



CCBHC Planning Phase Update

Presentation to the Behavioral Health Forum

October 21, 2016



Presentation Overview

- CCBHC Demonstration Application
- Measuring the Impact of the Demonstration
- Evidence-Based Practice Selection
- Peer Services Recommendations
- Public Comment



CCBHC Demonstration Application



Overview of Demo Application

- The CCBHC Demonstration Application is due to SAMHSA by October 31st, 2016.
- The application is composed of 3 parts (100 Points Total):
 1. Part I: Required Attachments
 - A total of 5 attachments, which are not scored.
 2. Part II: Program Narrative
 - 80 points total, no more than 30 pages.
 3. Part III: PPS Methodology Description
 - 20 points total, using a form provided by SAMHSA, with response not to exceed 30 pages.



Overview of Part I

- Part I is composed of 5 required attachments + an additional attachment on evidence-based practices

Attachment	Description
Attachment 1	CCBHC Certification Checklist
Attachment 2	A statement that describes the target Medicaid population(s) to be served under the demonstration program
Attachment 3	A list of participating lead CCBHCs, including DCOs
Attachment 4	A signed statement that verifies that the State has agreed to pay for CCBHC services at the rate established under the PPS
Attachment 5	A description of the scope of services required by the State in compliance with CCBHC criteria, that will be paid for under PPS-1
Attachment 6	Evidence-Based Practices (part of narrative section B)



Overview of Part II

- Part II is composed of 5 narrative sections

Description	Point Value
<u>Section A</u> : Solicitation of input by stakeholders in developing CCBHCs	10 points
<u>Section B</u> : Certification of clinics as CCBHCs	20 points
<u>Section C</u> : Development of enhanced data collection & reporting capacity	10 points
<u>Section D</u> : Participation in the national evaluation	15 points
<u>Section E</u> : Projection of the impact of the state's participation in the Demonstration program	25 points
GRAND TOTAL	80 POINTS



Overview of Part III

- Describe the data sources for cost and visit data.
- Explain how the DY1 rate will be updated to DY2.
- Identify the role of the Quality Bonus Payment (QBP).
 - California is not pursuing QBP.
- Identify whether CCBHC is dually certified as Federally Qualified Health Center (FQHC), clinic, or Indian Health Services (IHS) Facility.
- Certify that uncompensated care costs are excluded from the calculation of the PPS rates.
- Identify whether using CMS cost report or state developed cost report.
- Explain the relationship with managed care entities.
- Describe the Intergovernmental Transfer (IGT) process.



Stakeholder Review of Draft Application

- The draft demonstration application is available for public review and comment from October 19-26, 2016.
- The draft application & public comment form are posted to www.calccbhdemo.org.
- Please use the public comment form to submit comments.
- Send completed public comment forms to info@calccbhdemo.org by 5pm on October 26, 2016.



Measuring the Impact of the Demonstration



Measuring the Impact of the Demonstration

- **One key CCBHC goal:**
 - ↑ access to primary medical services for individuals with mental health conditions who experience high rates of chronic disease and die an average of 25 years earlier than the general population.
- **How to measure?**
 - Screening practices, timeliness of service access and actual Medi-Cal claims for outpatient, ambulatory care/physician services, inpatient services as well as pharmacy and labs.
 - Medi-Cal encounter and claims data in MEDS.
- **Expect ↑ outpatient medical and behavioral health care service utilization.**
- **↓ acute care services (hospital ED visits and inpatient admissions).**
- **Leverage HEDIS measures and other existing data measures collected as part of Medi-Cal managed care contracts.**



Data Sources

- Management Information System / Decision Support System (MIS /DSS) Data Warehouse
 - California Department of Health Care Services Medi-Cal Claims and Encounter Data
 - Includes Medi-Cal Fee-for-Service and Managed Care Capitation
- Medi-Cal Eligibility Data System (MEDS)



Potential Outcome Measures

Claims and Encounter Data Available

- Emergency medical transportation
- ED Utilization rates
- ED Utilization rates – MH and SUD
- Inpatient Utilization rates
- Inpatient Utilization rates – MH & SUD
- Ambulatory Sensitive Condition Admission (1. Grand Mal and other Epileptic Convulsions, 2. COPD, 3. Asthma, 4. Diabetes, 5. Heart failure and Pulmonary Edema, 6. Hypertension, 7. Angina)
- All-cause readmission (# of acute 30-day readmissions for any diagnosis)
- Outpatient office visits (Medical/MH)

State Required Quality Measures

- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Follow-Up After Hospitalization for Mental Illness (adults and child/adolescent)
- Follow-up care for children prescribed ADHD medication



Potential Measures

Health Status

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Comprehensive Diabetes Care (HbA1c level below 7)
- Cholesterol management (LDL-C <100 mg/dL)
- Controlling high blood pressure (<140/90)
- Adult Body Mass Index (BMI) Assessment and Follow-Up
- Weight Assessment and Counseling for Children/Adolescents
- Alcohol Use: Screening and Brief Counseling (SBIRT)
- Initiation and engagement of alcohol and other drug dependence treatment
- Tobacco Use: Screening & Cessation Intervention

MH Status

- Time to Initial Evaluation
- Screening for Clinical Depression and Follow Up Plan (e.g., PHQ-9)
- Comprehensive Diagnostic Assessment Completed
- Treatment Plan Completion rates
- Health Risk Assessment Completion rates
- Suicide Risk Assessment Completion rates (adults/children)
- Depression Remission at Twelve Months



Evidence-Based Practice Selection



CPS Findings: Domains & Items with Potential for Improvement

Domain: Outcomes

- Better able to handle daily life/social situations family life/relationship
- Symptom interference (with life goals)
- Personal goals: housing, employment, education

Domain: Functioning

- Coping Skills
- Relationships

Domain: Social Connectedness

- Crisis supports
- Supportive Relationships (family, friends, etc.)
- Social inclusion

Populations (across above domains and items)

- Age Group: 45-64
- Sex: Other
- Race: Black/African American, Asian, Other



Required EBPs

	EVIDENCE-BASED PRACTICE	OUTCOMES AREAS WHERE EBP HAS DEMONSTRATED EFFECTIVENESS
ALL CLIENTS	Motivational Interviewing (MI)	Health behavior change, decrease in negative health outcomes, increased participation in treatment ¹
	Dialectical Behavioral Therapy (DBT)	Improved relationships, decrease in self-injurious behavior, decrease in depression, anxiety, decreased impulsivity, improved emotional regulation and control ¹
	Cognitive Behavioral Therapy (CBT)	Increased skill set toward goal attainment, access to support groups to sustain skills, increased self-management and emotional regulation, increased daily functional skill, decreased social isolation, increased productive interactions (including with clinic staff) ¹
TAY, ADULT & OLDER ADULT CLIENTS	Strengths Model Case Management	Increased Independent living, increased competitive employment, increased post-secondary education, decreased psychiatric hospitalization, reduced symptoms, increased leisure time, increased community involvement, improved quality of life, reduced family burden
	Illness Management and Recovery (IMR)	Increased self-value, improved relationships, improved health stability, more community involvement
	Wellness Recovery Action Plan (WRAP)	Psychiatric symptoms, Recovery Assessment Scale scores, personal confidence, goal orientation, perceived recovery, hopefulness, self-advocacy, physical health (applied selectively) ²
CHILDR EN/ YOUTH	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Reduced levels of anxiety, increase in positive social interactions, reduced levels of depression, increase in ability to manage daily effects of trauma, stabilization of placement (when applicable), increase in positive social and family support ²

1: All CCBHC Candidates have EBP in use

2: Several CCBHC Candidate have EBP in use



Recommended EBPs

	EVIDENCE-BASED PRACTICE	OUTCOMES AREAS WHERE EBP HAS DEMONSTRATED EFFECTIVENESS
ALL CLIENTS	Pathways to Recovery (PTR)	Improvements in self-esteem, self-efficacy, social support, spiritual well-being, and psychiatric symptoms
	Individual Placement and Support Model of Supported Employment (IPS-SE)	Hours worked per week, jobs acquired, longevity of employment, job satisfaction, self-esteem, hope
	Family Psychosocial Education (FPE)	Reduced relapse rates, improved recovery of patients, improved family wellbeing
	Housing First model of Supported Housing	Maintenance of permanent housing, obtains housing earlier, higher perceived choice, less hospitalizations, decreased homelessness
	Supported Education	Reduced hospitalizations, increased self-esteem, career plan implementation academic and vocational improvements



Peer Services Recommendations



Our Process

1. Identify key stakeholders from CCBHC counties and around California who had been active in promoting and developing peer services;
2. Research and synthesize key resources for stakeholders;
3. Web meeting of stakeholders to review resources;
4. Gather materials from SAMHSA while participants provided additional information (sample job descriptions and contracts, previously proposed scopes of services, etc.);
5. Circulate compiled material to the advisory group;



Our Process

6. Convene second meeting of advisory group to review material;
 - Key input was to follow SAMHSA guidance where available and be clear that "Peer support services encompass adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists."
7. Develop recommendations and survey advisory group for agreement on final guidance
8. Advisory group input used to finalize guidance for the state, including:
 - Proposed definition
 - Core competencies, and
 - Additional proposed guidance related to roles, functions, and duties will be provided to the state.



Proposed Scope

- Peer support services encompass:
 - Adult peer support specialists
 - Transition-age youth peer support specialists
 - Family peer support specialists, and
 - Parent peer support specialists.

From [SAMHSA's CCBHC site for Person- and Family-centered Care and Peer Support](#), with clarifying language added.



Proposed Scope (cont.)

- Peer support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery.
- Peer specialists foster hope and promote a belief in the possibility of recovery.
- Peer support services also include services designed and delivered by family members of those in recovery.
- Family and parent peer support specialists provide services to parents of children experiencing serious emotional distress and family members of adults experiencing mental health challenges.

From [SAMHSA's CCBHC site for Person- and Family-centered Care and Peer Support](#), with clarifying language added.



Proposed Scope (cont.)

- Peer-support services are provided in a variety of settings and across different models of care.
- They may be provided in consumer and peer-run settings, and in agency or facility-based programs.
- Services can be divided into three categories: crisis and respite services; level-of-care transition services; and community-based services, including outreach, engagement, and ongoing recovery supports.
- CCBHCs are encouraged to use peer- and family-support services as broadly and deeply as possible.

From [SAMHSA's CCBHC site for Person- and Family-centered Care and Peer Support](#), with clarifying language added.

10/20/2016



Proposed Definition

- Peer support services encompass adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists.
- The role of the peer support worker has been defined as “offering and receiving help, based on shared responsibility and mutual agreement of what is helpful for individuals with lived experience from a diversity of backgrounds and cultures.”

Adapted from SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services, with clarifying language and input provided by the peer advisory group.

10/20/2016



Proposed Definition (cont.)

- Peer support has been described as “a system of giving and receiving help” based on key principles that include “shared responsibility, and mutual agreement of what is helpful.” (1)
- Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more.
- They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness. (2)

(1) Mead, S., Hilton, D. & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134-141.

(2) Jacobson, N. et.al. (2012). What do peer support workers do? A job description. *BMC Health Services Research*. 12:205



Questions and Public Comment

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Thank you for your participation!

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