Partners has provided comprehensive behavioral health services to a diverse clientele for over 65 years in Larimer County, Colorado. The organization emphasizes a holistic approach to care, aiming to address individual concerns to ensure the best possible treatment for clients. In 2022, SummitStone was awarded a CCBHC Planning, Development and Implementation Grant from SAMHSA. The grant enabled SummitStone to expand its staff and offer more comprehensive services.

CCBHC clients now have expanded access to primary care screening and monitoring, as well as more comprehensive primary care services through SummitStone's team of physician assistants and advanced practice nurses. Medical services are supervised by SummitStone's chief medical officer and associate medical director. In addition, SummitStone has secured the necessary memorandums of understanding, BAAs and qualified service organization agreements with Sunrise Community Health and Salud Family Health Center — both FQHCs — along with UCHealth Family Medicine Center. These ensure that all clients receive expert primary care screening, referral, evidence-based intervention and recommended vaccinations. CCBHC funding has allowed SummitStone to recruit a medical assistant for supporting outpatient primary care screening, and to launch a medical assistant training and apprenticeship program to address workforce shortages and invest in staff development.

SummitStone has expanded on-site services to the Murphy Center for Hope, a community-based organization serving people experiencing housing insecurity, as well as to the Longview Behavioral Health Services campus, which has an acute care facility and behavioral health urgent care. Funding for urgent care and primary care services was secured through both public and private partnerships. The Health District of Northern Larimer County's Community Needs Assessment, combined with Larimer County's Community Health Improvement Plan and SummitStone's Community Needs Assessment, helped demonstrate the behavioral health needs of the community to county voters. This clarity facilitated the funding of the new behavioral health urgent care center, while CCBHC funding has supported the expansion into primary care services. SummitStone coordinated with multiple regulatory agencies, including the Colorado Behavioral Health Administration, Colorado Department of Public Health and Environment, and Colorado Department of Health Care Policy and Financing, to ensure the necessary licensure and credentialing of the new services.

SummitStone noted that it has had a long history of developing collaborative, dynamic partnerships across Larimer County. One challenge it has historically experienced is aligning across systems to meet the ever-changing needs of the community. When collaborating with external partners, SummitStone often had to ensure timelines, resources and plans lined up with said partners for effective execution, which was particularly difficult when coordinating with other large systems. This led the organization to want to develop more of its own care coordination capabilities. SummitStone relies on a team of care coordinators and case managers to help monitor external referrals and ensure that clients are not experiencing any barriers when trying to access services. Partnerships with the community are essential both financially and operationally. Prioritizing community partnerships has strengthened community relationships and continues to foster trust. Additionally, staff flexibility, leadership support and the incorporation of staff input have facilitated a smooth transition into primary care work.

SummitStone acknowledged that having experienced professionals with extensive field knowledge is one of its staffing best practices as these professionals continue to inform the organization's expansion into primary care screening and monitoring. The current team for the CCBHC program includes physician assistants, medical assistants, bilingual and bicultural family peer specialists, case managers, doctors and a nursing director, with the chief medical officer overseeing the planning and execution of services. Involving a chief medical officer with a background in primary care and addiction medicine has been instrumental in identifying staffing needs that lead to hiring highly skilled personnel for the clinics.

To streamline its workflows for diabetes and hepatitis screenings, SummitStone follows guidelines from the American Diabetes Association and the U.S. Preventive Services Task Force, respectively. Providers can order A1C and hepatitis antibody tests, with blood samples drawn at outpatient clinics or bed-based care facilities. In certain cases, labs are managed by the providers, and referrals are made back to primary care for further evaluation and treatment.

The transition to an EHR system (Epic) has significantly enhanced the organization's operations. The online, globally accessible records have improved coordination and communication, making it easier to track screenings and tests. Despite the simplification of screening processes with the new EHR system, ongoing monitoring of external referrals remains challenging. SummitStone is working to optimize processes to improve tracking efficiency within the system. Although staff members successfully report all required data measures in the EHR, they continue to refine processes for data reporting to the state, identifying specific outcomes and using data for internal purposes. A key lesson learned has been the need for comprehensive protocols to determine client entry points, service receipt and treatment flow. As these processes are still relatively new, SummitStone is continuously working to develop and enhance its protocols.

Ohel Children's Home and Family Services

Since 1969, Ohel Children's Home and Family Services of New York has been providing services for mental health counseling and residences, older adult care, residences and programs for individuals with developmental disabilities, foster care placements, trauma and bereavement services, and shelter for victims of domestic violence. In 2023, Ohel was awarded a CCBHC Improvement and Advancement Grant from SAMHSA. Through the CCBHC grant, the organization enhanced and integrated mental health and SUD services as well as primary care screening and monitoring.

Ohel has a memorandum of understanding with an FQHC and community hospitals and monitors all external referrals and follow-ups for its clients. Having a registered nurse for its two CCBHC locations has helped immensely to meet the primary care screening and monitoring requirements. The nurse functions as part of an interdisciplinary team that includes psychiatrists, social workers, peer support staff, therapists and other medical professionals. While primary health screening is conducted by the therapists, with screening results recorded in the EHR, having a registered nurse review and finalize the screening paperwork helps mitigate any gaps in self-reported health information or screening conducted by a therapist. A primary health monitoring professional (a registered nurse) in the clinic facilitates case management for treatment and referrals. The nurse conducts any required bloodwork only at the request of the psychiatrist and may also advise on specific treatment services and referrals as needed. The clients also go through a health monitoring session with the nurse to assess a range of needs and ensure a whole-person care delivery approach. Ohel continuously engages in assessing needs and the influx of people requiring services to determine staffing practices and enhancements.

With leadership from its medical director, the team is developing a standardized decision tree and guidance protocols that will be instrumental in refining workflows and other pathways, specifically related to hepatitis and diabetes screening and monitoring. Utilizing evidence-based practices and strategies has been one of the clinic's core best practices. This includes intensive and frequent training and development opportunities for staff.

Ohel's staff also uses continuous data-reporting mechanisms to ensure that it meets the requirements for reporting on outcomes and quality measures. The team acknowledged that hiring a data analyst has not only solidified the data-reporting mechanisms but has enormously helped in analyzing data for both internal and external use. One way that Ohel uses data is by establishing specific protocols around screening and assessments. For example, scores for the PHQ-9 are reviewed every nine months to see if there is any potential correlation between high scores and any other reported medical conditions.

The team noted that one of its biggest challenges transitioning to the CCBHC model was securing the behavioral health team's support and endorsement. This required a very intentional and strategic communication strategy. Through an interdisciplinary effort and having nurses share real-life success stories of clients who have benefited from a whole-person health model, the Ohel team was able to successfully communicate the significance of and need for an integrated health services approach to the behavioral health team and leadership.

"We had a patient who came to us after he was rejected and dismissed by the emergency department staff multiple times for his complaints about experiencing chest pains. During one of his visits with us, our therapist encouraged him to see the nurse as he reported experiencing the same issue. As the nurse did his assessment, she saw that his vitals looked completely off and sent him to the ER again. At the ER, they were finally able to find out that he was not only having a heart attack but there was also a possibility of a stroke. If not for that nurse and integrated care, we would not have been able to save this person's life. People who have serious mental health conditions often have other untreated and undiagnosed health problems that go dismissed and unchecked for far too long."

Conclusion

CCBHCs increasingly play a vital role in facilitating access to care, improving outcomes for individuals served and addressing emerging community needs. There is ample evidence that people with behavioral health conditions are at increased risk of morbidity and mortality from chronic health conditions. Yet, many lack a PCP or regular source of care. Primary care screening and monitoring services are therefore an essential component of a CCBHC.

The CCBHC Certification Criteria specify what clinics must do regarding primary care screening and monitoring but leave clinics with significant flexibility in meeting these requirements. To successfully implement primary care screening and monitoring requirements, CCBHCs can learn from peers about best practices as well as common challenges and strategies to mitigate them. Important steps include determining the right program model for the community, defining the staffing plan, implementing change management strategies, designing appropriate workflows for clinical services and adopting a population health management approach, coordinating with external PCPs, and promoting client wellness and a healthy lifestyle.

By offering primary care screening and monitoring, CCBHCs help connect individuals with services they otherwise might not access, promote chronic disease self-management and improve overall health and functioning.

About Third Horizon Strategies

Third Horizon Strategies is a boutique advisory firm focused on shaping a future system that actualizes a sustainable culture of health nationwide. The firm offers a 360° view of complex challenges across three horizons — past, present and future — to help industry leaders and policymakers interpret signals and trends; design integrated systems; and enact changes so that all communities, families and individuals can thrive. Learn more at thirdhorizonstrategies.com.

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