

Transformation State Behavioral Health Systems: Findings from States on the Impact of CCBHC Implementation



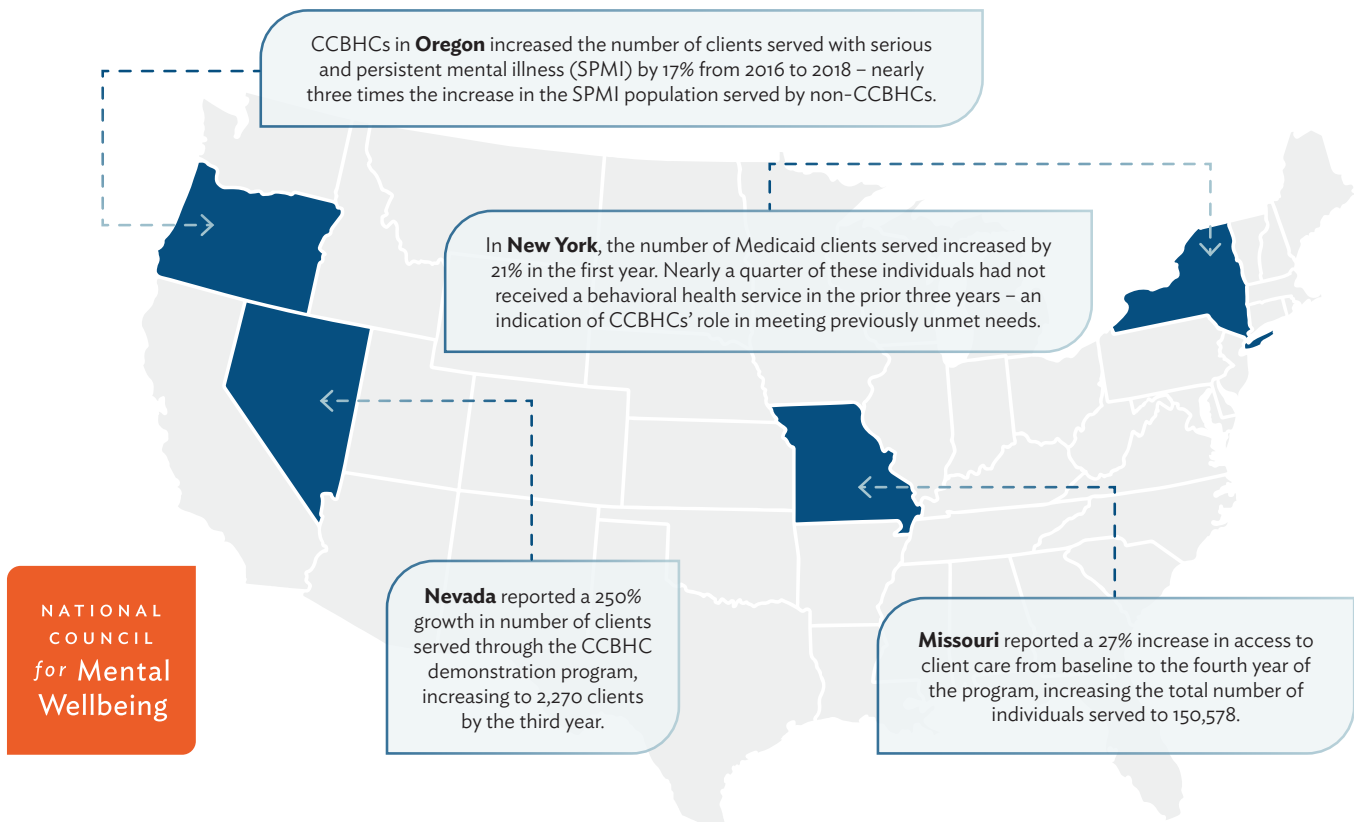
KEY FINDINGS SUMMARY

With the Certified Community Behavioral Health Clinic (CCBHC) demonstration in its fifth year, a growing number of states are exploring implementing the model to address complex challenges, from rising levels of drug overdoses and suicide to longstanding issues with fragmentation of mental health and substance use from primary care systems. Concurrently, Congress is considering bipartisan legislation to further expand the demonstration.¹ As policymakers contemplate expanding the model, what can they learn about its impact in demonstration states to date?

In the summer of 2021, the National Council for Mental Wellbeing conducted surveys and interviews with state CCBHC program directors in each of the eight original demonstration states to explore how states' behavioral health systems have transformed with the advent of the CCBHC model. **This summary document includes key findings and data highlights from the full report, which can be [accessed here](#).** State officials reported that over the full lifespan of the program, the CCBHC model has lowered costs, improved outcomes, contributed to building critical mental health and substance use care system capacity and infrastructure required to meet rising levels of need and integrated services with the rest of the health care system. State officials credit the CCBHC prospective payment system (PPS) as instrumental to the success of their CCBHC programs.

HIGHLIGHTS FROM THE REPORT:

The CCBHC demonstration increased access to mental health and substance use care, largely due to increased availability of same-day appointments, expanded hours of operation facilitated by increased hiring and concerted efforts to conduct outreach to underserved groups.





States reported reductions in emergency department and hospital visits among CCBHC clients, leading to cost offsets.



Oklahoma's three CCBHCs reduced the proportion of their clients seen in emergency departments by 18-47% (rates varied by clinic) and those admitted to inpatient care by 20-69% over the first four years of the program, compared to baseline.



In its first year, **New York** reported a 54% decrease in the number of CCBHC clients using behavioral health inpatient care, which translated to a 27% decrease in associated monthly costs. Similarly, the state reported a 46% decrease in the number of clients using the emergency department, leading to a 26% reduction in monthly costs. New York also saw a 61% decrease in the number of clients using general hospital inpatient services and a 54% decrease in all-cause readmissions.



New Jersey reported a decline in all-cause readmission rates from the first to second demonstration year.



Missouri reported that among clients with a prior emergency department visit engaged in outpatient care at a CCBHC, 76% experienced reduced emergency department visits and hospitalizations. Of those engaged in care who had some type of prior law enforcement involvement, nearly 70% had no further law enforcement involvement at six months.

The CCBHC demonstration helped states mitigate the effects of the mental health and substance use service workforce shortage by enabling clinics to hire and retain vital staff.



Prior research has found that CCBHCs participating in the demonstration program hired an average of 117 new staff positions each, with a median of 43.2. The most added staff include adult and child psychiatrists, licensed clinical social workers, nurses, counselors, case managers and peer specialists/recovery coaches.³ State officials cited expansion of staff as one of the biggest system improvements resulting from the CCBHC demonstration.



In **Nevada**, areas that rarely had access to psychiatrists prior to the demonstration now have an onsite psychiatrist and/or psychiatric advanced practice registered nurse, as well as providers that can offer medication-assisted treatment (MAT) for individuals with certain types of substance use disorders. Nevada referred to CCBHCs' ability to hire additional staff as "one big win for the [CCBHC prospective payment] rate."



Multiple states, including **Minnesota, Missouri, New Jersey, Nevada and Oregon**, reported that the CCBHC program led to a significant expansion of peer workers and family support specialists, individuals with lived experience of mental health or substance use conditions who support coordination and understanding of services for new clients.

Rates of initiation, engagement and follow-up for mental health and substance use care tended to improve under the CCBHC demonstration program, with CCBHCs reporting higher performance than non-CCBHCs on key metrics.



In **New Jersey**, the rate of follow-up after hospitalization for mental illness nearly doubled in the second year of the demonstration. New Jersey also reported that treatment initiation and engagement rates for alcohol and other drug use in adults increased from the first to the second demonstration year. CCBHCs far outperformed statewide averages on these measures.






New York CCBHCs outperformed other provider types in the state on numerous quality measures, including initiation and engagement of alcohol and other drug treatment and seven day follow-up after hospitalization.



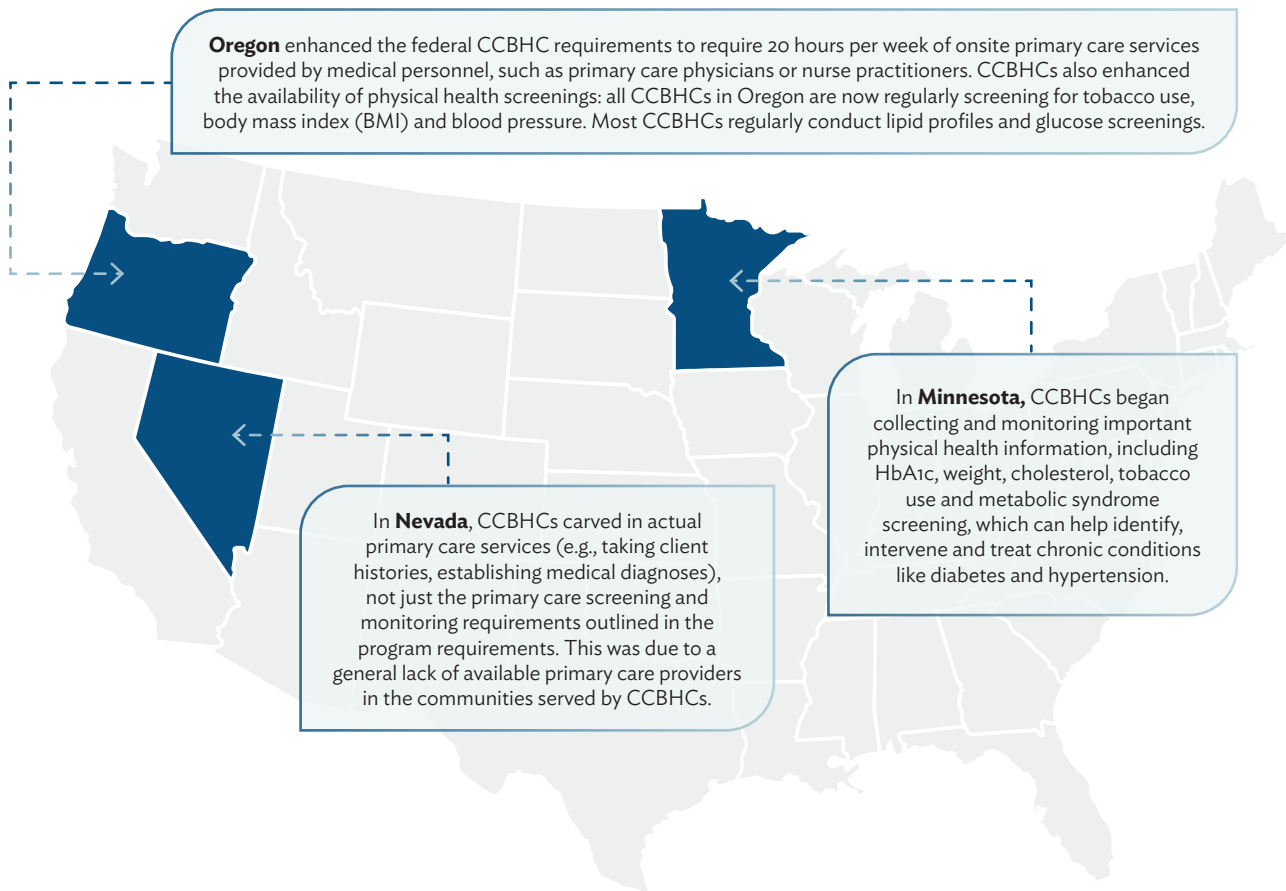
In **Missouri**, by the third demonstration year, CCBHCs had a 75% rate of 30-day post-hospitalization follow-up for adults hospitalized with mental illness, compared to a statewide average of just 33% for Medicaid providers.



The CCBHC demonstration increased access to a comprehensive, evidence-based services to curb the opioid crisis, including MAT.

-  In **New Jersey**, CCBHCs nearly doubled the number of clients receiving MAT from the first to the second demonstration year.
-  **Missouri** reported a 122% increase in MAT from baseline to the third demonstration year, increasing the number individuals receiving MAT from 3,128 at baseline to 6,929 by the third demonstration year.
-  **Oklahoma** had very few individuals receiving MAT prior to the CCBHC demonstration. State officials reported a 700% growth in this service from the year prior to the CCBHC demonstration to the fourth demonstration year.

The CCBHC demonstration resulted in improved integration of physical care with mental health and substance use care, with CCBHC sites in some states exceeding program requirements to offer onsite primary care services.



The CCBHC program contributed to building vital mental health and substance use service capacity and infrastructure required to meet rising levels of need for care while integrating services with the rest of the health care system. Other accomplishments included: increased utilization of evidence-based practices; expanded use of electronic health records (EHRs) and health information exchange; improved capacity to engage in care coordination with health system partners, law enforcement and other public service sectors; and more.