The Role of Certified Community Behavioral Health Clinics in Crisis Services and Systems

NATIONAL COUNCIL for Mental Wellbeing

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Table of Contents

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Glossary of Abbreviations

988 Lifeline	988 Suicide & Crisis Lifeline
ACT	Assertive Community Treatment
ASO	administrative services organization
ATC	Air traffic control
CCBHC	Certified Community Behavioral Health Clinic
CHIP	Children's Health Insurance Program
CIT	Crisis Intervention Team
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CQI	Continuous quality improvement
CSB	Community service board
CSOC	Children's System of Care
CTI	Critical Time Intervention
DCO	Designated Collaborating Organization
DMH	Department of Mental Health
ED	emergency department
EHI	electronic health information
EHR	electronic health record
FCMHC	Four County Mental Health Center
FFS	fee-for-service
FMAP	Federal Medical Assistance Percentages
FTE	full-time equivalent
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
FUH	Follow-up After Hospitalization for Mental Illness
FUM	Follow-up After Emergency Department Visit for Mental Illness
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIE	health information exchange
HIN	health information network
HIPAA	Health Insurance Portability and Accountability Act
HIT	health information technology
IPV	intimate partner violence
IT	information technology
LMHA	local mental health authority
MAT	medication-assisted treatment
MAUD	medication for alcohol use disorder
MBHC	Missouri Behavioral Health Council
MCO	managed care organization
MOU/A	memorandum of understanding/agreement
MOUD	medication for opioid use disorder
NASMHPD	National Association of State Mental Health Program Directors
NSPL	National Suicide Prevention Lifeline
OTP	opioid treatment program
PHI	protected health information
PPS	prospective payment system
PSAP	public safety answer point
S-TAC	State Technical Assistance Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SCS	Special Crisis Services
SED	serious emotional disturbance
SMI	serious mental illness
SPA	state plan amendment
SUD	substance use disorder

Executive summary

BACKGROUND

A nationwide movement is underway to develop comprehensive behavioral health crisis services, reinforced by the launch of the 988 Suicide & Crisis Lifeline in 2022. This coincides with a surge in demand for crisis services due to increased rates of suicide, fatal overdose, depression and anxiety. Amid this landscape, Certified Community Behavioral Health Clinics (CCBHCs) have emerged as a powerful resource for both crisis and ongoing care.

CCBHCs, which began as an eight-state Medicaid Demonstration in 2017, have rapidly expanded. Today, there are over 500 CCBHCs across 48 states and territories, with billions of federal dollars invested. The model is being adopted by more states through Medicaid state plan amendments, offering sustainable funding through a prospective payment system (PPS). The CCBHC PPS provides an opportunity for states and clinics to build and sustain sophisticated crisis systems and partnerships. States engaged in CCBHC implementation can align the model with other initiatives like 988 Lifeline rollout and crisis systems transformation.

This white paper informs CCBHCs, crisis providers, local systems, state authorities and funders about how to maximize CCBHCs' effectiveness in crisis services, with specific sections addressing the unique interests of each group. It focuses on how CCBHCs can meet the Substance Abuse and Mental Health Services Administration (SAMHSA)'s certification requirements for crisis services and how they can provide maximum value to state and local systems responding to the growing demand for comprehensive behavioral health crisis response.

WHAT IS A CCBHC?

The CCBHC model is a pioneering approach to integrated mental health and substance use care delivery. CCBHCs offer a wide scope of services, including crisis care, outpatient mental health and substance use services and care coordination. Key features include:

1. **Broad, integrated services:** CCBHCs provide a comprehensive continuum of mental health and substance use care for adults and children, including access to crucial health and social services.
2. **Enhanced accessibility:** CCBHCs serve all people regardless of diagnosis, insurance status or ability to pay, with 24/7 access to core crisis services.
3. **Quality and accountability:** CCBHCs meet defined certification standards ensuring high-quality, person-centered, evidence-based care that is responsive to client and community needs.
4. **PPS:** For participating states and CCBHCs, the PPS enables sustainable system change and flexible resource allocation to meet individual needs holistically and prevent crises.

A comprehensive behavioral health crisis system is an integrated network of structures, processes and services designed to address a population's urgent and emergent behavioral health needs. CCBHCs play a crucial role in this system, assessing community needs, contributing to planning and actively partnering in local crisis system collaboration and coordination.

Section I: The CCBHC model in relation to crisis systems

CCBHCs can serve a critical role as proactive partners in local crisis system collaboration, planning and coordination. **In terms of direct service delivery and partnership, crisis services must respond to both mental health and substance use emergencies, for all populations (including those with complex needs) throughout the lifecycle, with a continuum of best practices across prevention, response and postcrisis risk reduction**.

SAMHSA CCBHC certification criteria related to crisis services

SAMHSA's CCBHC certification criteria outline specific requirements for crisis services, which can be organized into six major categories:

1. Crisis system needs assessment
2. Crisis system partnerships and collaborations
3. Emergency crisis intervention (*someone to contact*)
4. Mobile crisis intervention (*someone to respond*)
5. Crisis walk-in and stabilization (*a safe place for help*)
6. Crisis system best practices

CCBHCs must provide these services either directly or through partnerships with Designated Collaborating Organizations (DCOs). DCOs are formal partners that can help CCBHCs meet core crisis service requirements, allowing for seamless integration and delivery of services across providers.

CCBHC progression in developing crisis services

The CCBHC model emphasizes the importance of community needs assessment, which informs the development of the service continuum and engages community partners. The progression of CCBHCs in developing crisis services depends largely on available resources and sustainability. CCBHCs can offer a continuum of behavioral health crisis services, including 24/7 call centers, mobile crisis teams, after-hours behavioral health urgent care, crisis centers with 23-hour observation and intensive crisis follow-up services. The extent of service development often correlates with funding sources, with more advanced work typically seen in CCBHCs leveraging PPS funding.

CCBHC contribution to systems planning and coordination

CCBHCs can significantly contribute to crisis system planning and coordination at various levels of implementation. Key areas of contribution include:

1. **Data-driven insights:** Using community needs assessment and other data and clinical expertise to identify gaps in the existing crisis system and guide planning.
2. **Cross-sector collaboration:** Facilitating partnerships with law enforcement, emergency departments (EDs), schools and other community organizations.
3. **Crisis system mapping:** Outlining existing resources, services and pathways available to people in crisis.
4. **Standardized protocols:** Developing consistent guidelines for assessment, intervention and follow-up across the crisis system.
5. **Innovation and best practices:** Serving as hubs for testing and adapting evidence-based practices to local contexts.

The ability of the CCBHC model to offer a wide range of services, collaborate with various stakeholders and contribute to system-wide planning and coordination makes them valuable assets in addressing the growing demand for accessible, high-quality crisis services.

Section II: Meeting basic CCBHC crisis requirements

CCBHCs are required to address essential elements of a comprehensive, community-based crisis response system for all ages, incorporating both mental health and substance use care. The CCBHC model, particularly when supported by the PPS methodology, offers significant opportunities for growing and sustaining comprehensive crisis services. The six key components of this system are:

1. **Leveraging community needs assessment:** CCBHCs must conduct a thorough assessment of their community's crisis system, gathering input from varied stakeholders to inform crisis system planning and identify service gaps. This assessment should highlight populations experiencing health disparities and gather input from people with lived experience, family members and representatives from underserved populations.
2. **Crisis system partnership and collaboration:** CCBHCs play a critical role in interfacing with various entities, including the 988 Lifeline, 911, law enforcement, hospitals, EDs and social services. This collaboration occurs at four levels:
    a. *System collaboration* on overall crisis system development for the community. A CCBHC may act as the prime convener or a key partner with the "accountable entity"(e.g., state, county, region, community services board).
    b. *Population management* through data-driven understanding of utilization, service gaps and response time problems, and continuous quality improvement. CCBHCs can play a crucial role in collecting, organizing and reporting data to other provider partners, facilitating a system-wide perspective on crisis care.
    c. System procedures and mechanisms for individual case-level *care coordination* across multiple system boundaries, sometimes termed "air traffic control" (ATC). This level enables accurate, timely tracking of a person's care utilization, transitions of care and connection to continuing services. CCBHCs can invest in developing systems to ensure that a person's protected health information follows them through the crisis system.
    d. *Program-specific relationships* that occur both within the crisis system (including with first responders) and outside it (with "customer" programs such as outpatient services, residential services, schools and human services agencies). These partnerships focus on client flow processes and establishing the crisis system as a safety net for other types of programs.
3. **Emergency crisis intervention services *(someone to contact):*** CCBHCs must provide or coordinate with telephone, text and chat crisis intervention call centers that meet 988 Lifeline standards. This can be achieved by either directly operating a local or regional crisis call center or contracting with existing crisis hotline services.
4. **Crisis intervention and 24/7 mobile response *(someone to respond)*:** CCBHCs are required to ensure 24/7 availability of community-based behavioral health crisis intervention services using mobile crisis teams. These teams should respond rapidly, arriving in person within one hour (two hours in rural and frontier settings) from dispatch, with a maximum response time of three hours.
5. **Crisis receiving and stabilization services *(a safe place for help):*** CCBHCs must provide crisis receiving/stabilization services, including at minimum urgent care/walk-in mental health and substance use disorder services for people seeking care voluntarily. Options include designating an area within the CCBHC clinic, establishing a dedicated crisis receiving and stabilization center, or contracting with external providers.

6. **A full array of crisis best practices:** CCBHCs should implement a comprehensive set of best practices across their crisis services:

   a. *ATC, crisis coordination and care coordination requirements:* Managing the flow of people through various stages of crisis intervention and coordinating real-time, seamless transitions between different levels of care.

   b. *Welcoming environment and trauma-informed care:* Creating a therapeutic setting that respects dignity and privacy, employing trauma-informed principles to avoid re-traumatization.

   c. *Recovery-oriented peer support:* Integrating peer workers throughout the crisis continuum to enhance engagement, model recovery and provide relatable support. Peers can fill various roles, from crisis line responders to care navigators and support group facilitators.

   d. *Triage:* Quickly and accurately assessing risk to determine the most suitable response for individual needs, including medical and substance use risk assessment.

   e. *Assessment:* Conducting thorough yet focused assessments in crisis settings, addressing immediate needs, risks and co-occurring conditions. This includes assessing for mental health, substance use and cognitive impairments.

   f. *Crisis response:* Implementing strategies for crisis mitigation, prevention and intervention. This includes open access policies, rapid access to medications, individual crisis plans and intensive crisis intervention. Critical Time Intervention (CTI) and other evidence-based protocols may be used for short-term crisis intervention.

   g. *Suicide and overdose prevention:* Implementing formal best practices, including risk screening, prevention strategies and access to overdose reversal medications. CCBHCs should consider adopting systematic approaches like Zero Suicide and provide opioid overdose prevention services.

   h. *Postcrisis follow-up:* Ensuring continued stabilization and smooth transitions to ongoing care, including rapid follow-up (within 24 hours), intensive interventions and care coordination. This may involve using the full CCBHC service array, offering home-based services or implementing evidence-based protocols like CTI.[1]

CCBHCs are encouraged to leverage technology, such as telehealth and virtual crisis care platforms, to extend their reach and provide immediate support. This can include implementing IT-driven crisis hotlines, chatbots, mobile apps and online support groups.

To maximize the effectiveness of their crisis services, CCBHCs should focus on developing strong partnerships with law enforcement, health care providers and human services agencies. This includes cross-training programs, establishing clear protocols for collaboration and developing shared response protocols.

By implementing these comprehensive crisis services, CCBHCs can significantly contribute to creating a more effective, accessible and person-centered crisis response system in their communities. This approach not only addresses immediate crisis needs but also helps prevent future crises and promote long-term recovery and wellness for people with mental health and substance use challenges.

Section III: Emerging metrics of success

CCBHCs are required to report several mandatory quality measures directly related to crisis services, including time to services, follow-up after hospitalization for mental illness, and follow-up after ED visits for mental illness and substance use. Beyond these required measures, CCBHCs and states should consider additional metrics to assess crisis capacities and quality of support.

1 The update of SAMHSA's National Guidelines for Behavioral Health Crisis Care (expected 2025), along with a new set of crisis definitions and standards, is likely to include a more prominent role for postcrisis follow-up as part of crisis receiving and stabilization services (a safe place for help), rather than as a suggested best practice.

The most significant learning curve for new CCBHCs is often in aggregating, understanding and using data effectively. Robust measurement strategies are crucial for continuous quality improvement and managing multiple providers and care transitions in crisis situations.

CCBHCs should focus on using metrics to gain a realistic internal understanding of crisis system performance, manage client care, drive improvement through benchmarking and demonstrate value to external stakeholders. By prioritizing these areas, meeting mandated reporting requirements becomes less challenging.

Section IV: Enhancing beyond basic requirements and establishing mature crisis systems and capacities

While CCBHC Demonstration grants provide an important first step, the availability of a PPS through federal Demonstration or other Medicaid payment authorities allows for long-term sustainability and growth of crisis services.

The PPS enables CCBHCs to:

1. Expand crisis system infrastructure, partnerships, workforce and service capacity.
2. Provide a wider range of crisis services tailored to individual needs.
3. Make significant investments in technology, facilities and other capabilities to enhance accessibility.
4. Develop and retain a specialized crisis workforce through various incentives and training programs.
5. Take on coordinated system oversight responsibilities for their regions.

States have several options for positioning crisis system costs in their PPS rates, including new models (PPS-3 and PPS-4) that allow for separate rates for special crisis services. These new options provide flexibility for states to support the expansion of critical, high-cost services like mobile crisis and on-site crisis stabilization.

CCBHCs can also leverage the PPS to enhance strategic partnerships through DCOs, allowing for comprehensive coverage across the crisis continuum while enabling each partner to focus on their strengths.

Section V: Using the CCBHC model to support statewide crisis services implementation

Moving from crisis services implementation to crisis system development and leadership

Using the CCBHC model to support statewide crisis services implementation stakeholders to work together towards creating a seamless continuum of care to effectively meet the needs of those served. Key steps for states include:

1. Conducting a thorough needs assessment to identify gaps in the current crisis services system.
2. Engaging CCBHCs in systems-level planning and design processes.
3. Clearly defining roles and expectations for CCBHCs and other crisis service providers.
4. Identifying specific requirements and expectations for CCBHCs in supporting identified gaps.

CCBHCs can take on different roles depending on the state's mental health authority structure. In states with designated Community Mental Health Centers (CMHCs) or local mental health authorities (LMHAs),

CCBHCs could become the lead agency for local crisis planning and coordination. In systems where there are regional entities (e.g., community service board [CSB] systems) or counties serving as accountable entities, CCBHCs can partner with them to help develop collaboration and coordination among all crisis stakeholders. In large urban regions, CCBHCs can work with regional leaders to facilitate formation of crisis collaborations in their local communities.

Opportunity to build infrastructure and fund population health management and prevention programs

The PPS methodology can be used to fund critical infrastructure needs and enhance population health management capabilities. Key points include:

1. Investing in health information technology and data systems to support effective population health management.
2. Expanding prevention and early intervention services.
3. Supporting workforce development and training programs.
4. Establishing continuous quality improvement and evaluation processes.

The PPS model provides financial stability for these investments, allowing CCBHCs to enhance their capacity for data collection, analysis and sharing. This enables them to identify health trends, risk factors and service gaps within their populations, facilitating targeted interventions and care coordination across providers.

Section VI: Next steps toward statewide systems

This section outlines key steps for implementing CCBHCs in statewide crisis systems, drawing on lessons learned from previous sections. It emphasizes the importance of developing a state vision for crisis system development and the role of CCBHCs within it, particularly when supported by the PPS.

For states:

1. To realize the full value of CCBHCs, states need to plan for statewide coverage across each geographic CCBHC coverage area and a PPS with appropriate quality metrics for crisis, and to maximize opportunities for sustainability through incorporating nonbillable costs (like ATC) into the PPS.
2. Designate a leadership team to define the state's vision for its crisis system and CCBHCs' role, with consideration of the state's unique administrative and financing structures.
3. Conduct a comprehensive gap analysis to identify current services, capabilities and areas for improvement.
4. Review current state expenditures on crisis services for the Medicaid population to identify potential opportunities for leveraging additional federal matching funds through CCBHCs.
5. Consider how to incentivize providers to become CCBHCs and provide ongoing support, including training and technical assistance.
6. Tailor certification and cost report approval processes to address system gaps and meet SAMHSA requirements. States can add specific certification standards to manage the CCBHC provider panel effectively.
7. Plan for statewide CCBHC coverage, considering population needs, provider capacity and geographical distribution.
8. For states with existing crisis systems, explore integrating CCBHCs through DCO agreements initially, with the option to transition services directly to CCBHCs later.

For counties and regional entities:

1. Collaborate with state leaders to facilitate CCBHC implementation at the local level, addressing administrative complexities.
2. Partner with the state to identify and support potential CCBHCs in their areas.
3. Engage with existing CCBHC grantees to integrate them into local crisis continuums and connect them with existing crisis services.

For CCBHC grantees:

1. Partner effectively with state and local entities to demonstrate value in the crisis system.
2. Collaborate with other CCBHCs to approach state leaders as unified partners in working toward long-term goals.
3. Engage with existing CCBHC grantees to integrate them into local crisis continuums and identify potential value of the PPS to support costs within the county/regional crisis continuum.

For crisis system providers and partners:

1. Develop partnerships with CCBHCs, including DCO relationships when feasible, to enhance data sharing and potentially access additional funding.
2. Help state and local entities understand the value CCBHCs bring to the overall crisis system, including improved access and expanded services.
3. View CCBHCs as beneficial to both individual services and the community, avoiding a sense of competition.

Collaboration and strategic planning are critical to maximize the long-term potential of CCBHCs with PPS funding to enhance and sustain comprehensive crisis services across states. A statewide network of CCBHCs contributing to crisis services ultimately leads to improved and expanded services for more people in need.

Background

There is a powerful movement under way to develop — for the first time — nationwide access to effective and comprehensive behavioral health crisis services. The Roadmap to the Ideal Crisis System (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021) articulated this vision: "An excellent behavioral health crisis system is an essential community service, just like police, fire and EMS. Every community should expect a highly effective behavioral health crisis response system to meet the needs of its population, just as it expects for other essential community services."

The nationwide launch of the 988 Suicide & Crisis Lifeline in 2022 has reinforced the promise of prompt connection to help for those experiencing behavioral health crisis, and has further increased visible need in every community for a comprehensive array of affordable, high-quality crisis services — such as mobile crisis, urgent care, crisis centers with 23-hour observation and residential crisis services — and for prompt access to appropriately intensive ongoing services after the initial crisis.

At the same time, demand for behavioral health crisis services is surging. Epidemic-level increases in rates of suicide and accidental overdose deaths, combined with increased rates of depression and anxiety following the COVID-19 pandemic, have overwhelmed the already limited response capabilities of our behavioral health care delivery system.

In a rare opportune moment, this emerging vision of crisis services, the advent of the 988 Lifeline, and the urgent and escalating demand have coincided with the arrival and rapid dissemination of a powerful behavioral health care delivery resource for both crisis and ongoing care: Certified Community Behavioral Health Clinics (CCBHCs). The extent of rapid growth of CCBHCs will be described below, followed by a more detailed description of the CCBHC model and why it offers so much value to the field.

This white paper provides information to help multiple audiences maximize the effectiveness of CCBHCs as key contributors to achieving the vision of universal access to effective behavioral health crisis services. It provides guidance to CCBHCs, other crisis providers, local systems responsible for crisis services, state behavioral health authorities and behavioral health funders about: 1) how CCBHCs can best meet the challenge of providing the array of crisis services required by the Substance Abuse and Mental Health Services Administration (SAMHSA) to achieve CCBHC certification, and 2) how CCBHCs can be best positioned — and funded over time — to provide maximum value to state and local systems attempting to respond to expanding demand for a full continuum of behavioral health crisis response.

NATIONAL DISSEMINATION OF CCBHCS

CCBHCs must meet rigorous criteria for providing a comprehensive range of high-quality, safety net services for mental health and substance use crises and continuing care, to support their communities and community crisis systems. The CCBHC model began as an eight-state Medicaid Demonstration in 2017, with 66 participating clinics that met the model's rigorous standards to qualify for a prospective payment system (PPS) that supported their anticipated costs of expanding services and reaching new populations. Based on the early successes of the Demonstration, Congress has acted multiple times to extend and expand the program. Most recently, through the Bipartisan Safer Communities Act, lawmakers authorized a nationwide expansion of the Demonstration to roll out over the next 10 years. Meanwhile, several states have also established CCBHCs within their state Medicaid programs outside the Demonstration.

Today, across 12 states, there are 190 state-certified CCBHCs receiving PPS rates or a comparable designated payment model (National Council for Mental Wellbeing, n.d.-b). Another 10 states were selected to join the Demonstration in July 2024 and will be launching their Demonstration efforts, with an anticipated total of 89 additional CCBHCs by July 1, 2025, while others are moving forward with plans to adopt the model via a Medicaid state plan amendment (SPA).

Since 2018, individual clinics have also taken on the work of meeting the CCBHC standards through the SAMHSA-administered CCBHC Expansion grant program. Although CCBHC grants are capped and time-limited, and grantees do not receive PPS funding (unless participating in their state's CCBHC Medicaid Demonstration or a state CCBHC program under Medicaid that provides a prospective or bundled payment separate from the Medicaid Demonstration), these grants offer a powerful opportunity to support clinics in developing and delivering a wide range of innovative services and capabilities. Grantees are expected to use their grants to meet the rigorous CCBHC service requirements (including for crisis services), enhance their services and supports beyond the criteria, provide uncompensated care, implement quality improvement/data reporting requirements and transform their organizations to better meet the needs of the people and communities they serve.

Taken together, there are now more than 500 CCBHCs across state certification and grantees, in 48 states and territories, with billions of federal dollars invested over the lifetime of the Demonstration and grant program. As the CCBHC model takes root, an increasing number of states have permanently established the CCBHC certification criteria and the PPS in their state Medicaid plans, with others actively planning to do so. Sustainable, ongoing access to PPS funding can significantly enhance CCBHCs' capacity and their impact both on behavioral health crisis systems and community behavioral health systems generally. One of the goals of this paper is to illustrate the differentiators and impact that the CCBHC model can have in aligning with crisis systems and transforming crisis care, particularly with sustainable funding through the PPS, and considerations for states in how they could leverage this model to enhance their own crisis system.

STATE-LEVEL CRISIS SYSTEMS ENHANCEMENT

The CCBHC PPS offers an opportunity for CCBHCs to be adequately and appropriately resourced to build out sophisticated crisis systems or crisis continuum partnerships. Because the CCBHC PPS is calculated using a formula that accounts for the anticipated cost of meeting program requirements — including costs associated with expanding and retaining a workforce, initiating or strengthening community partnerships, expanding care coordination functions and launching new service lines — CCBHCs that participate in their state's Medicaid Demonstration typically have a more robust financial foundation for engaging in these activities than their grantee peers, whose funding is more circumscribed and time-limited. Further, states that are actively engaged in leading CCBHC implementation through the Demonstration or a SPA can consciously and thoughtfully align the model with other state initiatives such as 988 Lifeline rollout and/or crisis systems transformation, engage localities to develop coordinated crisis response systems, and implement statewide standards, metrics, technology and more.

States are at many stages of development regarding their CCBHC and crisis systems initiatives. Some states may already have a robust continuum of crisis services and a strong CCBHC presence in crisis networks. Some may still be mapping out how CCBHCs and crisis systems should work together for maximum impact, while still others are learning about the CCBHC model and may be looking toward future implementation. These efforts are taking place in an environment where states have many intermediary systems responsible for crisis services development in their areas, including counties, community service boards and regions. These local systems vary widely in their level of awareness of CCBHCs' potential value and how to work with states to maximize the CCBHC PPS for investment in crisis services at all levels. Conversely, states may not know how best to partner with their local intermediaries to identify the best role for CCBHCs within their emerging crisis systems. This white paper provides support to current and potential participants in statewide expansion of CCBHCs with access to the PPS:

CCBHCs are serving an estimated **3 million people nationwide**. CCBHC status enables clinics on average to serve more people per clinic than prior to implementing the model, particularly among Medicaid CCBHCs, which reported a 33% increase in number of people served in 2024.

(National Council, 2024a)

- CCBHC grantees seeking initial CCBHC certification that need technical assistance on how to meet requirements related to crisis services.
- CCBHCs at all levels of development that wish to maximize the model's capabilities beyond basic certification requirements, to develop comprehensive and innovative crisis services
- Crisis providers (e.g., 988 Lifeline call centers, first responders, EDs, hospitals, mobile teams, residential crisis programs) that wish to understand (and potentially champion) the role of CCBHCs — especially with the PPS — as valuable partners in enhancing the capabilities of their crisis system continuum
- Federal, tribal, state, county, regional and community behavioral health system leaders that need technical assistance on how to work with and assist CCBHCs to address unmet needs, by facilitating development of a truly integrated, data-driven, person-centered and trauma-informed community crisis system.

In short, this resource provides support for multiple stakeholders to build and reinforce comprehensive, person-centered, and trauma-informed crisis services.

"It is of the utmost importance that leaders, whether state, county, or regional, governmental or provider system based, understand the advantages of the CCBHC model. This will be crucial in change management and to inform and motivate systems to look to the future and lean into innovation. The [ability of the] partnership between government agencies, advocacy groups and providers to understand both the challenges and advantages cannot be overstated. The model has the ability to create a paradigm shift in behavioral health, whereby parity, growth and creativity is limited only by our ability to leverage the model and work in partnership. Change can be difficult and at times creates fear. Knowledge and leadership are needed to dispel fears, misunderstandings [and] myths, and to drive change. Fortunately resources exist, which can educate leaders across all sectors, ensuring states and providers can be secure in their understanding of the model."

— National Association of State Mental Health Program Directors (NASMHPD)

What Is a CCBHC?

The CCBHC model is a pioneering approach to community-based, integrated and sustainably financed mental health and substance use care delivery, alleviating decades-old challenges that have led to a national crisis in access to care. The model is unique for its wide scope of integrated and coordinated care, accessibility mandates, collaborative partnerships, rigorous quality standards and the potential for states to provide access to the PPS methodology. CCBHCs — especially those certified and receiving PPS funding and working in coordination with their state — can dramatically increase access to care, expand their state's capacity to address the overdose crisis, reduce mental health-related hospitalizations, help address the workforce shortage and create innovative partnerships with law enforcement, schools, hospitals and community-based and peer-led organizations to improve care. Research shows that the CCBHC model has resulted in substantial expansions in staff, services, partnerships and clients served (National Council, 2024a).

SAMHSA's CCBHC criteria (2023c) encompass six program requirements, addressing staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority and governance.

Broad, integrated services

CCBHCs deliver a robust continuum of mental health and substance use outpatient and community services for both adults and children. Required offerings include:

- Screening, diagnosis and risk assessment
- Crisis services
- Outpatient mental health and substance use services
- Outpatient primary care screening and monitoring
- Person- and family-centered treatment planning
- Targeted case management
- Peer, family support and counselor services
- Psychiatric rehabilitation
- Services for veterans, members of the armed forces and their families

Many CCBHCs also provide and coordinate access to crucial related services like primary care and health-related social needs such as transportation, education, vocational assistance, housing supports and legal support. This integrated, whole-person approach aims to address the full spectrum of client needs and, when informed by the required community needs assessment, is delivered in a manner responsive to local community needs.

Enhanced accessibility

CCBHCs are mandated to serve any person who presents for care, regardless of their diagnosis, insurance status or ability to pay. Core crisis services such as 24/7 call lines, mobile crisis response and walk-in urgent care must be accessible around the clock. Guaranteed access to comprehensive coordinated care regardless of ability to pay or place of residence is especially important in a crisis context; unlike other providers, a CCBHC must provide follow-up care immediately after a crisis without waitlisting or refusing to serve people based on insurance coverage.

Quality and accountability

By meeting a defined set of certification standards, CCBHCs ensure delivery of high-quality, evidence-based care. Standards include domains of staff competencies, use of clinical decision support tools, integrated person-centered care planning, quality assurance practices, governance and accountability procedures, inclusion of people with lived and living experience in quality assurance and governance, responsiveness to local community needs and client and family member experience engagement. Ongoing fidelity to standards is evaluated through regular auditing.

The prospective payment system

For CCBHCs participating in the Medicaid Demonstration or another state program that provides a cost-based prospective or bundled payment under Medicaid, the PPS is central to enabling sustainable system change and ongoing support for the CCBHC model. In contrast to traditional fee-for-service models that reimburse per appointment or procedure, states can develop a cost-based Medicaid payment system in which CCBHCs receive set recurring payments that account for the costs associated with each enrolled client. Unlike grant funding, access to the PPS provides CCBHCs (and their state and local systems) with budget predictability while offering the flexibility to allocate resources toward activities and investments that meet client needs holistically and can improve outcomes while proactively preventing crises. Further, the PPS facilitates capacity growth and innovation to achieve elevated standards of access, breadth of services, quality and integration.

How to Use This Document

New CCBHCs

New or developing CCBHCs (particularly grantees) seeking to meet the criteria through attestation or certification are encouraged to use this document to understand the basic requirements and possible models to provide quality crisis services, even if the PPS is not yet available. This white paper will help developing CCBHCs identify and prioritize steps for crisis needs assessment, prioritization and planning for crisis services, partnership development, service development, workforce capacity building, technology innovation, quality and compliance. Focus on the following sections:

- **Basic CCBHC crisis requirements:** *Section II* will guide developing CCBHCs in establishing foundational crisis system partnerships and services to meet the minimum CCBHC criteria. Topics include assessing needs; developing agreements (including as Designated Collaborating Organizations [DCOs]) with key entities like 988 Lifeline call centers, public safety first responders and hospitals; establishing internal urgent care capabilities; and coordinating transitions. *Section III* describes considerations for incorporating quality measures and data use.
- **PPS rates:** While most new CCBHCs will not yet be covered under a state PPS, *Section IV* can help you understand how the PPS works, including cost considerations, and champion adoption of a PPS in your state to support your crisis service delivery.
- **Statewide approaches:** *Section V* offers suggestions to review your state's current crisis system resources and regulations and identify what partnerships and services you must implement to comply with state expectations and meet your communities' needs. Use *Section VI* to support planning for partnership with state and local entities and collaboration with other CCBHCs toward a long-term, unified vision.

Implementing the CCBHC model is a significant undertaking, but you need to start somewhere — so start with what you have and grow piecemeal over time. Don't let perfect be the enemy of good.

Developed CCBHCs looking to develop further

For CCBHCs that have already established initial crisis system partnerships and services and met criteria for certification as a CCBHC, focus on these sections:

- **Enhancing services beyond basic criteria:** *Section IV* provides considerations for applying the proficiency developed through meeting baseline standards to enhance collaborations that improve a community's crisis system, as well as identifying and implementing additional evidence-based and practice-based crisis interventions, technologies, specialty services and coordinating structures and further improving access to quality care — all reflecting the unique needs of the specific communities served — working with crisis system partners to fill gaps in the community crisis system.
- **PPS rates:** For CCBHCs funded through a PPS, *Section V* reviews the potential for leveraging flexible PPS reimbursement to expand crisis system capabilities and partnership capacities.
- **Statewide approaches:** *Sections V* and *VI* describe how experienced CCBHCs — with or without a PPS — can engage more substantively in collaboration with state, county and local government authorities on state and local (catchment area, county, regional) planning and development of crisis systems and support enhancements, including articulating the value of initiating or expanding statewide access to PPS funding.

Use this document to determine next steps to build on your existing crisis system foundation. Continue to assess community needs to guide selection of service and infrastructure enhancements feasible with your resources.

Crisis service systems entities

For leaders of crisis call centers, mobile crisis services, crisis stabilization facilities, EDs and other entities that serve people in crisis, focus on these sections:

- **Basic CCBHC crisis criteria:** *Section II* will aid in understanding the baseline capabilities CCBHCs are required to develop related to crisis services and potential partnership roles.
- **Enhancing services beyond basic criteria:** *Section IV* reviews models of deeper collaboration, innovative interventions, technology integration and specialty program development through which you may be able to partner with local CCBHCs — including as DCOs — to mutually enhance crisis systems.
- **PPS rates:** *Section IV* describes how a PPS allows CCBHCs access to additional resources (both direct service and infrastructure) that can directly and indirectly strengthen the crisis system, including through contracting with DCO partners.
- **Statewide approaches:** *Sections V* and *VI* offer insights into how CCBHCs and crisis system entities can collaborate with state, county and local government authorities, managed care organizations and other partners on implementing a statewide crisis system, supported by access to PPS funding strategies.

Use this document to identify partnership opportunities with CCBHCs to improve coordination, expand resources and better meet community crisis needs, as well as to help understand the value of PPS implementation at the state level.

State authorities, regional entities, and state/local governments

For state, regional, county and local government, accountable entities and policy leaders developing state and local crisis system infrastructure and regulations, focus on these sections:

- **Statewide approaches:** Section V describes strategies for working in partnership with regional and county partners (including managed care organizations, if present) to leverage CCBHCs to expand and standardize crisis system capabilities, improve consistency, promote coordination across entities and address gaps. Section VI provides succinct suggestions on next steps toward developing effective statewide crisis response systems.
- **PPS rates:** Section IV offers considerations for opportunities to adopt PPS models that will provide CCBHCs with flexibility, sustainability and the ability to invest in targeted statewide crisis priorities.
- **Enhancing services beyond basic criteria:** Review Section II to identify ways to collaborate with CCBHCs on piloting innovations in crisis technology, data infrastructure, specialty services and integrative models that can be scaled statewide.

Use this document to help design a business case for statewide implementation of CCBHC PPS funding, as well as to develop policies, funding collaborations and other crisis system improvement initiatives that harness the reach of CCBHCs to improve access to high-quality behavioral health crisis response statewide.

Section I: The CCBHC Model in Relation to Crisis Systems

A behavioral health crisis system is more than a single crisis program; it is an organized, integrated and collaboratively managed set of structures, processes and services that are in place to meet a population's urgent and emergent behavioral health crisis needs, as soon as possible and for as long as necessary (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021). CCBHCs are expected to include an assessment of the behavioral health crisis system in their community needs assessment to garner input from community stakeholders, inform crisis system planning and serve a critical role — and be proactive partners — in local crisis system collaboration, planning and coordination.

What may be new for many CCBHCs is that the CCBHC criteria not only specify that CCBHCs work with partners to develop a system that provides a full continuum of crisis services: They also require that all crisis services be designed to respond to both mental health and/or substance use disorder (SUD) crises and to populations of all ages, including children, youth and older adults, and people with or at risk for mental health and/or substance use challenges. Note therefore that wherever Crisis Services are referenced herein, they refer to mental health and SUD crises and populations of all ages, as well as the need to respond to complex populations of all kinds (including unhoused, medically involved, those with intellectual and developmental disabilities or brain injury, and justice system involved) that may be co-occurring with mental health and SUD challenges.

Effective partnerships in the design and development of local crisis systems are facilitated when there is clear accountability and responsibility in each designated region of the state in which the CCBHCs are operating, and a designated role for CCBHCs in those regions. In some states (e.g., Texas, Missouri and Oklahoma), the designated "accountable entity"[2] is the CCBHC itself. In many other states, the accountable entities may be county behavioral health departments, community service boards (CSBs) or other local, regional or state entities. In those instances, the CCBHC can be positioned (ideally with support of state leadership) to partner with those entities to develop the best crisis system for that community. In this way, their contributions can best work with state and local partners to enhance the overall effectiveness, accessibility and responsiveness of the crisis system, leading to improved outcomes for people in need of mental health and substance use crisis services.

Further, the intended contribution of CCBHCs to the community behavioral health crisis system goes beyond the impact of providing the specific crisis services. CCBHCs are designed to incorporate a continuum of best practices throughout *all* their services, which can have a significant impact on the response to emerging crisis situations (as defined by the people experiencing them or other concerned people) quickly and effectively, thereby stabilizing the crises or preventing these crises from becoming more severe, as well as facilitating ongoing "postcrisis" connection to best practice interventions for continued engagement and risk reduction. These best practices — which include welcoming open access and triage services, person-centered and trauma-informed care, suicide screening and suicide prevention, overdose prevention, peer recovery support services, crisis planning, care coordination and postcrisis follow-up services — are described in more detail along with the specific crisis service requirements in **Section II** of this paper.

2 The concept of an accountable entity is a structure that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures. For more, refer to **Roadmap to the Ideal Crisis System** (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021).

SAMHSA CCBHC CERTIFICATION CRITERIA RELATED TO CRISIS SERVICES

The **SAMHSA CCBHC Certification Criteria (revised March 2023) (SAMHSA, 2023c)** include guidance on crisis service provision throughout, as well as at least 18 criteria directly related to crisis services (compiled in **Appendix 1**), largely described in the two major crisis service criteria sections: Criteria 2.C (24/7 Access to Crisis Management Services) and Criteria 4.C (Crisis Behavioral Health Services).

It is helpful to organize these expectations into six major categories: crisis needs assessment, crisis system partnerships and collaborations, crisis system best practices (including open access and postcrisis follow-up), and the three core crisis services requirements that must be met directly or via a DCO partnership to meet criteria requirements[3] — emergency crisis intervention services, 24-hour mobile crisis teams and crisis receiving/stabilization.

Figure 1. Six planning and implementation categorical functions of crisis services, including SAMHSA's three elements of the crisis continuum (*)

1. **Crisis system needs assessment (criteria 4.C)**

2. **Crisis system partnerships and collaborations (criteria 2.c.4, 2.c.5, 4.C)**

3. **Emergency crisis intervention (*someone to contact*) (criteria 4.C)**
   - Provision of or coordination with the local 988 Suicide & Crisis Lifeline call center

4. **Mobile crisis intervention (*someone to respond*) (criteria 4.C)**
   - Rapid response anywhere within the service area for adults, children, youth and families

5. **Crisis walk-in and stabilization (*a safe place for help*) (criteria 4.C)**
   - At minimum, urgent care/walk-in mental health and SUD services for people seeking care voluntarily

6. **Crisis system best practices (including postcrisis follow-up and air traffic control) (criteria 2.c.2, 2.c.3, 2.c.6, 4.C)**

3 SAMHSA Criteria 4.C: Crisis Behavioral Health Services

In addition to these crisis services and other requirements, there are crisis requirements for:

- Training staff at orientation and annually on risk assessment, suicide and overdose prevention and response and the roles of family and peer staff. Trainings may be provided online (1.c.1).
- Risk-screening people at initial intake to identify any need for crisis services, and taking immediate action if needed (criterion 2.b.1).
- Providing immediate crisis response to a person already receiving services in a CCBHC, if necessary (2.b.3).
- Ensuring that no person is denied crisis management services because of place of residence. Anyone should receive, at a minimum, crisis response, evaluation and stabilization services in the CCBHC service area regardless of place of residence (2.e.1).
- A crisis plan and education for each person receiving services (2.C and 3.a.4).
- Care coordination arrangements with other crisis providers (2.C and 3.C).
- Documentation requirements for screening assessment and diagnosis that are also applicable to crisis services (4.D).
- A continuous quality improvement (CQI) plan, which addresses how the CCBHC will review known significant events, including at a minimum: 1) deaths by suicide or suicide attempts of people receiving services, 2) fatal and nonfatal overdoses, 3) all-cause mortality among people receiving CCBHC services 4) 30-day hospital readmissions for psychiatric or substance use reasons, and 5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan (5.b.2).

CCBHC PROGRESSION IN DEVELOPING CRISIS SERVICES

CCBHCs are not required to offer the full continuum of crisis services directly. By also contracting with many behavioral health crisis services throughout the crisis continuum — including 24/7 call centers, mobile crisis teams, after-hours behavioral health urgent care, crisis stabilization centers with 23-hour observation and care,[4] and intensive crisis follow-up services — all tailored to community needs, CCBHCs can help the community crisis system meet fundamental requirements for access to someone to contact, someone to respond and a safe place for help during crisis.

Comprehensive service array

CCBHCs may offer their required crisis services directly or by contracting with a DCO. DCO relationships are more than simple collaborations or contracts; they incorporate specific requirements for the DCO to meet certain performance standards and share information with the CCBHC, making the DCO's services function as an extension of the CCBHC's own service continuum. When CCBHCs perform the crisis system needs assessment described herein, part of that assessment will be to determine which of the required crisis services are best performed by the CCBHC directly and which may benefit from DCO relationships with other service providers (e.g., public safety first responders, hospitals, residential crisis providers, residential SUD services). For more detail about how CCBHCs can use DCO relationships to expand their own capacity to deliver required crisis services, Using Designated Collaborating Organizations to meet CCBHC Crisis Services Requirements on page 26.

4 Note that crisis centers with 23-hour observation are not a requirement of CCBHC certification.

Resources and sustainability

Resources for crisis system development (both infrastructure and services) often rely on multiple sources, including federal, state and local (regional, county, city, tribal, etc.) funding. The extent of this investment can vary considerably by state and community. In this context, CCBHC grant funds may be critical, not only by establishing compliance with the CCBHC criteria per se, but also by enhancing crisis systems by enabling creative solutions such as sharing staff and infrastructure, especially in under-resourced and rural regions. PPS funding ensures sustainability and broader flexibility to both expand services and strengthen local crisis system infrastructure. Accordingly, more advanced crisis systems typically are seen in those states and communities that can leverage PPS funding. Attaining all levels of service provision requires funding and financial sustainability; a CCBHC's ability to reach the most advanced and innovative stages of crisis delivery — and to contribute most effectively to their local crisis system — will be directly influenced by these factors.

The National Associaltion of Counties (NACo)County Funding Opportunities to Support **Community Members Experiencing a Behavioral Health Crisis** charts five types of funding sources for local crisis care: federal, state, federal/state and county governments, and nongovernment sectors. These sources may provide direct (as with CCBHC grant funds) or pass-through funding, such as the minimum 5% set-aside of SAMHSA Mental Health Block Grant funds for evidence-based crisis systems.

The subsequent sections of this paper will describe considerations, recommendations and opportunities across multiple stages of crisis services development through which CCBHCs may progress during their implementation, including achieving basic compliance, building CCBHC infrastructure and positioning to expand services and capacity with PPS funding.

USING DESIGNATED COLLABORATING ORGANIZATIONS TO MEET CCBHC CRISIS SERVICES REQUIREMENTS

What is a Designated Collaborating Organization?

A Designated Collaborating Organization (DCO) is an outside nonprofit, for-profit or governmental entity that formally partners with a CCBHC to provide some or all required crisis services on the CCBHC's behalf.[5] Contracted DCO partnerships can help to meet core crisis service requirements, seamlessly integrating and delivering services across providers. Further, criteria refer to use of a state-sanctioned crisis provider as a DCO for crisis services, thereby supporting established systems/services. Services provided by DCOs must conform to the applicable CCBHC criteria.

Using partners to deliver crisis services through DCO arrangements, and building crisis services that directly benefit the operations of other providers in your community, builds a broad and sustainable constituency advocating for your community crisis system and your CCBHC's role in it.

Common examples of DCOs

- Local or regional crisis call centers responding to 988/911 and operating 24/7 crisis hotlines
- Mobile crisis teams
- Crisis stabilization facilities

Why partner with DCOs?

There are several key benefits for CCBHCs collaborating with DCOs for crisis services:

- Allows resource-strapped CCBHCs to comply with 24/7 service requirements that would be unrealistic or too costly to provide independently.
- Leverages existing specialized providers already equipped for effective crisis response.
- Making specialized crisis services available for specific subpopulations, such as children or non-English-speaking populations
- Avoids duplicative services and infrastructure in the same region and competition for scarce workforce resources.
- Provides crisis access for clients when the CCBHC has limited capacity.
- Strengthens alliances and increases mutual support with other community providers.

Effective DCO partnerships

To ensure successful outcomes, both the CCBHC and DCO need to have a detailed understanding of one another's organizational structure, staffing, costs, incentives, constraints and overall business model, as well as the CCBHC certification and reporting requirements. With thoughtful development and management, CCBHC partnerships with skilled DCOs can be instrumental to expanding crisis system capacity, increasing access and providing specialized crisis services (including to populations with unique or higher intensity needs) outside the CCBHC's usual range of capabilities.

5 While SAMHSA requirements at 4.a.1 state that the CCBHC must deliver directly the majority (51% or more) of encounters across the required services, this stipulation does not apply to crisis services (SAMHSA, 2023c).

CCBHC CONTRIBUTION TO SYSTEMS PLANNING AND COORDINATION

At all stages of implementation, CCBHCs can contribute to and take a leadership role in crisis system planning and coordination for the community, either directly or with state, regional, county and community partners. CCBHC criteria emphasize that the CCBHC must perform a community needs assessment at least every three years, to inform development of its service continuum and engage in well-developed collaborations with community partners to plan and deliver a comprehensive safety net continuum of care across services and populations. Those enhancing implementation beyond standard criteria — typically with the support of PPS funding — may achieve deeper advancements in systems coordination locally and beyond. CCBHCs' ability to do this is developed over time and impacted by funding availability and sustainability.

"Philadelphia often experiences problems with flow through its crisis system. Specifically, boarding in crisis response centers and emergency departments remains a problem. Although this problem has multifactorial origins, one reason is because there are inefficiencies in the care transition pathways. Another reason is because there are inadequate stepdown/subacute options. CCBHCs can support those transitions, particularly for their designated populations."

— Philadelphia Department of Behavioral Health and Intellectual Disability Services

EXAMPLES OF OPPORTUNITIES FOR CCBHCS TO CONTRIBUTE TO AND TAKE A LEADERSHIP ROLE IN CRISIS SYSTEM PLANNING, DIRECTLY OR WITH PARTNERS	
Data-driven insights	CCBHCs can leverage their access to data and clinical expertise to identify gaps in the existing crisis system. By analyzing community needs assessment findings, trends, service utilization patterns and outcomes, CCBHCs can guide system planning to address specific needs. For instance, if data reveals a spike in crisis calls among a certain demographic group, the CCBHC can propose targeted interventions and resources to better serve that population.
Cross-sector collaboration	CCBHCs have the unique ability to collaborate with various stakeholders, including law enforcement, emergency departments, schools, social service agencies and community organizations. They can convene multidisciplinary meetings, workgroups or task forces to foster dialogue and collaboration.
Crisis system mapping	CCBHCs can contribute to crisis system planning by mapping out the existing resources, services and pathways available to people in crisis. A crisis system map may outline the various entry points, routes and options, highlighting where integration and coordination can be enhanced to reduce bottlenecks.
Standardized protocols	CCBHCs can take a leadership role in developing standardized protocols and procedures for crisis response. By establishing clear guidelines for assessment, intervention and follow-up, CCBHCs ensure consistency and quality across the crisis system.
Innovation and best practices	CCBHCs often have the flexibility to pilot new approaches and interventions within the crisis system. They can serve as innovation hubs, testing evidence-based practices and adapting them to local contexts.

"Four Country Mental Health Center Inc. (FCMHC) is a CCBHC serving five counties in southeast Kansas, primarily rural and frontier communities. FCMHC received a SAMHSA CCBHC Expansion grant in May 2020. At that time, FCMHC was the only Kansas grantee and there was no state infrastructure to support the CCBHC model of care. Crisis services were identified as a priority early in the development and planning process, largely due to enduring challenges with admissions into the Kansas state mental health hospital system, which had initiated an admissions moratorium in 2014. The data derived from the community needs assessment indicated several target areas, including substance use disorder/detox services, justice-involved populations, and enhanced supports for individuals admitted to emergency room. Due to funding and staffing limitations, FCMHC began addressing the crisis continuum by developing programs that were more likely to reduce and/or prevent utilization of emergency services. These programs include Assertive Community Treatment, co-responder, correctional transition programs and specialized veterans services. Key partners are local law enforcement agencies, emergency facilities, homeless shelters, veterans services and Federally Qualified Health Centers in the region. These services were added to the previously existing array of crisis continuum services, including crisis screening, assessment, stabilization beds and mobile crisis response services. Kansas passed CCBHC legislation in 2021, and FCMHC is now a fully certified CCBHC."

— Four County Mental Health Center, Inc.

Expert insights: The importance and opportunity of marketing and communications

- CCBHCs need to engage in a substantive public relations campaign — consider the ongoing awareness efforts for the 988 Lifeline — toward destigmatization of mental health supports. Awareness-raising is missing at the local, state and national level. CCBHCs must make sure people understand who CCBHCs are, what they do and why, and how it all fits together.
- Stigma is still very real. Marketing can help to build trust in a community (e.g., by reinforcing that CCBHCs are not a law enforcement response). The unique needs of rural communities benefit from additional focus on stigma reduction.
- View connections between the CCBHC team and other parts of the system as a version of marketing.
- Use the community needs assessment to build relationships, soliciting input from traditional and nontraditional community and social service programs and from underserved communities, and responsively express CCBHC value to stakeholders.
- Include support for marketing and communications in your budget (e.g., working with an outside PR firm, outreach staff positions, dedicated staff face time with stakeholders).
- Training and technical assistance around communications is available to states via the **SAMHSA CCBHC State Technical Assistance Center (CCBHC S-TAC)**.
- CCBHC Expansion grant recipients can also request individual technical assistance from the **CCBHC Grantee National Training and Technical Assistance Center** on a variety of topics including marketing and communications.

Section II: Meeting Basic CCBHC Crisis Requirements

CCBHCs must address essential elements of a CCBHC community-based crisis response system, that apply to all ages and should incorporate mental health and substance use concerns (see Figure 1):

1. **Leveraging community needs assessment to inform crisis services and partnerships**
2. **Crisis system partnership and collaboration**
3. **Emergency crisis intervention services (*someone to contact*)**
4. **Crisis intervention and 24/7 mobile response (*someone to respond*)**
5. **Walk-in urgent care and crisis centers with observation (*a safe place for help*)**
6. **A full array of crisis best practices:**
    - a. Air traffic control, crisis coordination and care coordination requirements
    - b. Welcoming and trauma-informed care
    - c. Recovery-oriented peer support
    - d. Triage
    - e. Assessment
    - f. Crisis response: Intervention and prevention
    - g. Suicide and overdose prevention and medication
    - h. Postcrisis follow-Up

1. LEVERAGING COMMUNITY NEEDS ASSESSMENT TO INFORM CRISIS SERVICES AND PARTNERSHIPS

The National Council's **CCBHC Community Needs Assessment Toolkit** is a resource for CCBHC organizations, including SAMHSA CCBHC Expansion grantees, completing the required community needs assessment in preparation for implementation (National Council, 2024b). It highlights practical frameworks, resources and tools that organizations can use to plan and execute a high-quality needs assessment in their local communities.

A community needs assessment uses data and varied stakeholder input to identify system strengths and service gaps, inform action planning and allocate resources appropriately to serve the needs of those who reside in the service area, across the lifespan. This critical CCBHC requirement offers insight prior to and throughout planning and implementation (at minimum every three years), informing staffing, language and culture, accessibility, outreach, partnerships, services and more. While not explicitly stated as a requirement, a crisis services needs assessment should be integrated, as relevant, into the required community needs assessment. As with a comprehensive needs assessment, one focused on crisis systems should highlight populations experiencing health disparities in the geographic area served; it must gather input from people with lived experience and family members, as well representatives from underserved populations or those facing disparities.

KEY DATA POINTS FOR A CRISIS SYSTEM NEEDS ASSESSMENT	
Current service array	What services are currently being offered and by whom? Where are the gaps? How does service volume compare to recommendations of the **Crisis Resource Need Calculator**? To what extent are people with behavioral health crises encountering the criminal justice system or medical emergency departments (EDs) rather than being served in settings specifically designed for behavioral health crisis response?
Types of services and programs to assess	Includes 988 Lifeline, mobile crisis, urgent care, 23-hour or longer observation and crisis stabilization services, inpatient psychiatric or SUD treatment, crisis follow-up, transportation. Assessment may be guided by CCBHC criteria, national crisis guidelines for adults (SAMHSA, 2020) and youth (SAMHSA, 2022) or a combination suited to the community served.
Population-specific needs	What services are available and appropriate across the lifecycle, and for populations experiencing health disparities or with linguistic needs? Gather published local data and conduct interviews and/or focus groups to gather qualitative data from varied stakeholders representing children, youth, transition age, adults, older adults, lived experience with mental health and substance use challenges, linguistic needs and gaps, and racial nondiscrimination. Consider performing person-centered mapping exercises to explore how clients would experience engagement with the current system.
Systems considerations	Note current hours of availability, scale of services, system collaborations already in place, and current roles of law enforcement and the ED.
Assessing crisis system metrics	What metrics are used to assess the performance of the entire crisis system, as well as the performance of each individual service process or component? Does measurement take client perspective into account? Refer to the **report on Quality Measurement in Crisis Services** (National Council, n.d.-c) for more guidance.

"CarePlus New Jersey recently assessed the needs of neighboring counties through analyzing data from the electronic health record (demographics, service requests, etc.), as well as reviewing current interest from stakeholders and reviewing published county data. The assessment concluded that there was a great need to expand all nine core CCBHC services in neighboring counties, including entering into school contracts and developing mental health programming at the public school districts, as well as developing a workflow to complement existing services. Currently, CarePlus NJ is designing a workflow to include all local resources to address 988 [Lifeline] calls, with the goal of coordinating between CCBHCs within the same catchment.

— CarePlus New Jersey Inc.

"Our needs assessment is a vital step in identifying gaps in services in each market. A thorough assessment of considerations such as availability of mobile technology... allows us to see what's missing so that we can adjust and respond accordingly. This targeted approach ensures the replicated services are relevant, effective and responsive to the [varied] needs of each community we serve."

— GRAND Mental Health

2. CRISIS SYSTEM PARTNERSHIP AND COLLABORATION

For CCBHCs, partnership and collaboration with crisis systems and the entities that interact within them is multifaceted and dependent upon context and available resources. It can be helpful to approach this complex theme by compartmentalizing four levels of collaboration that contribute to effective crisis response practices.

FOUR LEVELS OF COLLABORATION FOR EFFECTIVE CRISIS RESPONSE		
Level 1	***System collaboration***	Overall crisis system collaboration for the whole community. The CCBHC may act as the prime convener or a key partner with the "accountable entity" for crisis system development (e.g., state, county, community services board). A detailed exploration of this level of collaboration is available in **Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response** (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021).
Level 2	***Population management system***	Includes aggregated utilization monitoring, data for evaluation and CQI that involve identifying risk system issues that require improvement. This is more data driven and detailed than the first level and may be conducted by a subcommittee of the larger collaboration.
Level 3	***Care coordination system***	System procedures and mechanisms for individual case-level care coordination across multiple system boundaries, sometimes termed air traffic control (ATC). For example, this level of collaboration enables accurate, timely tracking of a person's use of care (e.g., hospitalization), transitions of care and connection to continuing services.
Level 4	***Program-specific relationships***	These relationships can occur within the crisis system, through crisis services themselves as well as with first responders. These relationships also should occur outside the crisis system, in how crisis programs partner with "customer" programs such as outpatient services, residential services, schools and human services agencies. The partnerships within crisis services refer to client flow processes rather than care coordination per se, except to the degree to which care coordination is part of the crisis intervention process itself. Many of these types of relationships relate to specific care processes and policies regarding program access and transition planning (movement of clients into and out of each crisis service). The outside partnerships are established so that the crisis system provides a safety net for other types of programs, making it easy for these programs to ask for help when they have a client who is losing control.

LEVEL 1: SYSTEM COLLABORATION

CCBHCs as proactive partners in crisis system planning and coordination

Needs assessment and resource mapping data should guide decision-making about implementation, including how to address service gaps via collaboration. CCBHCs play a critical role in interfacing with various entities, including the 988 Lifeline, 911 public safety answering points (PSAPs), law enforcement, hospitals and EDs, to ensure coordinated and effective crisis response using appropriate data and effective implementation strategies. CCBHCs should consider which services should be provided directly to meet requirements, and conversely which services should be delivered by partners. Within those shared or contracted service agreements, determine what staffing models, referral channels and data collection workflows will best serve the partnership. Cooperative agreements between CCBHCs and partners will be unique to the context, needs, resources and players involved in planning and implementation.

Comprehensive development and implementation of crisis systems and services is an iterative learning process with trial, error and lessons on the ground, requiring trust, cooperation and flexibility among partners in order to deliver and enhance solutions. Formalizing partnership expectations — beyond service provision, including communication, decision-making and shared goals — is critical to develop, manage, evaluate and enhance effective partnerships.

The National Council's **CCBHC Contracting and Partnerships Toolkit for CCBHC Expansion Grantees** provides an overview of the types of community partnerships required under the CCBHC model (DCO and care coordination) and resources to help clinics establish or strengthen these relationships, including interpretation of CCBHC requirements as it pertains to these partnership types, sample agreements and checklists for partnering. This resource reflects the CCBHC criteria released in March 2023 (SAMHSA, 2023c).

"Alluma takes a community crisis response approach to mobile crisis services. Due to our large rural geography, it takes multiple entities to respond to people experiencing a mental health crisis in a timely way. Community is defined by a county in which we serve (currently six counties in our CCBHC service area). In each county, we partner with our county human services, sheriff's department, local city police departments, public health, homeless shelters, primary care clinics, schools, universities, local emergency departments and hospitals.

"We have spent dedicated time to develop joint interagency workflows to address our desired future state: Our crisis system intervenes in the least restrictive way possible to provide the service that best meets the needs of the person in crisis."

— Alluma

LEVEL 2: POPULATION MANAGEMENT SYSTEM

Crisis systems always involve multiple service providers, each of which has its own internal utilization and performance data that it uses to manage its crisis services. Since people in crisis routinely flow through different service providers in a crisis system, those providers must use the system collaboration framework established at Level I for effective management of the whole system. The framework supports the ability to develop and agree upon shared, standard ongoing utilization and performance measures to gain a data-driven understanding of service gaps and response time problems. CCBHCs can play a critical role by providing staffing to receive, organize and report the data to other provider partners.

Some common measures could include monthly utilization rates, referral sources, response time to initial referral, array of services used, outgoing referrals, time to response to outgoing referral, distribution of utilization across time of day and geographic distribution, and demographics of people receiving crisis care. Specific but deidentified performance measures, such as crisis service readmission rates and distribution of high utilizers by type of crisis service used within the individual providers, can also be useful. It can be particularly helpful for the system to track when pertinent personal health information is included in a crisis transition of care between providers, which is a measure of the functional outcome desired from a collaborative MOU. This aggregated data may be reported retrospectively on a monthly or quarterly basis for effective quality monitoring and improvement.

EXAMPLES OF POPULATION MANAGEMENT BEST PRACTICES	
Data analytics and predictive modeling	Information technology (IT) tools can analyze data to identify patterns and predict potential crisis situations. By monitoring trends and risk factors, CCBHCs can proactively allocate resources and design interventions to prevent crises from escalating.
Data sharing and interoperability	Collaborate with other crisis system partners, such as law enforcement, EDs and primary care providers, to ensure seamless data sharing and interoperability. This facilitates coordinated care and prevents information gaps.

"CCBHCs in Missouri, in partnership with the state's Department of Health and Senior Services and Missouri Medicaid agencies, collectively formed a statewide population management system. By jointly purchasing the population health management platform (CareManager) and funding a data team with subscription payments from participating CCBHCs, the system provides uniform data at a lower cost. The system has proven invaluable for crisis services planning, performance reporting and collaboration, with benefit to the full range of CCBHC services. At least two other states are undertaking similar arrangements for providing a statewide population health management and crisis services data system via cooperative CCBHC action."

– Former Director, MO HealthNet (Missouri Medicaid)

LEVEL 3: INDIVIDUAL CARE COORDINATION SYSTEM

Opportunities and best practices for information sharing within confidentiality requirements to support crisis services

This level of care uses a care management platform (also referred to as an **ATC platform**) to track the location, progress and needs of individual clients and share the clinically necessary subset of their protected health information (PHI) while moving through a crisis system. This allows for real-time management and, through IT automation, can significantly reduce the individual agency burden of the aggregate reporting described at Level 2. Interoperability also significantly reduces staff time needed to transmit client-specific medically necessary information during transitions of care. Effective sharing of information requires that system partners work together to align and optimize their policies and consents for sharing PHI. Fortunately, both HIPAA and 42 CFR Part 2 allow sharing PHI without individual consent in emergency situations. In addition, crisis provider agencies can align on including a consent to share information in crisis situations, as part of their consent to treatment. CCBHCs can play an important role by providing staffing for the collaborative efforts needed to align policies and procedures for information sharing, and they can potentially provide the population health management platform or substantial support consistent with the portion of their population using the platform.

Care coordination/management platforms

CCBHC care management platforms, often integrated into electronic health record (EHR) systems, can assist in streamlining and enhancing care coordination. These platforms centralize information, facilitate communication and track clients' progress.

EXAMPLES OF CARE MANAGEMENT PLATFORMS AND PRACTICES	
EHR	EHR systems allow for seamless sharing of critical information among care providers. This enhances continuity of care as people transition from crisis intervention to ongoing treatment, ensuring that no crucial details are lost during handoffs.
EHR integration	Care management platforms within EHR systems allow CCBHCs to document assessments, crisis plans, psychiatric advance directives, referrals and progress notes in a centralized and easily accessible format. Care coordination tracking across multiple EHRs can either be done by interoperability interfaces between all the participating EHRs or through a single shared, external care management platform.
Communication tools	Crisis care management platforms enable secure communication between care team members, ensuring that everyone involved in a person's care is informed and can collaborate effectively.
Appointment scheduling	People can schedule appointments, receive reminders and access their treatment plans through online portals, improving engagement and adherence to care plans. Shared scheduling functionality (through a care management platform or freestanding app) can allow multiple partners in a crisis system to schedule appointments 24/7 without needing to contact staff or log in to a different EHR.

Confidentiality and information sharing best practices

CCBHCs have many opportunities and best practices available for effective information sharing while adhering to confidentiality requirements, which is crucial to support comprehensive crisis services. Absent more stringent local regulation, the three current federal confidentiality requirements (**HIPAA, 42 CFR Part 2, ONC/CMS** Interoperability) not only currently allow but actually require sharing of health care information (except for SUD treatment) between providers, even without client consent (Public Health Service, Department of Health and Human Services [HHS], 2017; The Office of the National Coordinator for Health Information Technology, n.d.; Centers for Medicare and Medicaid Services [CMS], n.d.). Despite additional restrictions on the sharing of SUD treatment records, recent modifications to 42 CFR Part 2 have further aligned HIPAA and Part 2 (HHS, 2024a; HHS, 2024b).

Overall, health care providers, including crisis services and SUD treatment providers, must exchange information upon a treating provider request or for making a referral, even in the absence of client consent, unless they have it documented in their treatment record that the client has requested that information not be shared, in which case they still may share the information. It is important to consider the benefits and risks of information sharing to the current crisis and future treatment episodes, holding client safety as a priority. They must share information even absent consent if there is a bona fide clinical emergency, including one in which the client's prior written consent cannot be obtained.

See Appendix 2 for more information on confidentiality requirements related to crisis services.

EXAMPLES OF INFORMATION SHARING BEST PRACTICES	
Interagency collaboration	Collaborate with other crisis system partners, such as law enforcement, EDs and primary care providers, to establish protocols for secure information sharing. This ensures that all relevant parties have a complete picture of a client's situation.
EHRs	Use EHR systems to centralize and securely store clients' health information. EHRs facilitate seamless sharing of critical data among authorized care providers, ensuring continuity of care during crisis interventions and follow-up.
Consent-based sharing	Seek explicit consent from people to share their information with specific care providers involved in their crisis response. Consent-based sharing maintains clients' autonomy while enabling relevant stakeholders to collaborate effectively.
Secure and HIPAA-compliant platforms	Prioritize the use of IT platforms that adhere to privacy regulations, ensuring the confidentiality and security of clients' sensitive information. Consider universal consent across the local or state service sector.

"Provider organizations who provide crisis services could have financial support and a formal agreement to have frequent triage meetings. At least one community in Maine that has a CCBHC grant has a daily huddle that involves the ED, mobile crisis, inpatient unit and crisis residential program to work on rapid placement and identifying appropriate level-of-care changes (e.g., stepping down from the inpatient bed of one organization to the crisis residential bed of another organization). This same community also reviews the list of individuals who are waiting for their first appointments as a group of community provider organizations, provides outreach via peers and works together to ensure the individual has been routed to the community agency/service that will best meet their needs. This function could be particularly helpful for individuals who have been seen by crisis services and may need support with engagement, particularly while CCBHCs work toward rapid access to services, which is not yet a reality for many."

— National Association of State Mental Health Program Directors (NASMHPD)

"Many individuals with significant behavioral health needs, especially adults with serious mental illness (SMI) and youth with serious emotional disturbance (SED), will be served by CCBHC crisis services. With appropriate agreements in place, developing notification mechanisms so managed care organizations (MCOs) are immediately alerted to members who receive crisis services (crisis calls, mobile crisis response and other crisis stabilization services) will allow MCOs to initiate immediate care coordination mechanisms to which these members are entitled, to wrap around them and potentially stave off further escalation and further utilization of crisis services if not necessary. Finally, improved and swift access to services required by CCBHC standards will allow individuals improved access to service initiation post discharge from high levels of care, which will improve HEDIS [Healthcare Effectiveness Data and Information Set] measures."

— Carelon Behavioral Health

LEVEL 4: PROGRAM-SPECIFIC RELATIONSHIPS

Recommendations for interfacing with various community partners

Entities indicated in this section do not represent a comprehensive list of all community partners; additional potential partners and further details are integrated across subsequent sections within CCBHC service areas.

Law enforcement

In many areas across the country, law enforcement serves as first responders to those experiencing a behavioral health crisis, increasing risk of incarceration and death for people in crisis, particularly for people of color (Balfour & Zeller, 2023). Rapid community-based crisis response can intervene to connect people in crisis to services they need, diverting vulnerable people from criminal justice involvement. Developing strong working relationships and protocols for collaboration with law enforcement is essential for CCBHCs.

BEST PRACTICES FOR INTERACTIONS WITH LAW ENFORCEMENT	
Cross-training programs	CCBHCs should participate in cross-training with local law enforcement to improve officers' understanding of mental illnesses, de-escalation techniques and appropriate responses to behavioral health crises. This enhances law enforcement's ability to safely interact with people in crisis. **Crisis Intervention Team** (CIT) training, training around screening laws and locally specific information bring law enforcement together with behavioral health providers.
CIT	CCBHCs can collaborate with law enforcement agencies to establish CITs. They provide specialized training to law enforcement officers on de-escalation techniques, mental health awareness and appropriate crisis responses.
Co-responder programs	CCBHCs can partner with law enforcement to embed mental health professionals within police departments. These co-responders accompany officers during crisis calls, providing expertise and support in managing mental health crises.
Shared response protocols	Clear protocols outlining criteria for when police should contact CCBHC crisis teams for joint response, when to bring a person to a clinic for assessment, or when police should handle a call alone improve coordination and have potential to divert people experiencing crisis from jail or EDs.
Information sharing	Enabling timely two-way communication of alerts and clinically relevant information between CCBHCs and law enforcement, within privacy regulations, helps ensure all responders have adequate situational awareness.
Partnerships in the justice system	CCBHCs should seek opportunities to partner with law enforcement and courts to provide crisis intervention training, assist with diversion programs or offer treatment services as an alternative to incarceration.
Coordination at discharge/reentry supports	CCBHCs can help to ensure continuity of care for people reentering the community after a period of incarceration, via care coordination with community supervision. Formalized partnership between CCBHCs and criminal justice enables staff, including peer support workers, to address the needs of inmates prior to and at time of release, as well as those on probation or parole.

CCBHC funding can help provide technology for law enforcement and more

"CCBHC funding is built as a cost reimbursement model based on achieving defined outcomes. Through our GRAND model, we were able to demonstrate that iPads provided to police and first responders greatly reduced the number of mental health crisis visits to emergency rooms and inpatient hospitalizations. We were also able to show significant savings in law enforcement transport time, resulting in saved dollars for county taxpayers. Given these defined outcomes, we are able to add technology expenses to the CCBHC cost reporting."

— GRAND Mental Health

An example of local innovations in partnership with criminal justice agencies

"Among the most important partnerships CCBHCs have established are those with courts, law enforcement officers, jails and other justice-related facilities. CCBHCs and their criminal justice partners are working to divert individuals from arrest to treatment, provide support to incarcerated people upon re-entry and support emergency crisis response.

"BestSelf (provides counseling and education services in the Niagara County jail, along with MAT (medication-assisted treatment for addictions). This CCBHC also operates a mobile unit staffed by a counselor, a peer support specialist, and access to a doctor and nurse via telemedicine. The mobile unit meets inmates upon their release from incarceration and can transport individuals with opioid addiction to their first medication-assisted treatment appointment. The county's jail administrator stated, 'Now, because of our collaboration with BestSelf, we have seen reductions in recidivism among Erie County residents who were incarcerated here in Niagara County.'"

— BestSelf Behavioral Health

Primary care/hospitals/emergency departments

Hospital EDs will always have a role to play in even the best developed crisis systems. Often, ED teams lack the capacity to most appropriately support people in behavioral health crisis (Balfour & Zeller, 2023), making partnership with community-based organizations such as CCBHCs a critical component for an effective system (Schall et al., 2020). CCBHCs can assist by reducing hospital/ED utilization, helping them improve the quality of their services and helping to reduce the duration of time people in behavioral health crisis spend in EDs.

BEST PRACTICES FOR INTERACTIONS WITH PRIMARY CARE/HOSPITALS/EDS	
Shared care plans	CCBHCs can share care plans and relevant information with hospital and ED staff, ensuring that clients receive consistent care and interventions during their crisis episode and beyond. It is critical to ensure that care plans have a crisis prevention component that addresses many of the preventive steps and aftercare plans needed.
Diversion from EDs	CCBHC-related crisis care capacity can provide alternatives to EDs or other intensive interventions. Examples include on-site medical screening and triage, on-site or easily accessible laboratory and POC testing, on-site pharmacy or provision of medications, and physical infrastructure of the facility to provide for extended evaluation and treatment, stabilize intoxication and monitor and/or support the management of withdrawal.
Support to service in ED	CCBHCs can directly support crisis services in EDs by providing a staff liaison or peer support specialist to the hospital (preferably in person) who is dedicated to providing both diversion from and support of smooth transitions between the two entities, and/or by providing mobile crisis response.
Collaborative discharge planning	CCBHCs can collaborate with hospitals and EDs to ensure a smooth transition for people discharged after a crisis intervention. They can provide comprehensive discharge plans, referrals and follow-up care to ensure that people continue to receive necessary support.

Human services

CCBHCs interface with various human services sectors, including those that serve children, older adults, people who are unhoused and people experiencing intimate partner violence (IPV). These interactions involve collaboration, tailored interventions and specialized care to address the unique needs of each group.

Children's services

BEST PRACTICES FOR INTERACTION WITH CHILDREN'S SERVICES	
School partnerships	CCBHCs can collaborate with schools to identify and support children at risk of or experiencing mental health challenges. They can offer on-site or telehealth counseling, youth-specific substance use programs, direct linkage to care, consultations for educators, parent education programs and more. CCBHCs can offer assessment and clearance letters, sometimes required by school districts as a condition of a student returning to school after an incident that presents a potential danger to self, others or property.
Early intervention programs	CCBHCs can provide specialized early intervention services for children exhibiting signs of mental health challenges. These services may include play therapy, behavioral interventions and family support.
Child welfare	CCBHCs should ensure protocols describe its role in collaboration and communication with departments of children and family services, child protective services and/or another relevant agency when abuse and/or neglect may be identified as part of the crisis evaluation. CCBHCs can help manage crises, coordinate care to promote stability in placements and participate in alternative response programs.

"CarePlus New Jersey partners with all organizations in New Jersey's Children's System of Care (CSOC) — a state-wide system aimed to support children (ages 0-21) and their families through behavioral health crises — as well as the local Division of Child Protection and Permanency, to provide seamless coordinated care for youth. Partnerships exist with the local schools (currently operating mental health programming in 20 school districts), outside providers for intensive community services and private practitioners. Additionally, to coordinate emergency care for clients during and after hours, CarePlus NJ maintains a working relationship with all local hospital emergency departments. CarePlus NJ's children's crisis services enhance and complement the CSOC by offering rapid/same-day access to intensive in-community therapy, case management and crisis care."

— CarePlus New Jersey Inc.

Older adults

BEST PRACTICES FOR INTERACTION WITH GERIATRIC SUPPORTS	
Geriatric services	CCBHCs can offer specialized geriatric services to address mental health issues faced by older adults. They can provide counseling for grief and loss, depression and cognitive decline, as well as facilitate support groups for caregivers. CCBHCs can offer extra assistance with care coordination services for this population, which often has high needs across medical and social service systems.
Home visits	CCBHCs can conduct home visits to older adults who may have mobility limitations. This enables them to assess living conditions, social support and mental health needs.

Unsheltered, unhoused or unstably housed populations

BEST PRACTICES FOR INTERACTION WITH SHELTER AND HOUSING SUPPORTS	
Street outreach	CCBHCs can engage in street outreach to connect with unsheltered or unhoused people, offering immediate crisis intervention, access to shelters and referrals to mental health services.
Housing stability support	CCBHCs can provide counseling and support to unhoused or unstably housed people as they transition into stable housing, addressing underlying mental health and substance use concerns and providing ongoing support to maintain housing through crises.
Shelters	CCBHCs can provide outreach or liaison staff to shelters, offering immediate crisis intervention, access to shelters and referrals to mental health services.

IPV support

BEST PRACTICES FOR INTERACTION WITH IPV SUPPORTS	
Trauma-informed care	CCBHCs can offer trauma-informed care for people who have experienced IPV, providing therapy to address the psychological impact of trauma.
Collaborative partnerships	CCBHCs can collaborate with emergency/transitional shelters and programs and advocacy organizations to provide coordinated services, including counseling, safety planning and referrals to legal support.

3. EMERGENCY CRISIS INTERVENTION SERVICES: SOMEONE TO CONTACT

As noted, CCBHCs are required to provide or coordinate with telephone, text and chat crisis intervention call centers that meet 988 Lifeline standards for risk assessment and engagement of people at imminent risk. The primary options for CCBHCs in meeting this requirement are: 1) directly operating their own local or regional crisis call center, or 2) engaging in a written agreement such as a contract or memorandum of understanding/agreement (MOU/A) with an existing crisis hotline service (e.g., local 988 Lifeline call centers, suicide hotlines or county/regional crisis lines) or following a documented plan for coordination between the entities.

In addition to the call/chat/text center requirement, the CCBHC is required to coordinate with any existing ATC care coordination systems. The CCBHC criteria include these two services in the same requirement, because the call center is often an important central hub of the ATC system, even though initial contact for crisis services can occur in many other parts of the system.

Directly operating a local or regional crisis call center. Many CCBHCs operate a crisis call line, including a portion that report participating in the 988 Lifeline (National Council, n.d.-a).[6] Direct provision of 24/7 crisis hotlines involves hiring and maintaining staff as well as establishing the appropriate infrastructure and protocols.

CONSIDERATIONS AND RECOMMENDATIONS FOR IMPLEMENTATION	
Staffing models and needs	Hiring clinical staff to respond to phone, text and chat crisis contacts 24/7. Linguistic competence in at least the two most commonly spoken threshold languages in the service area, with translation services across a broad language spectrum.
Modes of communication offered	Preferably incorporates phone, text, videoconferencing and web-based chat capability, with easy, direct access (e.g., without operators or automated questions).
Infrastructure investments	Requires infrastructure like phone lines, computer systems, databases of local resources, and protocols for risk assessments, interventions, referrals and follow-up. Operations enabled for 24/7/365 access. Where capacity does not allow this, calls should be rerouted to a partner entity during uncovered hours.

6 Currently, 75% of CCBHCs operate a crisis call line, with 58% reporting they participate in the 988 Lifeline (National Council, n.d.-a).

Standard operating procedures (SOPs) and protocols	If opting to participate as a call center for the 988 Lifeline, align with standards like **Saving Lives in America: 988 Quality and Services Plan** (SAMHSA, 2024) and the **National Emergency Number Association Suicide/Crisis Line Interoperability Standard** (National Emergency Number Association [NENA], 2022).
Recommended training	Helpline staff should have training and demonstrated capacity in triage, engagement (e.g., motivational interviewing training) and risk assessment and intervention. Call responders are ideally well trained on the community crisis system resources available, to triage appropriately.
Connectivity with 988 Lifeline	Because the 988 Lifeline is not yet using georouting, many CCBHCs elect to host a designated number for their communities. A CCBHC with its own 24/7 line must coordinate that line with the 988 Lifeline and establish the same triage and care coordination functions as with the 988 Lifeline centers.

Considerations for interfacing with the 988 Lifeline, other crisis hotlines and 911 PSAPs. In some cases, communities possess existing crisis hotline infrastructure in the form of local 988 Lifeline call centers or 911 PSAPs, suicide hotlines or county/regional crisis lines. In these cases, CCBHCs may consider assessing the capacity and partnership opportunities that exist with these providers before establishing separate services. Coordination can be very different across organizations and call centers; there is a wide variety of configurations, staffing models and affiliations across more than 200 call centers currently in operation. Developing relationships and clear policies and practices is vital to develop and sustain trusting collaboration.

BEST PRACTICES FOR INTERACTING WITH EXISTING CRISIS HOTLINE SERVICES	
Crisis hotline collaboration	CCBHCs can act as conveners, bringing relevant entities to the table to build necessary collaborative relationships and role clarity. CCBHCs can collaborate with 988 Lifeline call centers and 911 PSAPs to ensure seamless transitions between crisis hotlines and appropriate crisis interventions. They can provide training to call center operators on recognizing mental health and substance use crises and establish protocols for warm transfers of people in need to CCBHC crisis teams.
Shared information	CCBHCs can share crisis resources, information about available services and educational materials with 988 Lifeline and 911 operators. This helps operators provide accurate and up-to-date information to people in crisis.
Law enforcement engagement	Actively educate law enforcement and first responders that CCBHC partnership is a tool in their toolbox, and how they can access supports. Support competency in crisis triage by collaboratively developing clear protocols that guide 911 personnel on when and when not to dispatch law enforcement, as well as which officers or teams of co-responders are available to respond to behavioral health crises.

COORDINATION WITH EXISTING CRISIS HOTLINE SERVICES	
Formal agreement	Entities create an agreement (e.g., contract or MOU/A) outlining referral and warm handoff procedures, consent/data sharing and coordination practices with both 911 and 988 Lifeline partners.
Ongoing coordination	Documentation and implementation of a plan for strategic ongoing communications, bidirectional trainings and/or programmatic evaluations of the partnership are essential to seamless coordination.
Aligning with standards	If coordinating with an outside call center, the CCBHC should ensure the provider's practices align with the standards within **Saving Lives in America: 988 Quality and Services Plan** (SAMHSA, 2024) and the **NENA Suicide/Crisis Line Interoperability Standard** (NENA, 2022).

4. CRISIS INTERVENTION AND 24/7 MOBILE RESPONSE: SOMEONE TO RESPOND

CCBHCs are required to ensure community-based behavioral health crisis intervention services using mobile crisis teams 24/7 to adults, children, youth and families anywhere within the service area including at home, work or anywhere else where the crisis is experienced. Response is rapid: It is expected that mobile crisis teams arrive in person within one hour (two hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed three hours. It is not expected that the visit will always fully resolve a crisis, however mobile response can de-escalate a crisis, increase access to help, encourage help-seeking behaviors and engagement and decrease the likelihood of unnecessary ED visits and arrests.

Technologies can be employed to support these efforts, including telehealth/telemedicine to connect people in crisis to qualified mental health providers during the interim travel time or to provide crisis care to people when remote travel distances make the two-hour response time unachievable. However, the ability to provide an in-person response is required when it is necessary to ensure safety.

In rural regions without nearby teams, training law enforcement officers in crisis intervention may help bridge gaps in access, although this is not ideal due to the risk of the criminalization of the person in crisis and risks to their safety due to differential training and access to weapons, exacerbation of stigma, and the fear and distrust of law enforcement, especially for minoritized people. CCBHCs can also use telehealth to provide remote crisis assessments to stabilize situations while mobile crisis teams travel. The CCBHC certification criteria do not directly address transportation needs for the person during a mobile crisis response. However, operational needs will require that a CCBHC address these needs when they occur, and within their policies, procedures and partnership agreements with other crisis response partners.

There are two primary models for CCBHCs to meet the requirement of providing prompt mobile crisis response: directly operating this service or coordinating with existing mobile crisis teams through a DCO.

Directly operating a dedicated CCBHC mobile crisis team of on-call mental health professionals available 24/7 to deploy to crises anywhere in the service area

BEST PRACTICES FOR DIRECTLY OPERATING MOBILE CRISIS RESPONSE	
Staffing models and staffing needs	Team composition may include nurses, counselors, social workers, peer specialists, other human service workers trained in crisis response and/or psychiatric consultants. Staff is traditionally paired in a team of two; a behavioral health crisis responder may also be paired with a traditional 911 responder.
Capabilities	Capacity should include the ability to provide on-site clinical assessment, risk assessment, crisis intervention, brief therapeutic interventions, collaboration with families/supports, information and referrals, and transportation (directly or indirectly). The second team member (when safe and appropriate), clinical supervision and/or psychiatric care may be achieved through telehealth platforms brought to the response site.
Infrastructure and capacity requirements	Must enable response within one hour (two hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed three hours.
SOPs and protocols	Develop clear protocols for providing mobile crisis response in a variety of settings, (including homes, schools, housing programs and on the street), for both mental health and substance use crises, and for children as well as adults, that do not arbitrarily restrict response to certain locations, scenarios or peoples with specific types of needs (e.g., do not respond in cases of active substance use or with medical history). Define when response in unsafe situations merits co-response with law enforcement.
Recommended training	Staff must be equipped to assess risk, de-escalate crises, refer to services and coordinate follow-up care. Where first responders are part of the mobile crisis team, they must be trained in crisis response best practices (e.g., CIT training).

Alluma offers an example of mobile crisis in a rural area

"Alluma has maximized all qualified provider types through Minnesota's crisis services system. Our team includes the following:

"Leadership

- **Crisis services director (mental health professional)**
- **Crisis supervisor (mental health practitioner)**

- Practitioner lead (mental health practitioner)
- Screening Lead (mental health practitioner)

"24/7 direct services

All of the above leadership positions provide direct services. In addition, we have scheduled at all times:

- **Crisis screeners:** These are people with specialized training in risk screening to gather necessary information such as demographic, reason for the call, completing the Columbia Suicide Screening Rating Scale, PHQ9, GAD7. They will triage and dispatch the mobile crisis response team.
- **Mental health practitioners:** Bachelor's-level providers or with 6,000 hours of supervised practice that have specialized training in crisis response. They mobilize to an individual or family in their home, their, ED, school, our crisis unit, clinic, etc. They conduct a crisis assessment, determine appropriate intervention, safety plan, mobilize supports, coordinate for inpatient hospitalization if needed. They also provide, after the initial crisis episode, follow-along for up to 10 days crisis stabilization services. These are designed to reinforce the safety plan, provide coordination to other supports or services, further assess for safety and do warm handoff to other services.
- **Mental health professionals:** Master's-level providers who can do all what a practitioner can do but tend to be on call after regular business hours to provide consultation and oversight of the practitioners. If needed, they will be mobilized based on volume of calls. Outpatient therapists take on-call schedules.
- **Peer specialists:** This position is staffed by people with lived experience in either mental health, SUD or both. They provide stabilization services to people who experience a crisis and provide support to clients residing in our Crisis Stabilization Unit.

"**Screeners** are scheduled to have one on 24/7, and the daytime practitioners cover screening if needed, based on volume. **Practitioners** schedule consists of two to three practitioners on Monday through -Friday from 8 a.m. to 5 p.m. (with variability), with another practitioner starting at 3 p.m. to overlap with day shift, working until 11 p.m. These are dedicated staff hired for the crisis team. In addition, we have on-call practitioners, consisting of community-based rehabilitation workers that cover the evenings and weekend shifts.

"The process for deployment starts with a phone call into our 24/7 crisis screening phone number. The screeners gather information, determines emergent or urgent. They may be able resolve the situation on the phone, and the call would end there (often, our number is used as a support number). If emergent or urgent determines if the call will be in person or through telehealth. Screener notifies the practitioner, practitioner contacts the caller and makes arrangements, estimated time, practitioner may call law enforcement if needed for safety or support or need for hospitalization. There are many details in each step of this process, to rule out or determine next steps."

— Alluma

Historically, people experiencing behavioral health crises are transported to emergency rooms, hospitals or crisis stabilization programs by law enforcement in marked police cars. Twelve states have developed alternatives to the transportation of clients by law enforcement (NASMHPD Research Institute, 2023). Consider the value of reducing stigma and trauma by using unmarked cars and employing people with behavioral health training as drivers, such as peers or others who can begin supportive conversation during the journey. Law enforcement also benefits from reduced demand.

Coordinating with existing mobile crisis teams

BEST PRACTICES FOR COORDINATING WITH EXISTING MOBILE CRISIS TEAMS	
Formal agreement	Formal DCO agreements are necessary to outline the scope of services, response times, referral procedures, staff pay rates (e.g., on-call or hourly rates depending on services/timeframe), information sharing and ongoing collaboration.
Ongoing coordination	Documentation and implementation of a plan for strategic ongoing communication, bidirectional training and/or programmatic evaluation of the partnership are essential to seamless coordination.
Aligning with standards	The external mobile team(s) must have capacity to effectively serve the full region 24/7. SAMHSA plans to release a mobile crisis team toolkit that will offer granular implementation details.
Population-specific	*Children/youth:* Identify crisis staff with child/youth-specific expertise, either internally or through DCO relationships, and develop strong relationships with child-specific community-based resources and supports. If there are Mobile Response and Stabilization Services (MRSS) within a community, explore the potential for DCO collaboration; if not, consider adoption of the model for the youth served by the team. *Substance use:* Develop team skills in the clinical and risk assessment for SUDs for all people, including skills around identification and crisis planning for people experiencing intoxication and withdrawal, as well as SUD-related risk assessment including to overdose risk. Develop capacity, directly or through a DCO, for the ability to promptly connect people with medication for opioid use disorder (MOUD) or medication for alcohol use disorder (MAUD).

An example of a mobile crisis DCO arrangement

"In the Kansas City metro area, CommCare is the regional 988 Lifeline call center, and each CCBHC is a referral source for mobile crisis response. We created a DCO arrangement (written contract) with CommCare to provide the 988 Lifeline call center response and began work to create our own internal 24/7 mobile crisis response team. We already had a team of crisis response clinicians available 24/7, but we did not have sufficient staffing to meet the expected volume of calls and mobile crisis outreach needs that was expected with the start of 988 [Lifeline] in 2022 and 2023. We began recruiting crisis clinicians to work evenings and weekends but were struggling to obtain an adequate number of applicants and recruits.

"As an alternative, we initiated conversation with Compass Health, a large CCBHC which adjoins our service area on the east side of the Kansas City metro. Compass already had psych inpatient services with corresponding crisis response staff and capacity to add more. They also had two or three mobile crisis team members that lived in our service area, so were readily available to provide that service as an add-on to Compass' existing crisis resources. Therefore, we decided to contract with Compass as a DCO to handle the mobile crisis response needs in our service area. We executed a written contract, with expected services and responsibilities of each party.

— Beacon Mental Health (formerly Tri-County Mental Health Services)

5. CRISIS RECEIVING AND STABILIZATION SERVICES: A SAFE PLACE FOR HELP

CCBHCs are required to provide crisis receiving/stabilization services that include, at minimum, urgent care/walk-in mental health and SUD services for people seeking care voluntarily: "Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted" (4.c.1). The CCBHC may not be able to accept all people with urgent or emergent behavioral health crises, due to legal restrictions surrounding public safety first responder drop-off and/or restricted acceptance of the most acute cases due to facility, staffing or other infrastructure restrictions; however, these services should identify the person's immediate needs, de-escalate the crisis and connect them to a safe and minimally restrictive setting for ongoing care for any level of need, including suicide prevention and for crises related to substance use. Of note, there is the most variation across CCBHCs with respect to how to operationalize this element of the CCBHC criteria, especially for those using the PPS, offering more intensive and comprehensive stabilization services that can accept people of higher level of need, which can more effectively divert more people from emergency rooms and law enforcement engagement.

When not providing crisis stabilization services directly but through a DCO, CCBHCs still must have the capacity to follow up with clients immediately after discharge and provide postcrisis transition services and care coordination. Options for crisis stabilization services include:

1. Designating an area within the CCBHC for people to access urgent crisis assessment and supports. There should be enough space to accommodate triage, intervention, observation and stabilization. For days and hours when urgent crisis assessment access is not available, there must be clear procedures for accessing an alternative safe place for help 24/7.
2. Establishing a crisis receiving and stabilization center providing urgent evaluation, observation stays, counseling, peer supports, pharmacotherapy and medication administration. This requires dedicated infrastructure and staffing resources.
3. Contracting with external behavioral health crisis units to serve CCBHC clients requiring walk-in stabilization services. Agreements must outline intake procedures, admission criteria, coordination of care protocols and discharge planning roles.

CCBHC services are required to address the entire age range, including crisis stabilization. Home-based stabilization is the least restrictive best practice for children and youth and is a preferred approach for other age ranges. It should be available to the extent possible as part of a broader array of CCBHC stabilization services. Technical guidance in crisis stabilization for youth populations is provided in **A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth**, produced by SAMHSA in conjunction with NASMHPD (Schober et al., 2022).

BEST PRACTICES FOR CRISIS RECEIVING AND STABILIZATION SERVICES	
SOPs and protocols	Develop clear protocols for inclusion and exclusion, warm handoffs, processes for after the first 24 hours, and what to do for those who cannot be stabilized (i.e., get worse). Use the needs assessment to map out the process for involuntary treatment in cases where that may be needed, including transportation, decision points and financial liability. Form partnerships with EDs and hospitals to coordinate mental health and substance use crisis response, even though these medical settings do not provide the peer supports and recovery orientation of behavioral health-focused options. CCBHCs should have SOPs and protocols that support crisis diversion to community alternatives when appropriate.
Levels of need	At minimum, CCBHCs must provide urgent care/walk-in mental health and SUD services for for people seeking care voluntarily; they need not manage the people with highest need in the ambulatory setting. All CCBHCs should consider how they will facilitate access to care for any level of need, including addressing substance use withdrawal management, internally or via partners/system.
Funding	CCBHC grant funds or the PPS can be used to cover the initial 23 hours of crisis stabilization or ongoing intensive outpatient crisis treatment services but cannot be used to cover the residential component of crisis stabilization costs, including room and board. Funding for the residential component of the crisis continuum will require referral to outside programs or braiding CCBHC grant/PPS funds with other sources of funding.

"The GRAND Response Access Network on Demand (G.R.A.N.D.) Model is composed of three key components:

1. **Urgent Recovery Centers (URC) that provide 24/7 crisis stabilization services.**
2. **iPads with the GRAND Model integrated support access app that are distributed to GRAND clients, first responders, hospitals and other community partners in order to provide instant access to a GRAND therapist anytime, anywhere.**
3. **All iPad and crisis calls are answered by fully trained and engaged clinicians who are on site at a GRAND URC.**

"In addition, we partner with Oklahoma Department of Mental Health and Substance Abuse Services' 988 Lifeline, providing therapeutic transport to an Urgent Recovery Center for callers who require in-person treatment and reside more than 30 miles from the nearest available crisis center. We now provide therapeutic transport to residents within 30 miles of a crisis center, as well as those outside the 30-mile range."

— GRAND Mental Health

6. CCBHC CRISIS SERVICES BEST PRACTICES

SAMHSA released the **National Guidelines for Behavioral Health Crisis Care** in 2020 and is planning to release an updated crisis guidelines document that will include youth crisis care. In this updated document, SAMHSA will incorporate concepts from the **Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response** (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021), which includes extensive information on crisis services best practices, including measurable standards.

For more information that is specific to best practices in serving children and youth, see the **National Guidelines for Child and Youth Behavioral Health Crisis Care** (SAMHSA, 2022) and **A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth** (Schober et al., 2022).

a. Air traffic control, crisis coordination and care coordination requirements

ATC refers to managing the flow of people through various stages of crisis intervention and coordinating real-time seamless transitions between different levels of care (SAMHSA, 2023c; SAMHSA, 2020). CCBHCs can lead or partner with other entities in the community, including payers, for crisis coordination and care coordination requirements. The ability of the CCBHC PPS cost-base rate methodology to include the costs of IT systems needed for triage/ATC, coordination and crisis PHI exchange can be particularly valuable for local crisis systems that do not currently have these IT system capabilities.

ATC	CCBHCs help provide quality care coordination through the use of technology, akin to that of ATC, by assessing and directing people to appropriate crisis services; functioning as the initial point of contact or a source of crisis intervention or postvention services; helping people navigate the complex crisis system efficiently and ensuring they receive timely and relevant care; dispatching mobile crisis or directing the person to an immediate-access behavioral health urgent care or crisis stabilization center. Technology used may include GPS-enabled mobile teams, true system-wide access to available crisis residential, inpatient or other beds, and/or outpatient appointment scheduling through the integrated crisis call center.
Crisis coordination	CCBHCs play a central role in coordinating crisis response efforts among different stakeholders, such as law enforcement, EDs, social services and community organizations. They facilitate communication and collaboration to ensure a unified and effective response to crises.
Crisis PHI exchange	People in crisis benefit greatly when crisis responders have immediate access to information about their current and recent health conditions, treatment providers and previous episodes of crisis. Subsequent care after initial crisis intervention is of higher quality when subsequent providers have full information about the prior response. CCBHCs should invest in developing the capacity to promptly and systematically ensure that a person's PHI remains available for partner sharing as they move through the crisis system.

Care coordination requirements	CCBHCs are responsible for ensuring that people in crisis receive comprehensive and continuous care beyond the immediate crisis intervention. They coordinate with various service providers to create a holistic care plan tailored to each person's needs and connect them to ongoing treatment and support services.
Transitional support	CCBHCs facilitate smooth transitions between different levels of care, ensuring that people moving from crisis intervention to ongoing treatment do not experience gaps in services. They provide guidance, resources and support during these transitions.

b. Welcoming environment and provision of trauma-informed care

The ideal crisis care system has facilities that are welcoming and therapeutic and that respect people's dignity and privacy to positively impact outcomes for clients in crisis, including many with histories of trauma. Crisis services delivery must incorporate awareness of individual, societal and systemic challenges faced by clients, such as stigma, discrimination and health disparities. The crisis setting must be prepared for clients that are potentially reluctant, frightened or agitated. Further, it must also welcome disconcerted families, inundated first responders and law enforcement personnel, and other partners. **Trauma-informed principles** (SAMHSA, 2023b) should be employed to avoid re-traumatization of clients and reduce secondary trauma in staff.

Balancing safety and engagement is critical, as is taking care that security measures do not compromise the therapeutic milieu. Design and safety should be balanced to create a welcoming space that enhances mental health and SUD care.

BEST PRACTICES FOR A WELCOMING, TRAUMA-INFORMED ENVIRONMENT	
Approach to service delivery	Particularly for those with lived experience, encounters with crisis services can be extremely traumatic, characterized by loss of power, control and dignity, imposition of involuntary interventions, and physical/chemical restraint and incarceration. It is essential that CCBHCs approach service delivery with an aim to eliminate those experiences as much as possible and promote engagement, empowerment and hope, including the use of strategies like advance directives to promote choice. All staff should be trained and mentored in employing person-centered, trauma-informed and recovery-oriented delivery of supports.
Welcoming space	Physical spaces incorporate evidence-based design (Ulrich et al., 2008) principles and promote the safety of staff, clients, visitors and the public. Spaces feature natural light and positive distractions, noise reduction, effective ventilation systems, a homelike feel (as much as possible) including comfortable furnishings, adaptable rooms, etc. Client and family privacy is balanced with the need for observation to maintain safety.
Stakeholder consultation	Input from stakeholders, including clients, families, crisis staff and law enforcement, should inform crisis space and process design to ensure they balance the full range of needs.

Safety first/"no force first" measures	"No force first" means setting a tone of welcoming engagement and partnership rather than leading with efforts to "take control" and threats of force, such as restraint and seclusion. These types of interventions are always minimized to the greatest extent possible, even in settings that welcome people who are brought in involuntarily. Best practice approaches to safety and security maximize welcoming engagement — often with peers — rather than using uniformed security staff, which often exacerbate rather than ameliorate risk. Attention to developing, rehearsing and continuously improving de-escalation processes and security measures is highly important, including annual security plan reviews, incident reporting and quality improvement processes, and management of agitated behavior by trained staff rather than security personnel.

c. Recovery-oriented peer support

For more information on developing peer support directly and via partnership, refer to **Certified Community Behavioral Health Clinics, Peer-delivered Services and Peer-operated Agencies: Opportunities for Collaboration and Expansion** (Rosenthal et al., 2019).

Use the **Organizational Self-assessment Tool for Integrating Peer-delivered Services in CCBHCs** (National Council, 2021) to assist in developing an implementation work plan.

Interdisciplinary teams should maximize peer involvement, employing peers as experts in client engagement. Meaningful peer involvement should extend beyond use as support staff, to full team members with clear roles, responsibilities and career paths, reinforced in regulations, reimbursement policies and quality metrics. All staff should be trained to understand the peer role and to practice developing successful skills in working with, supporting and being supported by peers on the interdisciplinary team.

Integrating peer workers into CCBHC crisis services

Peer workers with lived mental health and SUD experiences are a vital resource for enhancing CCBHC crisis services. Studies show that peer support improves outcomes like engagement, hope, quality of life and treatment retention (Johnson, et al. 2018; Lee & Yu, 2024; O'Connell et al., 2018; Treitler et al., 2024). As CCBHCs expand crisis access, an integral strategy should be incorporating multiple layered peer workers throughout the entire service array. Peers distinguish crisis services by improving the care experience via:

- Modeling resilience and recovery and instilling hope — their presence alone suggests, "you can get through this."
- Shared understanding of challenges, which builds trust and willingness to open up.
- Lateral relationship, which feels more compassionate than clinical authority.
- Plain language explanations, which meet people where they are.
- Nonjudgment, which helps remove stigma and shame barriers.

With urgent care's disorienting and stressful nature, peers comfort and empower those in crisis.

Peer roles across the crisis continuum

Peers can fill a variety of roles — including and in addition to certified peer specialist — to strengthen crisis systems and should be used to the full extent of their capabilities.

PEER ROLES ACROSS THE CRISIS CONTINUUM	
Peer providers (including peer support specialists)	A peer provider (e.g., peer support specialist, recovery coach) is a person who uses their lived experience of recovery from mental and/or substance use disorders or as a family member of a person in recovery, plus skills learned in formal training, to deliver services in behavioral health settings to promote recovery and resiliency. In states where peer support services are covered through the state Medicaid plans, the title of Certified Peer Specialist often is used. SAMHSA recognizes that states use different terminology and certification requirements for peers, but it has released **model standards for peer certification** (SAMHSA, 2023a).
Peer providers in emergency departments	Peer providers such as peer support specialists can offer a range of services in EDs, including general recovery support, naloxone distribution, and Screening, Brief Intervention and Referral to Treatment (SBIRT) services. Peer support is valuable in providing follow-up support after discharge to facilitate ongoing care, support recovery and enhance relapse prevention.
Crisis line staff	Peers on call center staff provide relatable support on hotlines and can naturally infuse their recovery-oriented perspective from lived experience in their work while adhering to the specific protocols and guidelines governing the hotline.
Warmline staff	Distinct from crisis lines, peer-run warmlines offer conversational emotional support and resources in a supportive environment, provided by those with — and willing to acknowledge — lived experience, and they can focus on engagement through the mutual exploration of the caller's recovery goals and plans to achieve them. Most states in the U.S. have warmlines.
Mobile team members	Peers who respond in person to community crises can build rapport, model recovery, instill hope and complement a clinician in a team-based approach.
Care navigators	Peers guide people through the navigation of community-based treatment and recovery resources, sometimes within a treatment or recovery program. They can explain procedures, connect people to resources and ensure smooth transitions between levels of care.
Follow-up coordinators	Peers relate deeply as they call or visit people postcrisis to check in, assess needs and motivate engagement in ongoing treatment.

Peer respite staff	Peer-run respite centers offer homelike crisis support outside clinical settings. Peers' experiential knowledge and engagement skills shine in this model. Here, peers can engage from the front door (a concierge offers a welcome and crisis de-escalation supports), through provider engagement and wraparound follow-up care.
Support group facilitators	Peer-led groups for those recovering from crises provide social connection and practical wisdom.
Peer perspectives improve service delivery	Adding peer perspectives across the spectrum from hotlines to postcrisis care makes services more relatable, transparent and recovery oriented.
Peer perspectives improve organizational approach	At the organizational level, peer advisory groups or steering committees and peer representatives at every level of CCBHC staffing infuse lived/living experience perspective throughout development and delivery. Certification criteria require the active participation of people with lived experience and family members in governance.

Optimizing use of peer roles

Peer crisis services can divert people from hospitals/EDs and justice systems through rapid stabilization in community settings like respites. Peers' direct experience underscores that clinical environments can feel rigid and isolating during crises. For those who do not require hospitalization, wish to avoid a litany of processes required in the hospital setting, or are uncomfortable working with a clinical provider, peer-run respite can be a more palatable, immediate option. Peers' flexibility helps route people to the least-restrictive solutions.

"Prior to becoming a CCBHC, BestSelf worked with New York Association of Psychiatric Rehabilitation Services (now known as The Alliance for Rights and Recovery) to develop better utilization and integration of peers into crisis response services. When SAMHSA CCBHC funding arrived, we needed a new way to create 24/7 access, and that's when the clubhouse idea was formed, and peers were an integral part. Six years ago, we had just six peers. Over time, BestSelf created listening opportunities via a peer steering committee, creating a peer manual with roles and responsibilities and a career ladder; we now have more than 60 peers on staff."

— *BestSelf Behavioral Health*

Expanding and supporting the peer workforce

The sheer volume of 24/7 crisis services requires expanding the workforce; incorporating peers in every aspect of the delivery model maximizes resources and boosts bandwidth of an understaffed crisis care system. Peers offer a flexible talent pool with intrinsic motivation and personal experience that provides unique preparation for supporting people in crisis. Further, peer development reinforces purpose and supports employment goals, while certification and paid training programs prepare capable responders. With role clarity, training and support, peers become indispensable in compassionate crisis systems centering lived wisdom.

BEST PRACTICES IN SUPPORTING PEER ROLES	
Relevant, appropriate training	Provide extensive, trauma-informed, peer-relevant training and regular retraining as needed on crisis systems and services. Comprehensive training on crisis systems and services should focus on both theoretical knowledge and practical applications. Support the achievement of peer certifications by providing necessary resources and financing options. Integrate clinical training with a strong peer perspective to ensure holistic learning experiences.
Respectful, clear roles and responsibilities	Clarify roles and scope aligned with experience level. Create a peer manual with roles and responsibilities and adjust job descriptions as needed. Consider the vocabulary used in reference to peers and their contribution: Language such as "colleagues" rather than "peers" may better reflect a welcoming, fair, team-based approach.
Supportive supervision structures	Create layered supervision structures that include peer supervisors, as well as mentor/mentee opportunities. While supervisors do not necessarily need to possess lived experience, they should receive appropriate training in supporting and advocating for peers. When the team understands the role and value of the peer, they are better equipped to maximize peer potential.
Professional growth and support structures	Facilitate professional development opportunities and advancement, with clearly defined career ladders. Create supportive supervision structures that include peer supervisors and mentorship opportunities. Clarify roles and responsibilities with respect to peers' experience levels and provide appropriate job descriptions.
Adequate compensation	Ensure "thrivable" wages — don't exploit peers' motivation to help.
Fair staff communication	Ensure equal treatment in the care process by developing processes and procedures that deliver the same information to all team members at the same time.
Peer safety	Consider organizational ethics regarding peer autonomy and safety. Balance client needs with ethical treatment and safety of peer workers.
Access and fairness	Peers expand crisis access through shared identity and trust. Reflecting the demographics of the served populations can bridge cultural disconnects and provide relevant assistance.

"This is how we are dealing with the workforce shortage. For every therapist on staff, you should have two peers. About 10% of our staff are peers, and 50% of our executive team are peers, including our CEO. Oklahoma has a great peer educational program — it is one week in duration and free of cost. Each year, peers are required to attain 12 continuing education unit hours."

— GRAND Mental Health

"Building use of peers and community recognition of the role takes work. In the past, benchmarking began at 1% of interactions involving peers; now it sits closer to 40%. Having a system that has already learned that value has really helped the state."

— Oklahoma Department of Mental Health and Substance Abuse Services

"Peers represent our largest employment audience and play a vital role in bridging the gap in workforce shortages. Lived experience staff play a critical role in MH [mental health] and SUD treatment. Their firsthand understanding fosters empathy and connection. In addition, their presence helps reduce stigma and complements traditional clinical approaches. GRAND employs several strategies to support our peer specialists, including:

1. Dedicated training programs that focus on living well and promoting wellness with healthy boundaries This recognizes the importance of continuous education for peer support specialists to enhance their skills, resilience and overall wellbeing.
2. GRAND's provision of wellness days every other Friday allows peer support specialists to take paid time off to focus on their wellbeing.
3. The implementation of recovery support calls specifically for peer staff provides a proactive approach to addressing the ongoing recovery needs of employees. These calls serve as a platform for sharing experiences, seeking advice and providing support, fostering a sense of community among peer support specialists.
4. Training involving peers in educating others underscores the importance of peer-driven support within the organization.

"This approach contributes to a supportive and empathetic work environment, reinforcing the sense of understanding and camaraderie among peer support specialists. By incorporating these elements into our peer support approach, we are able to demonstrate a holistic commitment to the wellbeing of our peer support specialists, acknowledging and addressing their ongoing recovery needs while fostering a culture of support, education and healthy boundaries within the workplace."

— GRAND Mental Health

d. Triage

Triage for behavioral and medical risk is critical in determining urgency of need and initiating effective crisis response. Regardless of where and how a person in crisis presents to the system — via routine appointment, walk-in services, urgent care, emergency room, presentation in a community setting (school, emergency shelter, transitional home, etc.), 911, 988 Lifeline, mobile response or police intervention — their level of risk must be quickly and accurately assessed to determine and deliver the most suitable response for their needs.

BEST PRACTICES FOR TRIAGE	
Initial triage	Triage for level of risk (emergent, urgent, routine) is a core component of all CCBHC services. In addition, first responders, law enforcement, 988 Lifeline call centers, and 911 operators, as well as CCBHC staff and community partners, need to know how to triage a behavioral health emergency situation and connect quickly with crisis responders, unless medical needs or risk of violence supersede.
CCBHC medical triage	The CCBHC urgent care and/or crisis center setting must have capacity to routinely triage for emergency medical need and provide routine medical screening and triage as needed, thus eliminating the need for people in crisis to be transferred to an ER or medical setting when there is no serious medical indication for doing so.
Substance use risk	CCBHC crisis centers must triage for substance use risk and use, including present intoxication, as well as overdose risk and potential need for opioid overdose reversal.

e. Assessment in the crisis setting

Assessment in the crisis setting must be thorough enough to inform decision-making and focused enough to work within a fast-paced setting where limited information may be available. Assessments should comply with state and federal regulations and include the following (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021):

Need for emergent intervention

Determine emergent medical, mental health or substance use related needs (e.g., significant injury, dangerously unstable vital signs, overdose, severe agitation or psychosis, severe substance intoxication/withdrawal). For non-emergent medical needs, what is needed in the moment to help the person maintain comfort and stability during the crisis intervention process (e.g., medications, medical equipment like insulin or needles, monitoring)?

Immediate initiation of information gathering

Assessment should not be delayed because the person in crisis is too agitated/psychotic/intoxicated to provide organized information or carry on a conversation. In these cases, collect as much information as possible from collateral sources and chart review, along with an assessment of the person's mental status and immediate risk, and document the level of immediate risk and why a more detailed assessment cannot be performed at this time. Maintain safety in a welcoming manner, initiate any appropriate intervention (e.g., medication) and reassess as soon as the person can be engaged in conversation.

Communication with collaterals[7]

All confidentiality regulations permit communication with collaterals without release when necessary for assessment and intervention in a potentially harmful crisis or life-threatening emergency. This understanding must be communicated to all crisis providers with the expectation that communication with collaterals is a rule, not an exception, in such situations, and that absence of communication would be an adverse quality metric.

Co-occurring mental health challenge

If the person is presenting with a crisis request related to SUD, always consider the likelihood that co-occurring mental health challenges may need to be addressed, as well. Has a mental health challenge or disorder contributed to the crisis presentation? Are there suicidal thoughts or signs of agitation and/or psychosis that need to be stabilized? What is the current status of prescribed psychotropic medication use or discontinuation? Be aware of conditions that may trigger either out-of-control substance use or requests for help with substance use, including onset of medical illness, increase of mental health symptoms (e.g., paranoia due to stimulant use), hospital discharge or the occurrence of a recent adverse life event. Assess the level of co-occurring capability needed in the SUD program to which the person will be referred.

Co-occurring substance use

If the person is presenting with a crisis related to mental health symptoms, always welcome discussion of how substance use may have contributed to or exacerbated the crisis presentation. Are there signs and symptoms of acute substance intoxication and withdrawal that may need to be addressed in the mental health crisis setting? Do not assume that, if the person is actively using substances, they are interested in or should be sent to an SUD program; stage-matched SUD interventions should be included in mental health crisis care.

Co-occurring cognitive impairment

Does the person have evidence of baseline cognitive impairment? If so, is it more likely due to intellectual/developmental disability (since childhood), acquired brain injury, possible onset of dementia or an acute state of delirium?

What is the best way to assess the cognitive baseline and engage the person in accordance with their cognitive capacity? How will this impairment impact the crisis intervention and follow-up to deal with this crisis and, if possible, future crises?

Why now

This is a narrative of the progression of the crisis with focus on identifying the most recent precrisis baseline and the strengths/supports/services that helped the person to achieve that baseline, and then determining the sequence of events that led the person to seek (or be brought to) services now. This can lead to the identification of what services/supports need to be reestablished to return to baseline, and how to work on enhancing the person's strengths to avert future crises.

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7 A collateral is usually a spouse, family member, or friend who participates in therapy to further the treatment interests of the client. The collateral is not considered to be a client and is not the subject of the treatment.

Risk assessment

As discussed in detail elsewhere, there should be an assessment of the risk of harm to self or others, including a mental status exam, an inventory of static and dynamic risk and protective factors and access to firearms and other lethal means. Formal suicide risk assessment (e.g., Columbia Suicide Risk Scale), overdose risk screening (or assessment) and violence assessment are needed.

Level of current engagement

What is the person's most important request at the moment? How does this relate to their recovery goals? To what extent and for what issues is the person willing to receive help, and what kind of help? If the person is unwilling to accept help, do they meet criteria for involuntary intervention? In all instances, what is the best way to engage the person in a collaborative plan?

Prior engagement with the behavioral health system

What has been tried? What worked and what didn't? Why? Who is responsible for this person's care? Are there system/administrative barriers that need to be addressed? Was there a crisis intervention/ prevention plan? Was the person able to use this plan?

Community stressors and supports

Are there psychosocial factors (e.g., housing, transportation) that are contributing to the crisis? Are there supports that can be leveraged to help the person be successful after discharge?

Level of care assessment

All staff should have training in using standard level-of-care assessment tools (e.g., ASAM Criteria for SUD and Level of Care Utilization System [LOCUS and CALOCUS-CASII for mental health]), to make structured level-of-care determinations and to communicate in a common language to other crisis providers.

f. Crisis response: Intervention for prevention and mitigation of crisis

In addition to providing direct crisis services and coordinating with other partners to create a community crisis system, CCBHCs by design have core capacities that can reduce the incidence and recurrence of crises for adults and children with both mental health and SUD needs. CCBHCs should approach crisis response by defining "crisis" as it is self-defined by the person or family experiencing the crisis. Crisis response therefore does not focus only on those experiences which involve 911 or life-threatening emergencies. If the entire CCBHC is oriented to respond to self-defined crises as soon as possible, by making it easier for both new and existing clients to get help as quickly as possible, serious crises can be mitigated or prevented.

This approach applies both at the "front end" — making it easy for people to call for help or walk in for help when they are still at a low level of distress (e.g., "I ran out of medicines, and I missed my doctor's appointment," "I am experiencing a lot of anxiety and am at risk of relapsing on substances") — as well as for postcrisis care (facilitating connection to necessary wraparound services to promote continuity following a more serious crisis event such as an ER visit or hospitalization. The list below covers important crisis mitigation, prevention and intervention strategies, and the next section covers postcrisis care.

STRATEGIES FOR CRISIS MITIGATION, PREVENTION AND INTERVENTION	
Open access	Open access means that people in the community with behavioral health needs can come in the door with routine or urgent needs without an appointment.
Rapid access to medications	In addition to providing access to someone to talk to, open access processes include various approaches to providing access to urgent medications (e.g., for people who have missed an appointment or run out of medication). This is an important strategy for preventing relapse.
Rapid access to medication for opioid use disorder	People with OUD have high risk for overdose, particularly with previous overdose. These people need *immediate* access to initiation of medications such as buprenorphine to engage them in treatment. CCBHCs can develop such capacity to prevent future OUD crises and premature death, including provision of secondary prevention services such as naloxone, and fentanyl and xylazine testing strip distribution.
Initial risk assessment and triage	Identifying a crisis promptly makes it more likely that needs can be met at lower levels of service intensity and with less harm and impairment to the person than would occur if identification of the crisis was delayed (see criterion 2.b.3). When a person first presents to a CCBHC for service, a triage assessment must be performed in part to identify any emergency/crisis needs and to ensure that people with urgent needs are seen as promptly as is necessary, including receiving an initial evaluation within one business day (see criteria 2.b.1 and 4.c.1 for crisis response timelines and detail about required services).
Individual crisis plans	Individual crisis plans facilitate earlier identification of crisis at lower levels of intensity when needs can still be met at lower levels of crisis service intensity and more effectively as a result of prior planning. Following any crisis or psychiatric emergency, in conjunction with the person or family receiving services, a CCBHC is required to create, maintain and follow a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises (see criterion 2.c.6). The crisis plan must include, at minimum, getting counseled about the use of the 988 Lifeline, local hotlines, warmlines, mobile crisis and stabilization services, should a mental health and/or SUD crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services, and they are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible (see criterion 3.a.4). Although it is not a CCBHC certification criterion, we recommend a crisis plan including access to overdose prevention kits.

Intensive crisis intervention	The flexibility of the CCBHC model allows for intensive crisis intervention services to be provided immediately upon access and triage anywhere in the CCBHC, thus offering the opportunity to avoid referral from the CCBHC to an emergency room or higher level of care. Sustainable approaches to intensive and flexible crisis follow-up may include office-based or home-based services multiple times per week, for a period from a few weeks to a few months, to ensure that the person stabilizes sufficiently to transition to the appropriate intensity of "routine" outpatient care. These services may be helpful for people in mental health crisis who may be continuing to use substances. Continuing crisis-oriented home-based services can be an extension of mobile crisis, as in Mobile Response and Stabilization Services (Lav & Lewis, 2022; SAMHSA, 2022 [p.22]), a best practice model for children and families. Office-based follow-up can be an extension of open access/behavioral health urgent care.
Critical Time Intervention	Crisis intervention is not psychotherapy, although each encounter should be therapeutic in nature. By definition, it is person/family centered and problem focused, helping the client address the issues at hand that are disruptive, and then transitioning to ongoing services. CCBHC criteria do not prescribe a particular model of crisis interventions, but it is helpful to train staff in best practice approaches to problem-focused, short-term interventions. Evidence-based protocols such as Critical Time Intervention (CTI) may be used through short periods of crisis intervention, which may range from two weeks to three months (Center for the Advancement of Critical Time Intervention, n.d.). CTI and other best practice approaches emphasize involvement of natural supports and other collateral caregivers (family members, friends, clergy), as well as coordination with other service providers who may be involved already or newly added to the client's support network.
Care coordination	Care coordination is a required activity. Specific care coordination and warm handoff procedures are necessary throughout the service continuum for effective crisis intervention. These protocols may include connecting to ATC to ensure that people do not get lost in transition, as well as negotiating continuing collaboration (as between schools, residential programs, shelters or probation with behavioral health services at the CCBHC) and effective warm handoff protocols, including between different programs in the CCBHC itself.

An example of integration of SUD crisis services

"To help address SUD needs in the crisis continuum, we offer medication-assisted treatment assessment and induction at all of our Behavioral Crisis Center (BCC) locations, which also serve as safe, effective spaces for stabilization for those who do not require emergency medical intervention. Our Springfield BCC is located on the same campus as a social-setting detox and a short-term residential facility for those in our program, making for seamless referral and intake for clients — including those who may have manageable co-occurring MH [mental health] conditions — who are interested in those services following immediate stabilization in the BCC. Additionally, all crisis line operators are trained to effectively route SUD-related calls (as well as MH-related calls) to the proper behavioral or medical authorities, as needed."

— Burrell Behavioral Health

Virtual crisis care platforms

Virtual crisis care platforms enable CCBHCs to extend their reach and provide immediate support through digital channels. These platforms offer crisis interventions, counseling and coping strategies remotely.

VIRTUAL CRISIS CARE PLATFORMS	
Telehealth and virtual services	IT enables CCBHCs to offer telehealth services, allowing people to access crisis support remotely. Virtual sessions for assessments, therapy and consultations can ensure timely interventions, particularly for those who may have mobility or transportation challenges.
988 Suicide & Crisis Lifeline	The 988 Lifeline is available via text and chat as well as videophone for ASL services and provides the standard service in accordance with the **988 Quality and Services Plan** (SAMHSA, 2024).
Crisis chatbots	Implementing IT-driven chatbots provides immediate access to support. These tools can offer real-time assistance, information and coping strategies to people in crisis, ensuring a swift response even outside of regular business hours.
Multimedia and multichannel support	Use multimedia resources such as videos, podcasts and downloadable guides to provide a variety of crisis-related information and coping strategies. Offer support through multiple communication channels, including text, phone and email.
Mobile apps	Mobile apps can significantly enhance the accessibility of crisis services. Identify or develop mobile applications that provide crisis information, access to hotlines, self-assessment tools and real-time support (e.g., the **Crisis Text Line**).
Online support groups	CCBHCs identify or host virtual support groups, where people facing similar challenges can connect, share experiences and learn coping strategies (e.g., **7 Cups**).

g. Suicide and overdose prevention and medication

CCBHCs are required to implement formal best practice approaches to suicide prevention and opioid overdose prevention. These procedures are required in *all* settings, not just settings labeled "crisis." Both suicide prevention and overdose prevention should be considered as high-level targets for organizational quality improvement, using frameworks like **Zero Suicide** to establish an agency goal and measurable target for continuing progress. Components of these efforts include the following:

Best practice suicide screening

CCBHCs are expected to implement formal suicide risk screening, with procedures for when the screenings are used and what follow-up interventions are needed following positive screens, usually with a risk stratification process. The most commonly recommended suicide screening is the **Columbia-Suicide Severity Rating Scale (C-SSRS)** (Posner, 2007), but others are acceptable.

Suicide prevention

Comprehensive implementation of crisis intervention plans that include formal use of suicide prevention best practices is required for CCBHCs. Many CCBHCs have adopted systematic approaches like Zero Suicide. Best practices include procedures for caring contacts,[8] EHR flags to stimulate outreach for high-risk people, teaching clients how and when to ask for help when they experience suicidal thoughts, training in lethal means counseling, peer support to help with coping and recovery skills and a consistent reminder of hope.

Opioid overdose prevention and secondary prevention programs

All CCBHCs are required to maximize access to opioid overdose reversal medications like naloxone, both in their own services and in collaboration with community partners. Mobile crisis service staff and other crisis staff should be trained in how to administer and distribute naloxone on scene. CCBHC crisis services and other secondary prevention services are recommended, including providing at-risk people and their supports with overdose reversal education and safety planning, fentanyl and xylazine testing strips and supplies to promote sterile injection and reduce infectious disease transmission.

Opioid overdose follow-up outreach

People who have been revived from opioid overdose are at a high risk for future lethal overdose and therefore are a high-priority target for rapid outreach, engagement and intervention. CCBHCs are required to provide or collaborate with such efforts in their communities. Such efforts may be incorporated into the work of mobile crisis intervention services, or they may involve separate teams — often composed of peers in OUD recovery — who can make contact with the person who has overdosed as quickly as possible (within one hour is ideal, but no longer than 24 hours later), to try to provide hope and facilitate connection to MOUD.

Rapid access to MOUD

People with OUD have high risk for overdose, particularly with previous overdose. These people need immediate access to initiation of medications such as buprenorphine or naltrexone to engage them in treatment. CCBHCs can develop such capacity to prevent future OUD crises and premature death. Linkage with immediate access to methadone through opioid treatment programs (OTPs) is also valuable for people who need a more robust intervention than can be provided with buprenorphine.

h. Postcrisis follow-up

Continued stabilization is imperative to reduce risk during the transition from crisis care to outpatient or community treatment-as-usual care, particularly in cases where a client was not engaged in routine care prior to the crisis. CCBHC crisis services should provide continued stabilization and warm handoff to other community-based care, including such best practices as CTI and wraparound services for families. Intensive postcrisis intervention follow-up should occur within 24 hours. Crisis systems should systematically track the rates at which people receive follow-up in subsequent care following a crisis service and rates of seven- and 30-day readmission to crisis services following discharge from an episode of crisis care.

8 Caring contacts are brief, personalized communications sent to individual clients post-discharge that convey messages of hope and support and provide resource information over a period of one or more years. Studies have demonstrated effectiveness in reducing suicidal ideation and behavior in randomized clinical trials (Motto, 1976; Comtois et al. 2019; Skopp et al., 2022).

STRATEGIES FOR POSTCRISIS FOLLOW-UP	
Comprehensive continuity of care and care coordination	
Service integration	Care coordination is essential during both the crisis and postcrisis periods. Use the full CCBHC service array to offer continuity of care beyond acute crisis intervention, until the client is successfully transitioned to outpatient care, and integrate recovery-oriented peer support services, which have been shown to significantly enhance engagement and outcomes. Offer assistance in addressing social and administrative barriers to continuing care (e.g., help with benefits, housing, transportation).
Addressing barriers	Assistance with overcoming social and administrative barriers, such as obtaining benefits, securing housing and arranging transportation, is crucial. This holistic approach helps clients focus on their recovery without being hindered by external challenges.
Personalized care and overdose safety plans	Developing personalized care plans that reflect the unique needs of each person is crucial. These plans should be regularly reviewed and updated based on the person's progress and changing needs. For people at risk of overdose, safety plans include specific steps to take in the event of an overdose.
Recovery coaches	Employing peer recovery coaches who have lived experience with mental health or SUD challenges can provide relatable support and encouragement. Their involvement can enhance trust and engagement, which are vital for sustained recovery. (See **Recovery-oriented Peer Support** on page 51 for more recommendations.)
Intensive case management	Intensive case management provides individualized support and case management services to people with severe mental illness or co-occurring disorders.
Immediate post-hospital (or crisis episode) follow-up	
Next-day appointments	Following discharge from hospitalization or an acute crisis episode, most individuals or families cannot simply resume routine care. They need to be seen rapidly and may need to be seen intensively or in the home. Behavioral health urgent care models should ensure that these people are seen within 24 hours post-discharge.
Open access model	Implementing an open-access model in behavioral health urgent care ensures that people can receive immediate attention without long wait times. This model is particularly effective in maintaining engagement and preventing relapse during the critical postcrisis period.
Intensive and flexible follow-up	Depending on the person's needs, follow-up care may need to be intensive and could involve home-based services. These services ensure that people receive the support they need in a familiar environment, which can be less stressful and more conducive to recovery.

Family wraparound services	Incorporating wraparound services for families can provide a supportive network that addresses not only the clinical needs of the individual but also the psychosocial needs of the family. This comprehensive support helps create a stable environment conducive to recovery.
First-episode psychosis programs	First-episode psychosis programs focus on young people experiencing their first episode of psychosis, providing intensive and coordinated care to promote recovery and prevent further deterioration.
Medication reconciliation and support	Episodes of hospital care and intensive crisis interventions can often include medication changes. Post-episode follow-up within the next 24 hours should include medication reconciliation and evaluation of whether the person has been able to obtain access to any new medications prescribed, has been able to implement their medication changes, has concerns, is experiencing new side effects or has questions about the medication changes.
Overdose prevention centers	Supervised facilities where people can use pre-obtained drugs under medical supervision to prevent overdose deaths.
Sober living homes	Transitional housing environments that support people recovering from SUD by providing a structured and sober living space.
Intensive crisis intervention follow-up	
Flexible (or person-centered) approaches	As noted previously, the flexibility of the CCBHC model also allows for sustainable approaches to intensive and flexible crisis follow-up, which may include office-based or home-based services multiple times per week for a period from a few weeks to a few months, to ensure that the person stabilizes sufficiently to participate successfully in outpatient care. Home-based services can be an extension of mobile crisis; office-based follow-up can be an extension of open access/behavioral health urgent care.
Home-based and mobile crisis extension	Home-based crisis intervention programs provide intensive, short-term crisis intervention services directly in the homes of individuals and families experiencing a psychiatric crisis.
Overdose prevention outreach programs	Provide secondary prevention services to people actively using substances, aiming to reduce the negative consequences of drug use. CCBHC crisis services and other secondary prevention services are recommended, including providing at-risk people and their supports with overdose reversal education and training, fentanyl and xylazine testing strips and supplies to promote sterile injection and reduce infectious disease transmission.

Community-based/mobile care services	
CTI	Evidence-based protocols such as CTI also may be used throughout the postcrisis transition period. CTI is an evidence-based model designed to prevent relapse during the critical transition period from crisis to community care. It typically involves three phases over two weeks to three months, focusing on reducing the person's vulnerability during this high-risk period.
Assertive Community Treatment	Assertive Community Treatment (ACT) is a well-established, evidence-based program designed to provide comprehensive, community-based psychiatric treatment, rehabilitation and support to people with SMI.
Mobile crisis teams	Mobile crisis teams consist of mental health professionals who provide on-site crisis assessment, intervention and stabilization services.
Mobile recovery units	These are vehicles equipped to provide a range of recovery support services in various community locations.
Care coordination	Care coordination is a required activity during the postcrisis period, as well as during crisis intervention itself.

Section III: Emerging Metrics of Success

For a detailed approach to choosing crisis system metrics to apply to your CCBHC(s), see **Quality Measurement in Crisis Services**, a National Council Medical Director Institute publication (National Council, n.d.-c).

CCBHC QUALITY MEASURES RELATED TO CRISIS SERVICES

Mandatory CCBHC measures directly related to crisis services include:

1. Time to Services (I-SERV) — including sub-measures of average time to Initial Evaluation, Initial Clinical Services, Crisis Services (beginning July 2024)
2. Follow-up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)
3. Follow-up After Hospitalization for Mental Illness, ages 6-17 (child/adolescent) (FUH-CH)
4. Follow-up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)
5. Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)

What to measure and why

Beyond the SAMHSA/CMS-required performance measures, CCBHCs, systems and states can and should require and support reporting of additional data and performance measures, to help them understand, manage and publicly demonstrate the impacts and value of their crisis system. Consider what metrics are meaningful for assessing crisis capacities and quality of supports. Additional metrics of value may include ED and police diversions responded to, response time for call, mobile crisis and emergency/urgent appointments.

"We believe strongly in monitoring activities related to crisis response and client care. We dashboard essential data for continued clinical quality improvements. We track call response time, readmissions, admission to higher levels of care, etc. We firmly hold true the notion that you can't improve a practice or resolve a problem if you are not aware of it, and you cannot be fully aware of it if not regularly monitoring."

— GRAND Mental Health

"Missouri was one of the eight initial states starting the CCBHC Demonstration. By the **fifth year** of operation, Missouri CCBHCs were reporting 74% follow-up after hospitalization for mental illness in 30 days for adults (versus the national median of 54.7%) and 75% for children and youth (national median 66%). Regarding emergency department follow-up visits following mental illness they were performing at 41% within seven days (national median 39.6%) and 66% within 30 days (national median 52.1%). The number of hospital emergency department visits had decreased by 16% per thousand member months, and the number of hospital encounters per thousand member months had decreased by 27%. In terms of diverting people in crisis from law enforcement, between 2021 and 2022 there was a 41% increase of referrals from law enforcement for crisis diversion." (Centers for Medicare and Medicaid Services, 2023)

Include measurement of care by unlicensed providers

Most HEDIS[9] measures only count client interactions with licensed mental health professionals toward meeting the requirements of the particular performance measures. However, CCBHCs frequently use unlicensed, qualified staff to meet service needs that in other settings would be delivered by licensed staff; this requires analysis that differs somewhat from traditional HEDIS measures. CCBHCs should capture data that backs up involvement of unlicensed staff, including peers. When required to report HEDIS measures that do not include qualified providers, such as Follow-up After Hospitalization for Mental Illness (FUH), the CCBHC should also report the same measure including any follow-ups by unlicensed providers. This provides a more accurate measure of the actual care the clients received and makes more sense in the context of substantial payments being made for unlicensed health care providers involved in hospital follow-ups in both the CCBHC and Health Home for Chronic Conditions Medicaid programs. While CCBHCs must report the above required measures using the stipulated provider specifications, they should concurrently report the same measures calculated using both licensed and unlicensed staff, with notation that it is a more accurate representation of the actual services provided.

Figure 2. Some HEDIS follow-up measures allow for inclusion of peer support services.

HEDIS measure: Peer Support Service With any Diagnosis of SUD or Drug Overdose

HCPCS:

G0177 — Training and educational services related to the care and treatment of patient's disabling mental health problems

H0024 & H0025 — Behavioral health prevention information dissemination service

H0038 — Self-help/peer services

H0039 & H0040 — Assertive Community Treatment program

H0046 — Mental health services not otherwise specified

H2014 — Skills training and development

H2023 — Supported employment

S9445 — Patient education, not otherwise classified, non-physician provider

T1012 — Alcohol and/or substance use services, skills development

T1016 — Case management

ICD-10: F10.xx-F19.xx or T40. xxxx-T43.xxxx, T51.xxxx

Incorporating peer services in measures

Recently, some HEDIS follow-up measures allow for inclusion of peer support services (Figure 2). For the Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) measure, the National Committee for Quality Assurance (NCQA) revised the measure name to Follow-up After ED Visit for Substance Use. Substance use services provided by a peer recovery support specialist now count toward meeting this measure.

CCBHCs should capture data that is indicative of the use and impact of peer support services. One option is using the service codes listed in Figure 2. When required to report HEDIS measures that do not include peer specialists as qualified providers, such as FUH, the CCBHC should also report the same measure including the follow-ups that were done by peer specialists and other unlicensed providers.

9 Healthcare Effectiveness Data and Information Set

USING DATA EFFECTIVELY

Perhaps the biggest learning curve for a new CCBHC is becoming competent in aggregating, understanding, stratifying and using data. Robust measurement strategies are imperative for continuous quality improvement, and skilled data usage is particularly important where multiple providers and care transitions must be managed, as with crisis situations. While performance reporting is mandated, it is not the most meaningful outcome of using data and metrics for success in CCBHC crisis systems.

The major uses of metrics for success in CCBHC crisis systems are:

1. Provide a realistic internal understanding of crisis system performance (i.e., "the big picture").
   - Provide open data access and technical assistance to support partner agencies in evaluating the crisis system.
2. Aid enrollment and panel management.
   - Evaluate adherence to evidence-based protocols for suicide risk screening, discharge planning, medication reconciliation, etc.
3. Support client-level monitoring.
   - Manage services and care transitions as people move through the crisis system, including disease registry.
   - Support care management to identify care gaps and generate to-do lists.
   - Monitor rates of crisis recidivism and ED use among high-risk client groups over time.
   - Survey individual satisfaction with coordination during crisis episodes and transitions.
   - Assess disparities in crisis care access, coordination and outcomes between demographic groups.

Expert insights

"Improved and swift access to services required by CCBHC standards will allow individuals to have improved access to service initiation post discharge from high levels of care, which will improve HEDIS measures."

— Carelon Behavioral Health

"We believe strongly in monitoring activities related to crisis response and client care. We dashboard essential data for continued clinical quality improvements. We track call response time, readmissions, admission to higher levels of care, etc. We firmly hold true the notion that you can't improve a practice or resolve a problem if you are not aware of it, and you cannot be fully aware of it if not regularly monitoring."

— GRAND Mental Health

"We should be mindful that Demonstration outcomes are different from expansion outcomes; data from burgeoning CCBHCs will reflect subpar performance versus more developed CCBHCs. Consider excluding the ramp-up period (initial six months or so) from outcomes analysis."

— National Council Medical Director Institute

4. Aggregate reporting to use in performance benchmarking to drive improvement. Transparent benchmarking improves attention and increases involvement.
   - Measure timeliness and level of care coordination between CCBHCs, hospitals/EDs, call centers, mobile crisis units and other partners.
   - Track use of crisis services before and after implementation of prevention-oriented, open-access models.
5. Telling your story to external audiences to build support by demonstrating the value CCBHCs bring to crisis systems.
6. Provide mandated reporting.

The first five items listed above are determined by what a CCBHC thinks it needs to manage and succeed as part of the local crisis system, and they should come before the externally mandated reporting. By achieving the first five items, the final item will not pose a challenge.

"We asked the legislature for seed money to do more urgent care and crisis units in our CCBHC model. Coming July 2024, every county over 20,000 [residents] will have an urgent recovery center. Our data shows that we have seen reductions in jail entries and reduced inpatient hospitalization dramatically."

— Oklahoma Department of Mental Health

Illustrating CCBHC impact: An example of effective CCBHC data use on a national scale

In June 2024, the National Council published its annual **CCBHC Impact Report**, which provides an example of how effective use of data illustrates CCBHCs' potential in crisis service systems planning, implementation and partnership (National Council, 2024a).

Section IV: Beyond Basic Requirements: Establishing Mature Crisis Systems and Capacities

GROWING AND SUSTAINING CRISIS SERVICES WITH THE CCBHC MODEL

CCBHC Demonstration grants are an important first step for many agencies, allowing them to enhance their crisis services by working toward CCBHC certification standards to the extent possible given the duration and amount of grant funding. With the availability of the CCBHC PPS methodology through the federal Demonstration or other Medicaid payment authorities, the new CCBHC crisis services become sustainable over time. The federal Demonstration has a longer time horizon than the SAMHSA CCBHC grants, and use of other Medicaid payment authorities extends the support indefinitely. The PPS protects against services being eroded by inflation, as compared to grant funding or fee-for-service (FFS) rates that do not automatically increase as the cost of providing crisis services increases. CCBHC PPS funds are available to Demonstration states, as well as states using other Medicaid authorities and several federal departments, including the Department of Justice, Department of Agriculture and Department of Health and Human Services.

"When an initial PPS is set, it sets the base for forward movement. After an initial full year of service, and at designated points thereafter, a thorough review of the cost report is utilized to establish the next round of PPS payments. This allows a CCBHC to invest in staff, programming, training and infrastructure, secure in the knowledge that eligible items will be included in the future cost report and therefore informing the next PPS."

— NASMHPD

LEVERAGING THE PPS TO EXPAND CRISIS SYSTEMS

While meeting fundamental certification requirements is an important first step, CCBHCs operating under a state PPS have far greater flexibility to strategically invest in crisis system infrastructure, partnerships, workforce and service capacity. With a PPS, CCBHCs receive a set reimbursement amount per client per month based on the anticipated cost of care, which can be leveraged to create a sustainable financial framework for expanding services and improving the health outcomes of the population served. This flexibility in funding allows CCBHCs to provide a wider range of crisis services tailored to individual needs, rather than being limited to only reimbursable services under FFS. For example, under a PPS, a CCBHC could provide comprehensive crisis assessment, stabilization, observation, referral to follow-up care and transportation for a client as part of the bundled PPS payment. FFS would require separate reimbursement codes and paperwork for each service, creating administrative burden and barriers. Additionally, adjustments to the PPS to further account for client severity and complexity of crisis cases, through risk-adjusted rates or outlier payments, could help support specialized intensive services for the highest-need clients.

PPS funding enables CCBHCs to create more comprehensive crisis services in line with requirements, including through the transfer of funds to DCOs. The CCBHC PPS methodology makes it easier to increase volume and access, and the services required for CCBHC certification can better meet the community's

needs. The initial PPS rate setting allows inclusion of anticipated costs above and beyond the historic costs of crisis services. CCBHCs involved in initial rate setting or replacement should work with their state to include the anticipated cost of the level of access and volume of CCBHC-required crisis services their community wants and needs. Some common anticipated costs that have been included in initial rate setting are increasing the number of mobile crisis teams to improve geographic distribution, increasing the number or capacity of crisis receiving and stabilization centers, increasing staffing or contract funding for 988 Lifeline and crisis lines to reduce call wait times, and covering IT costs for meeting care coordination requirements with other crisis providers. Further, under the PPS, CCBHCs can continue to build out services and add coverage for improved services over time through rebasing rates (i.e., setting new cost-related rates based on prior year costs).

"Having a statewide network of CCBHCs with PPS in Maine would have been helpful in providing a sustainable funding stream for ongoing support and expansion of our crisis centers; Overdose Prevention Through Intensive Outreach, Naloxone and Safety (OPTIONS) program; intensive case management services; secondary prevention resources and services; and appropriate, timely services to triage to from Maine's existing mobile crisis and Maine Crisis Line services. While these programs and services are operating in Maine already, they can be challenging to obtain or ineligible for other Medicaid reimbursement mechanisms; some are grant dependent; some are vulnerable to state budget cuts; and many would be vulnerable to discontinuation or reduction if a future administration does not consider them priorities for state spending. Having stability of a PPS with significant federal match built into MaineCare rules could provide more protections for these programs and services; may improve workforce recruitment if programs are seen as having more financial stability as opposed to unknown future post-grant/contract; and would reduce inefficiencies of multiple contracts."

— NASMHPD

"An as-yet-unknown percentage of persons who are served through expanded crisis services will need ongoing treatment through referral to the outpatient system. A prospective funding mechanism tied to the comprehensive service array offered via the CCBHC model will facilitate the ability to plan for these services and absorb the excess need that crisis service expansion is likely to create."

— Philadelphia Department of Behavioral Health and Intellectual Disability Services

"In our crisis continuum, services funded via PPS include:

- **Risk assessment and crisis/safety planning (done as standard operating procedure via CCBHC services).**
- **24/7/365 after-hours crisis line for CCBHC clients (staffed with clinical supervisors on a rotating on-call basis).**
- **In-person community-based outreach with a three-hour maximum response time during business hours (staffed with peers and clinical staff for safety and two-person response).**
- **Immediate access to crisis appointments, either in person or virtual, during CCBHC operating hours (staffed with existing CCBHC clinical staff).**
- **Three-hour maximum response time for in-person visits (via DCO contract).**
- **Overnight availability for in-person appointments — via the DCO contract, we pay an on-call rate for staff members to be available for crisis calls for 11 p.m.-7 a.m., and pay the staff's regular hourly rate for in-person visits required during that timeframe."**

— Central Nassau Guidance and Counseling Services

More robust service provision

By including the anticipated new cost in their PPS rate, CCBHCs can enhance their existing crisis services, such as comprehensive crisis receiving and stabilization facilities offering a broader spectrum of urgent assessments, observation stays, medication services, withdrawal management and peer supports. The CCBHC PPS anticipated-cost methodology makes it easier to implement entirely new, effective, innovative crisis services beyond the CCBHC required crisis services, allowing communities to flexibly adjust for the different needs of rural and urban communities. Urban communities may choose to implement ED diversion to further address ED boarding and reduce inpatient hospital use. Virtual care and remote crisis support and service for first responders and others can benefit rural communities, where the workforce limitations may be even greater than in urban or suburban areas. PPS cost reports can also flexibly address the needs of specific subpopulations, such as including the cost of new crisis staff with more advanced credentials or with special background and expertise in providing crisis service to special populations.

Funding is often a constraint on behavioral health providers' ability to fully leverage or optimize health information technology (HIT). CCBHC grantees can leverage SAMHSA grant funding to support initial investments, when possible. However, sustainable support for leveraging HIT is most achievable through PPS funding, where initial infrastructure and ongoing costs can be incorporated into the CCBHC cost report and prospective rate. The CCBHC PPS methodology's ability to include the cost of IT systems needed for ATC, coordination and crisis health information exchange is particular valuable for local crisis systems that otherwise lack this capability.

With adequate and sustainable PPS funding accounted for up front in rate calculations, CCBHCs can consistently maintain enough staffing, facilities, vehicles, supplies and other direct service capacity to fulfill a broad range of crisis needs without gaps.

"Burrell's CCBHC PPS has truly been the fuel that has allowed our expanding services to take flight in the community. Because of CCHBC, we have been able to invest in system supports at a level unheard of prior to this model. In support of our Behavioral Health Crisis Centers and expanded crisis services, we have particularly invested in facilities and facility management to build out infrastructure, the IT and physical equipment needs of additional staff, the recruitment and hiring of trained and in-demand professionals to staff these 24/7 crisis services, and public relations and marketing efforts to engage the public and local stakeholders — especially the medical community, law enforcement and referral partners in the mental health and SUD spaces."

— Burrell Behavioral Health

Infrastructure and accessibility

CCBHCs need to make significant investments in infrastructure, technology, facilities and other capabilities that make crisis services more robust and accessible. For example, reimbursement can cover:

- Cloud-based care coordination and health information systems linking the CCBHC with hospitals, call centers, providers and justice agencies for seamless coordination.
- Data analytic capabilities to enhance management, planning and communicating the impact and value of your crisis system.
- Online therapist matching and scheduling platforms that allow for prompt appointments after crisis episodes.
- Dedicated crisis call center phone systems, chat/text platforms and databases.
- Video technology for remote crisis assessments, especially in rural regions.
- Crisis stabilization center and observation unit facilities providing appropriate therapeutic environments.
- Adding more staff for expanded capacity for walk-in urgent care appointments.
- Transportation services to ensure access to stabilization.
- Dedicated staff support for quality control, including IT specialists and data and evaluation staff.

"The PPS model facilitates funding of services not currently covered. For example, Arizona recently passed a law to allow for alternative transportation (in lieu of law enforcement) for involuntary individuals, but it is not yet clear how this will be financed. CCBHCs could fill this gap. PPS-funded services can also cover nonbillable care coordination activities, such as clinic staff working with clients while they are in the hospital or crisis facilities, helping individuals enroll in services and apply for benefits, and postcrisis wraparound care. Finally, CCBHC/PPS payment models can support the move from fee-for-service to value-based payment incentives tied to outcomes like readmissions, seven-day follow-up after a crisis episode, etc."

— Connections Health Solutions

Sustainability

Sustainability is an immediate challenge for CCBHC crisis service and crisis system enhancements funded by grants. State implementation of a CCBHC PPS methodology — through either successfully applying for and joining the federal CCBHC Demonstration or independently coming to agreement with CMS to use a Medicaid state plan amendment or waiver authority — is the most reliable way to achieve sustainability of the initial gains made under grant funding. Further, because the PPS is only available through state sponsorship, it provides better alignment on the state-specific CCBHC approaches and goals between state agencies and provider communities, which also substantially enhances overall operational sustainability. The PPS addresses the sustainability challenges of increasing costs of care over time and changes in types and service over time, via requirements for periodic cost rebasing and the state's option to allow for anticipated costs when it seeks to implement new types of crisis services or increase access to crisis services.

"The CCBHC PPS model has the potential to further strengthen and enhance the Arizona crisis system. Cost-based payments can help strengthen the workforce by compensating for the rising cost of staff, reducing turnover and ensuring adequate 'firehouse model'[10] staffing for programs with lower volumes, such as those covering rural areas or youth services."

— Connections Health Solutions

Workforce investments

Direct service expansion and technology investments will flounder without specialized crisis staff. The PPS enables smart workforce investments like:

- Incentives, tuition reimbursements and scholarships to recruit and train mental health professionals, peer supports and outreach workers for 24/7 crisis response roles.
- Salary enhancements to attract and retain skilled crisis care nurses, counselors and social workers.
- Resources to support internships and on-site training programs with local colleges and universities.
- Support for crisis telehealth partners to provide remote expertise across large service areas.
- Extensive crisis intervention, risk assessment, de-escalation and trauma-informed care training for all client-facing staff.
- Peer specialist certification programs to develop lived experience expertise.
- Leadership development for ATC and system coordination roles.

Payment freed from visit limitations gives CCBHCs latitude to build a robust crisis workforce.

10 The "firehouse model" denotes operations of (and the funding mechanisms to support) mobile crisis service providers who are on call and able to be dispatched at all times to anyone in crisis, regardless of insurance status — similar to other emergency services like fire departments (SAMHSA, 2020).

"CCBHCs need business acumen to build infrastructure to prevent bottlenecks. That might mean building more locations; turning resumes around in 24 hours and hiring on the spot when needed; instilling key performance indicators that relate to resume review and bonuses. Put people in positions where they are happy. Clinicians get to be clinicians and other roles are hired for with people that want to do marketing, for example."

— Missouri Behavioral Health Council

"In Missouri, the PPS payment model has assisted our CCBHCs across our state in creating the infrastructure needed to achieve ongoing growth in both workforce and clients served by embedding it within their overall cost. Currently, we are onboarding about 77 new FTEs a week (currently over 4,300 FTEs). We have also developed a robust training institute for all new employees that they attend prior to starting their role. We have been able to do this by identifying unmet needs in the communities (state-defined) we serve and bringing the services to them by same-day access to care, serving almost 3,000 new individuals every month."

— Compass Health Network

Coordinated system oversight

On top of expanded services and capacity, the PPS provides resources for CCBHCs to take on coordinated system oversight responsibilities for their regions, such as:

- Serving as the designated crisis system access point to conduct assessments, assign severity levels and connect people to appropriate services.
- Operating a 24/7 crisis bed inventory and referral tracking system.
- Monitoring high utilizers and flagging risk factors based on health record integration.
- Managing transitions through care coordination teams working across providers.
- Assessing capacity, gaps and outcomes through data analytics.

This ATC role brings improved efficiency, performance monitoring and person-centered coordination.

STATE OPTIONS FOR POSITIONING CRISIS SYSTEM COSTS IN THEIR PPS RATE(S)

This section covers specific considerations for states when structuring their specific PPS rate methodology. CMS initially offered states two PPS options: a daily model known as PPS-1 and a monthly model known as PPS-2. PPS-2 allowed states to set distinct rates for special populations with higher-intensity needs. Originally, crisis service costs were to be included with all other CCBHC costs in developing a single daily PPS rate for each CCBHC (PPS-1) or more than one monthly PPS rate for multiple separate populations (PPS-2).

In February 2024, CMS release **updated PPS guidance** that included two additional PPS options for states that cover the high-cost and specialized care delivered through mobile and on-site crisis intervention services directly to people in need.

- PPS-3 offers states the option to reimburse CCBHCs daily, including through daily Special Crisis Services (SCS) rates, which allow states to set separate PPS rates for CCBHC crisis services.
- PPS-4 offers states the option to reimburse CCBHCs monthly, including monthly SCS rates. Quality Bonus Payments[11] are also required under this PPS-4 structure.
- Overall, this updated PPS guidance is effective as of January 1, 2024, for existing CCBHC Demonstration states and as of July 1, 2024, for newly selected states added to the program in 2024 and 2026.
- The new guidance also removes the previous requirement that PPS-4 have different rates for special populations. States now have the option to offer a single PPS-4 rate for all populations. Further, in response to numerous states that legislated costs for the 988 Lifeline into the PPS, CMS clarified that states may claim Federal Medical Assistance Percentages (FMAP) for the 988 Lifeline only as an administrative expense and not through the PPS rate.

For stakeholders accustomed to FFS payment, the PPS represents a shift in cost estimation and reporting. States should be prepared to support clinics with their cost reporting skill development and to review cost reports for accuracy, practicality and actuarial soundness. Further, states will need to consider optimizing claims and data infrastructure to understand changes in outpatient behavioral health system costs, along with changes to costs and utilization across other health care settings, such as primary care and hospitals.

11 The separate PPS rate for selected qualifying crisis services can make it easier to document costs eligible for FMAP match, which is higher than for other CCBHC services.

Separate cost-based rate for special crisis services for CCBHC Demonstration participants

In [its May 2023] guidance, CMS sets forth three approaches for CCBHC Demonstration states using the proposed PPS-3 (daily) or PPS-4 (monthly) rate methodologies to create a separate daily cost-based rate for mobile crisis and on-site crisis stabilization services and receive enhanced federal funding. CCBHC Demonstration states would need to select at least one of the options for daily special crisis service rates. Mobile crisis and crisis stabilization are some of the most expensive services to provide due to the cost of the multidisciplinary provider team, the immediate response requirement and the supplies and medications necessary to maintain readiness. The proposed daily rates for special crisis services are intended to support expansion of these critical services.[12]

Option 1: Mobile crisis services that meet CMS criteria for qualifying community-based crisis intervention services

This option allows for a separate reimbursement rate for qualifying mobile crisis services that would be matched at 85% federal matching rate (FMAP) for the first three years (i.e., twelve fiscal quarters) that mobile crisis services meet the requirements of Section 1947(d) of the Social Security Act. Qualifying mobile crisis services require clients to be treated in the community by a multidisciplinary team trained in trauma-informed care, de-escalation and secondary prevention strategies. Absent congressional action, the 85% FMAP is set to expire on March 31, 2027.

Option 2: Mobile crisis services authorized under CCBHC programs that do not meet the CMS criteria for qualifying community-based intervention services

This option allows for a separate reimbursement rate for mobile crisis services that do not meet the statutory criteria that would be matched at the standard Children's Health Insurance Program (CHIP) rate.

Option 3: On-site crisis stabilization at the CCBHC

This option allows for a separate reimbursement rate for on-site crisis stabilization services that would be matched at the enhanced CHIP rate.

(FTI Consulting, 2023)

Since only mobile crisis and on-site crisis stabilization services can receive enhanced federal funding, all other crisis service costs will be included in the PPS-1 or PPS-2 rate. All CCBHCs getting a PPS-3 daily rate will also get a PPS-1 daily rate. All CCBHCs getting a PPS-4 monthly rate will also get a PPS-2 monthly rate.

For all PPS rates that states propose, some component of crisis service triggers a PPS payment; costs for other services that do not trigger a PPS payment are averaged into PPS rate, and in that way are also reimbursed. Choosing high-volume traditional services for triggering PPS payments and carrying the cost of low-volume, sporadic and nontraditional services as costs averaged into the PPS has the advantage of easier administration and reporting and more even cash flow.

Effective crisis interventions can be at locations (ERs, jails, courts) or provided by staff that are not billable under usual Medicaid FFS plan options or may be services that do not have a defined billing code (e.g., crisis consultation to law enforcement) under usual Medicaid FFS plan options. All these costs can potentially be covered by including them in a PPS rate as a non-triggering service. States implementing CCBHC crisis services should carefully review their budgets for any crisis-related spending for providing services to, or building capacity for serving, Medicaid recipients that is currently paid for by state or local revenue funds without any federal match participation. Most of these costs will be Medicaid matchable as a CCBHC cost, unless related to residential treatment.

12 There are quality bonus payments under the PPS methodology that allow states to reward clinics for achieving quality improvement targets set using CCBHC quality measures established in the SAMHSA criteria.

Using DCOs to enhance strategic partnerships

CCBHCs can use reimbursement through the PPS to contract with external providers that augment services and fill critical niches across the crisis continuum, beyond minimal CCBHC-required services. This allows each partner to focus on its own strengths while still ensuring comprehensive coverage. For example, clinics can contract with separate youth-focused mobile crisis teams, withdrawal management providers or crisis residential programs to handle crises requiring those specialized services, while the CCBHC provides 24/7 intake, triage and general stabilization.

The expectations of collaboration and accountability within DCO partnerships can be difficult to establish and maintain without adequate funding and incentives. The PPS provides an opportunity to engage with partners to adequately assess the costs of their service delivery and the additional activities and infrastructure required to meet CCBHC requirements and allocate funding to adequately resource partners, support and incentivize best practices and sustain collaborative efforts. Shared infrastructure investments, like integrated care coordination software or interoperability connection costs accessible to the CCBHC and partners, can further integration.

"In Missouri, we have six 988 [Lifeline] crisis call centers, of which three are CCBHCs and the other three are DCOs for the other statewide CCBHCs. We have a 988 [Lifeline] task force that is [composed] of these six centers as well as additional stakeholders, including other CCBHCs. Missouri used its state authority to interpret and approve CCBHC certification standards to require that the CCBHCs be part of and actively involved in the governance of the statewide 988 [Lifeline] system. DCO funding made it possible to bring in nine CCBHC 988 Lifeline call center providers. This created statewide approaches to crisis line, mobile crisis and behavioral health crisis centers and urgent cares. By bringing everyone to the table, we are ensuring standardized crisis services for all Missourians. The state-led collaborative approach was particularly helpful in resolving differences in coming to agreement over how to provide services in areas of the state where CCBHCs had overlapping service areas. This helps to provide a consistent message for those utilizing 988, especially first responders in understanding what we can provide, and help with getting individuals connected to real-time behavioral health services when they need them. The CCBHC standard requirements, along with bringing in outside providers using the DCO relationship, both permitted and incentivized a consistent single statewide 988 [Lifeline] crisis call approach

— Compass Health Network

Section V: Using the CCBHC Model to Support Statewide Crisis Services Implementation

MOVING FROM CRISIS SERVICES IMPLEMENTATION TO CRISIS SYSTEM DEVELOPMENT AND LEADERSHIP

Using the CCBHC model to support statewide crisis services implementation encourages states, CCBHCs and their community partners to work together toward creating a seamless continuum of care for people experiencing a crisis, as opposed to operating within a fragmented system of services that may not adequately meet the needs of those served.

- **State crisis system needs assessment:** The first critical step for states is to conduct a thorough needs assessment to identify gaps within their current crisis services system. This assessment should cover the entire continuum of crisis care, from early intervention and crisis prevention to crisis response services and postcrisis support. States need to evaluate the availability, accessibility and quality of current services, identifying areas where needs are not being met, especially for underserved or minoritized populations.
- **Systems-level planning and design engagement:** Once gaps have been identified, states are expected to ensure that CCBHCs, whether grantees or non-grantees, actively participate in the systems-level planning and design process. This means that CCBHCs should not only be informed about the strategic direction and needs identified in a statewide needs assessment, but they also should be involved in creating and implementing solutions. CCBHC engagement ensures that the planning process benefits from their expertise and insights, particularly in areas such as evidence-based practices, community engagement and service integration. This collaborative approach facilitates the development of a cohesive and coordinated crisis system that leverages the strengths of CCBHCs and community partners to meet identified needs.
- **Defining roles and expectations:** A clear definition of roles among the various players in the crisis system is essential for effective collaboration and service delivery. It is critical that states delineate the roles of CCBHCs in relation to other crisis service providers, such as EDs, law enforcement, social services and other mental health and substance use service providers. This clarity helps to ensure that each entity understands its responsibilities and how it fits into the broader system of crisis care, promoting seamless coordination and integration of services.
- **Identifying requirements and expectations:** Based on the identified crisis gaps and the roles defined for CCBHCs, states must then specify what they expect from CCBHCs in terms of supporting these gaps within the parameters of the CCBHC model. This could involve setting additional criteria or requirements for CCBHCs, such as specific services that must be offered, standards for accessibility and response times, or expectations for coordination with other crisis services. These requirements should be aligned with the CCBHC criteria while also allowing for the flexibility needed to address local needs and gaps. These might include enhanced services for particular populations, additional staff training on crisis intervention strategies, or specific metrics for success in addressing crisis gaps.

Implementation of the CCBHC model within a PPS model offers a strategic avenue for states to develop or enhance a more cohesive and effective crisis services continuum, by incentivizing the provision of comprehensive, coordinated and quality care with a fixed payment rate for services. The PPS model also provides a mechanism for fairer funding and resource allocation, ensuring that CCBHCs across the state have the financial support to maintain a consistent level of service. The PPS model provides a financial framework that supports the integration of services and collaboration among CCBHCs and other providers and stakeholders.

In this context, a CCBHC within a PPS model can assume various roles depending on the existing mental health authority structure within the state. For instance, in states like Missouri, Texas, Oklahoma and Vermont, where there is already a designated Community Mental Health Center (CMHC) or Local Mental Health Authority (LMHA), a CCBHC could directly take on the role of the lead agency for local crisis planning and coordination. This position enables the CCBHC to leverage its resources and capabilities to spearhead efforts to identify gaps in crisis services, design comprehensive response strategies and ensure the delivery of coordinated care across the continuum.

In scenarios where states operate under a county or CSB system, a CCBHC can play a pivotal role in encouraging the convening of existing accountable entities and other stakeholders. Through this collaborative approach, CCBHCs can help to establish a structured and integrated crisis services framework that aligns with the unique needs of the community. This could involve coordinating with local governments, other mental health and substance use service providers, emergency services and community organizations to develop a more integrated plan for crisis prevention, intervention and recovery services.

Furthermore, in large urban areas or regions with an array of providers and payers, CCBHCs can partner with regional leadership to help lead the formation of community focused crisis collaborations within the region. By partnering with a network of providers, payers and other relevant stakeholders, CCBHCs can work toward creating a coordinated and comprehensive crisis response system for a defined geography. This approach allows for the potential pooling of resources, sharing of best practices and implementation of standardized protocols across providers, enhancing the overall effectiveness and efficiency of crisis services.

Example of state level planning

"The Missouri CCBHC service model includes the requirements for Zero Suicide, trauma-informed care and a statewide provider-operated data warehouse/management IT system that were developed from the beginning by the joint Missouri DMH [Department of Mental Health] and provider coalition operations committee. The requirements were by consensus of the joint operations committee members that included both DMH and provider opinion leaders. Zero Suicide was originally a Missouri provider coalition proposal, and the trauma-informed care was originally a DMH proposal. Missouri intentionally avoided the state and providers first holding separate internal meetings and each coming up with their proposal and vision that would later have to be reconciled. The Missouri process was to have joint discussions from the beginning, before anybody had even come to a final preference or position on the different pieces of the service model. This approach builds consensus in a way that extends rather than damages relationships. The states and their provider group were able to build in the staffing expectations and cover the cost of the required staff training time service cost and the IT infrastructure needed to implement the innovative services that are possible but not required in the CCBHC model."

– Former Director, MO HealthNet (Missouri Medicaid)

"We set up multiple work groups with CCBHCs and the state. This became more challenging with more planning grants and more clinics, so we have had to reestablish what that relationship looks like over time. State medical directors can only partner with collectives that have herd discipline. Collectives need to get in order to work with the Medicaid office. Don't be afraid to ask the questions, and also be strategic about what you ask for; asking for everything will slow things down. Where the state did not have bandwidth, our partnership with the state association helped to leverage for action."

— Alluma

OPPORTUNITY TO BUILD INFRASTRUCTURE AND FUND POPULATION HEALTH MANAGEMENT AND PREVENTION PROGRAMS

HIT and data systems that support effective population health management are critical but costly infrastructure needs. By using the PPS methodology to fund these investments, states and CCBHCs can enhance their capacity for data collection, analysis and sharing. This includes adopting EHRs that are interoperable with other health and social service providers, implementing health information exchanges (HIEs) and using data analytics tools. These technologies enable CCBHCs to identify health trends, risk factors and service gaps within the population they serve, facilitating targeted interventions and the coordination of care across providers.

The financial stability provided by the PPS model allows CCBHCs to expand their offerings to include a broader range of prevention and early intervention services. This can include community outreach programs, school-based services, early screening and assessment, and wellness programs aimed at preventing the onset of behavioral health conditions. By investing in these services, CCBHCs can work upstream to mitigate risk factors and reduce the incidence and severity of mental health and substance use disorders in their communities.

Building a skilled workforce is vital for effective population health management and prevention. The PPS funding model can support the development of training programs for staff on the latest evidence-based practices in integrated care and the use of data in population health management. Investing in workforce development ensures that the CCBHC staff are equipped to provide high-quality, person-centered care that meets the evolving needs of the population.

Additionally, CCBHCs must establish continuous quality improvement and evaluation processes to assess the effectiveness of their population health management and prevention efforts. This involves setting measurable objectives, collecting and analyzing data on outcomes and making data-driven adjustments to programs and services. The PPS methodology provides the financial stability needed to support these ongoing evaluation efforts, ensuring that CCBHCs can adapt to changing needs and continuously improve the health outcomes of their populations.

"The Missouri Behavioral Health Council (MBHC) is a unique state association, in that we provide more than just advocacy to our members. In addition to our administrative arm, we also have a training and events team, an HIT team and a clinical team. To help support all the MBHC lines of service, our CCBHC members built into their cost reports a management fee for training, technical assistance and our statewide HIT platform. The management fee, approved by DMH and the Missouri Department of Social Services, MO HealthNet Division, is calculated based on expected annual PPS visits. All the MBHC services are then provided back to the CCBHCs in an efficient, uniform and collaborative approach. Throughout each year, MBHC plans and hosts trainings for CCBHC-required evidence-based practices, CCBHC learning collaboratives and CCBHC leadership meetings. MBHC plans and facilitates quarterly Data Advisory Board, Health Home director, medical director and clinical director meetings. MBHC provides program management for several Missouri-specific CCBHC crisis programs, such as Community Behavioral Health Liaisons, Emergency Room Enhancement, Youth Behavioral Health Liaisons and the statewide crisis dispatch and referral platform. And finally, MBHC hosts the statewide HIT platform used to coordinate care, manage alerts and care gaps, monitor health outcomes and inform population health and decision-making strategies."

— Missouri Behavioral Health Council

"Braided funding mechanisms can also add additional support to PPS-funded CCBHCs. In Washington state today, regional ASOs [administrative services organizations] convened by the state charge MCOs a per-member per-month rate, so all of their members can access crisis services offered primarily by CMHCs, many of which will ultimately be CCBHCs. These payments bolster the capacity of the CMHC/CCBHC providers, to allow them to provide crisis services based on capacity. Similar to the PPS payments they will receive for others, CCBHCs can blend these funds to allow greater capacity to bolster response that would not be possible on traditional fee-for-services payments. Leveraging PPS and capacity MCO funding where enacted has the potential to improve the responsiveness and quality of vital crisis services, support an expanded workforce funded by these enhanced funds and ensure access to all comers. This is a strong example of MCOs, states, ASOs and CCBHCs working in concert to tackle capacity and workforce challenges."

— Carelon Behavioral Health

OPPORTUNITIES TO PLAN FIRST AND FUND LATER

The PPS model provides an opportunity to plan first, and then use the model to determine the costs and reimbursement aligned with the plan. Ongoing refinements to the PPS aim to give CCBHCs the resources and flexibility to create crisis systems that can truly serve the needs of their communities.

Examples of this might include:

- Identifying and resourcing the role of the CCBHC as (or in partnership with) the "accountable entity" for the community crisis system, and supporting local collaborations with hospitals, first responders and other services.
- Ensuring resources to build the mental health and SUD crisis continuum (988 Lifeline, behavioral health urgent care, mobile crisis, crisis centers, residential crisis services, intensive follow up) for adults and children to scale, and with adequate resources to pay for 24/7 "firehouse" capacity.
- Ensuring resources for "indirect" but critical infrastructure, like transportation and training.
- Establishing resources for individual care coordination, ATC and collective population management.
- Developing local and state strategies for enhancing engagement and retention of the behavioral health crisis workforce.
- Expanding telehealth services for rural or underserved populations, to extend their reach. CCBHCs can determine the costs associated with launching and sustaining this program, including technology acquisition, staff training and ongoing operational costs.
- Implementing a community outreach program based on assessed need and gaps in services, such as a community outreach program aimed at preventing substance use among teenagers.

OPPORTUNITIES FOR STATEWIDE CONSISTENCY

The PPS model also allows for statewide consistency in crisis services and crisis system operation across each community. This consistency is crucial for ensuring that people experiencing a behavioral health crisis can expect a similar quality and scope of services, regardless of where they are located within the state. While a PPS doesn't automatically lead to standardization, development of the following common aspects of service delivery, measurement and funding may facilitate a more uniform and fair approach to crisis care:

- Development of common crisis system service models — standardization guarantees that anyone experiencing a crisis will receive timely and appropriate care, regardless of their location — directly or indirectly supported by the PPS model.
- Development of crisis system performance metrics that can be connected to PPS-2 payment methodology and incentives.
- Standardization of expectations for how various community entities (e.g., law enforcement officials, hospitals) are expected to partner with the CCBHC and the community crisis system.
- Development and implementation of a standardized training curriculum on crisis intervention strategies, trauma-informed care and the use of evidence-based practices in treatment. This ensures that all staff, regardless of their specific location, are equally prepared to meet the needs of people in crisis.
- Development of comprehensive training program that includes simulation-based learning experiences and expert-led workshops focused on enhancing the skills of crisis intervention teams.

"MBHC works collaboratively with the Missouri DMH by sharing the responsibility of work to be done to improve crisis services. MBHC staffs a crisis services manager who works directly with the DMH crisis services coordinator. This partnership allows the CCBHC providers to have a voice on statewide crisis services policy and procedure decisions. For example, the state's 988 Committee started at MBHC at the suggestion of a leader of a member CCBHC. As the 988 [Lifeline] work began to increase, DMH acquired an FTE [full-time equivalent] dedicated to the work. MBHC dedicated part of an FTE to organize, schedule and communicate with the state's National Suicide Prevention Lifeline (NSPL) call centers and work with the committee chair (leadership from a CCBHC/NSPL call center) and DMH to plan meeting agendas, create draft documents and solicit feedback from CCBHCs and the call centers. (Note: Not all the NSPL/988 [Lifeline] call centers were/are members of MBHC, nor are they all CCBHCs.) When the committee determined that it was time to engage 911, MBHC contacted the Missouri 911 Service Board to engage 911 Service Board members into the 988 Committee. MBHC also served as the conduit to contract with an expert third party to complete a SWOT analysis of the Missouri crisis system. All the steps taken throughout the planning and implementation of [the] 988 [Lifeline] was done with open communication between DMH, MBHC, the crisis call centers and CCBHCs."

— Missouri Behavioral Health Council

Section VI: Recommendations for Behavioral Health System Leaders: Next Steps Toward Statewide Implementation of CCBHCs in Crisis Systems

WHAT HAVE WE LEARNED IN THE PREVIOUS SECTIONS

Summarizing the main points of the previous sections and the implications for state systems that have not yet fully implemented the CCBHC PPS in their crisis systems, here's what have we learned:

- **CCBHC basic requirements:** All CCBHCs — grantees and PPS funded — are required to meet basic requirements for crisis services provision, directly or with DCOs, as well as to partner effectively within their communities to help build a comprehensive crisis system with a full continuum of crisis services.
- **CCBHC expanded capabilities with the PPS:** CCBHCs with a PPS, as they mature, can provide additional capacity — including services, workforce and technology development — that further enhance the value they can bring to the community crisis system.
- **Statewide CCBHC expanded crisis system capacity with the PPS:** States that have implemented the CCBHC model with a PPS statewide have been able to achieve significant progress in the development of crisis services and systems to scale throughout the state, as well as to have a funding source for elements of crisis services that are not easily supported by FFS billing, such as ATC and 24-hour "firehouse" availability.
- **CCBHC and PPS crisis metrics demonstrating value:** Evolving crisis system metrics can be aligned with CCBHC metrics and PPS performance incentives, to further connect crisis system development to identifiable measures of progress that can demonstrate the value of CCBHC PPS implementation in crisis systems to all stakeholders, including Medicaid agencies and MCOs.

In this section, the focus is on helping states, counties/regional entities and other stakeholders to identify next steps that might help them advance their ability to use CCBHCs systemwide, with the PPS, to help develop their capacity to take crisis systems to scale in every community.

NEXT STEPS FOR STATES

Note: Help is available. The newly launched **CCBHC State Technical Assistance Center (S-TAC),** funded by SAMHSA, is able to provide individual consultation and technical assistance to states on all aspects of CCBHC implementation, including crisis services, as well as providing learning communities where state teams work with subject matter experts to advance their state's ability to implement CCBHC funding and services in their crisis systems.

Developing the state's vision of crisis system development and the CCBHC's role

No matter what level of progress a state or tribe has made in developing its crisis system to scale, and no matter what level of development of CCBHCs and CCBHC funding within that state, it will be helpful to begin by designating a leadership team at the state level, in partnership with intermediaries as appropriate, to define the state's vision for its crisis system and the role of the CCBHCs within that vision. There are many potential funding opportunities (planning and Demonstration grants, for example) and many strategic implementation details (types of services, type of PPS, workforce designations, procuring statewide population health management data platform through CCBHC shared funding, etc.) to be determined in each state, and those myriad decision points will be best informed by having a sense of direction for the state's ultimate target.

*See **Appendix 4** for a visioning exercise developed by the CCBHC S-TAC to help states participating in the CCBHC Crisis Learning Community.*

Once the state has a vision for allocation of responsibility to "accountable entities," and an approach to assigning roles for CCBHCs within each designated geography in partnership with those accountable entities, the state can then begin to address how to design its PPS to match its administrative and financing structure.

State-level strategic planning, in collaboration with intermediaries (e.g., counties, CSBs, MCOs) and providers (CCBHC grantees and non-grantees), with the long-term vision in mind is the best approach to maximizing value from statewide CCBHCs, with the PPS as the backbone of the crisis system.

It is least complicated in states where there is a lead provider that is also logically designated as the accountable entity, as in Missouri, where there are designated CMHC/CCBHC administrative agents, or in Texas, where the LMHAs are CCBHCs statewide. However, it is still possible to delineate, even in more complex systems. For example, Michigan's regional Prepaid Inpatient Health Plans manage Medicaid for the SMI/SED population, as well as

Over the long term, CCBHCs *with a PPS* work best when the following conditions are put in place:

- There is statewide coverage, with CCBHCs in each designated geography having a defined role in the crisis system. This allows for common metrics and financial planning across the state.
- There is regular re-basing (every two years minimum), so that CCBHCs can invest in developing services and infrastructure during each funding cycle with the security that those investments will be recouped through the cost report into their future PPS rates.
- The rate structure and quality incentives are designed to reinforce the development of all aspects of the crisis continuum in each designated geography.
- Current transitional funding mechanisms — such as temporary enhanced FMAP for mobile crisis — are carefully planned and transitioned into the CCBHC funding structure, not only to provide for sustainability, but also for supporting essential "non-billable" infrastructure development that FFS models cannot support.

behavioral health acute care services, and work on the ground with local community mental health boards for each county, as well as with MCO health plans that integrate a "mild/moderate" payment benefit. Michigan developed a statewide funding approach for CCBHC implementation, including within crisis services, that fit its structure (Michigan Department of Health and Human Services Behavioral and Physical Health and Aging Services Administration, 2023).[12]

Using CCBHCs in state systems with differing administrative financing structures

States vary widely in the administrative and financing structures they have developed to support their behavioral health and crisis service systems. They can be county-based, assigned catchment areas that are not specific to single counties, or without assigned service areas. They can have relatively close provider panels, highly specific types or open panels without provider type restrictions. Through use of specific choice points, the model can be adapted to the full range of administrative and financing environments.

Defining the crisis system needs specific to your state

The Roadmap to the Ideal Crisis System (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021) provides a crisis system self-assessment tool that can help work groups identify current services and capabilities as well as crisis service system gaps that merit attention. Gaps in services and supports may then be cross-referenced with (a) basic SAMHSA CCBHC certification criteria related to crisis systems, and (b) those that extend beyond the minimal requirements, as laid out in Section III of this report. The state should review current expenditures of state funds used to support crisis services in the Medicaid population that are not currently billable to Medicaid through existing payment mechanisms. Next, further assess which of these expenditures are allowable costs, either as direct service or indirect infrastructure in CCBHC cost reports. This identifies the state's potential to leverage additional federal matching funds for current crisis services, if those services were provided via a CCBHC. Taken together, these gap and financial analyses illuminate opportunities for implementing a more comprehensive crisis service system through CCBHC implementation.

Approaches for states with SAMHSA CCBHC grants (non-PPS)

The gap analysis process described above is best used in ongoing collaborative planning that engages both state staff and providers. SAMHSA CCBHC grants to provider organizations and planning grants to states have greater impact for both entities when the resources are used with consultation and collaboration between them.

Approaches for states in the CCBHC Demonstration or with CCBHCs under other Medicaid authorities

Assuring the state ends up with an appropriate number of quality CCBHCs

As noted previously, CCBHCs are most valuable to the state's crisis system when there is a functional CCBHC contributing to crisis system development in every designated region in the state. Therefore, states can productively consider how to incentivize providers to initiate and sustain the process of becoming a CCBHC (including with state funds in addition to federal grants), while investing in the continued provision of training and technical assistance to help the emerging CCBHCs develop quality crisis services and meet evolving quality metrics. The long-term benefit of having CCBHCs using a PPS to support statewide crisis services, let alone other services, is likely to be worth the investment.

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12 For a description of the PPS approach used in Michigan, see Section 5 (page 29, "CCBHC Payment") of the **Michigan Department of Health and Human Services' CCBHC Handbook**.

Note that states retain control of their CCBHC provider panel by determining when to certify that an organization is meeting CCBHC standards, approval of each CCBHC cost report, performance metric reporting and discretion in adding state-specific CCBHC certification standards. States define their own CCBHC certification process, which may include agency attestations that standards are met, desk review by state staff or contractors and on-site certification visits. States may require CCBHC accreditation by outside accreditation bodies as a condition of certification, or a combination of outside accreditation and their own separate certification review processes. States may decertify CCBHCs that fail to meet state certification standards. States develop their own process for review and approval of CCBHC audited cost reports. Setting a high bar for granting and continuing certification and approving cost reports, combined with availability of standardized performance data to identify quality problems, provides strong mechanisms for assuring high-quality, appropriately priced service. The comprehensive service and performance requirements in the CCBHC model limit the provider panel to relatively sophisticated organizations with strong management capabilities. The state's ability to add certification requirements provides additional opportunity to manage the CCBHC provider panel.

Integrating CCBHCs into the state crisis system

Many states have already invested substantial planning and funding resources into the development of their state crisis systems in the wake of 988 Lifeline implementation, and they may not be as far along in the development of CCBHCs. Enhanced Medicaid FMAP funding for mobile crisis may be directed to state-sanctioned crisis providers that may not yet (or may never) be CCBHCs. In states with an existing state-sanctioned, certified or licensed system or network for the provision of crisis behavioral health services, the CCBHC can provide crisis services directly or through a DCO agreement (SAMHSA, 2023c).

The long-term value of the CCBHC PPS still makes it worthwhile to thoughtfully plan the development of a statewide CCBHC network contributing to crisis services, and to ultimately transition a significant portion of the crisis system funding to the PPS. This does not mean that the state-sanctioned crisis services (mobile crisis and/or crisis centers with observation) need to be dismantled. States could initiate CCBHCs using DCO delegation to the state-sanctioned crisis system and later decide to switch and have their CCBHCs provide crisis system services directly. Note that if the state-sanctioned crisis system operates under less stringent standards than SAMHSA CCBHC criteria, they must request approval from HHS to certify CCBHCs in their states (SAMHSA, 2023c, criterion 4.c.1).

State-managed certification and cost report approval processes can be tailored to ensure that CCBHCs address identified system gaps as well as SAMHSA certification requirements. System gaps and capabilities that are not mandated but are potentially addressable within the CCBHC model can be addressed by the state's own specific certification standards and performance measures. The state may provide guidance on allowable anticipated costs for new services and capabilities and hold CCBHCs accountable to that guidance via the cost report approval process. Existing crisis service system providers that do not wish to become or are not capable of becoming CCBHCs (or providing state-funded services to Medicaid recipients that cannot currently be billed through Medicaid) can be paired as DCOs to a CCBHC. This approach supports provision of integrated crisis services across providers and leveraging additional funding through federal match of previously unmatched state money. See Section IV for additional information on applying PPS payment to additional crisis services.

"From a state perspective, one of the most important considerations should be the number and locations of CCBHCs with statewide coverage to adequately meet the needs of persons served, allow for providers to ensure adequate numbers to sustain a business model, as well as not overburdening the state system with cost. This can be done in a variety of ways. First and foremost, the state should look at the overall population with consideration of the representative number of persons likely to have a need for treatment and support for mental health and addiction issues, the current number of providers in an area and which of those would likely be able to develop into CCBHCs. An excellent tool for state mental health authorities is to create a certification process which delineates requirements both from a national perspective as well as any additional requirements unique to the population or challenges in a particular area. This can also be utilized to designate the number of CCBHCs in a given area or region. If a state is utilizing a SPA under CMS, requirements can be contained within the SPA for the same considerations."

— NASHMPD

NEXT STEPS FOR COUNTIES AND REGIONAL ENTITIES (CSBS, MANAGING ENTITIES, REGIONAL MCOS)

Given the potential advantages of a well-developed statewide distribution of CCBHCs with a PPS for the enhancement, funding and sustainability of crisis services within each county or region, counties and regional entities can contribute to this development in two important ways. First, at the state level, county and regional behavioral health entities should come together (in their own association, for example) and meet with state leaders responsible for planning crisis system and/or CCBHC development, coming to the table with this important question: What can we do to help make this work at the local level? The administrative complexities that must be worked out are likely to pay off, as costs that must be supported at the local level with unmatched dollars (often through local tax levies) can be offset over time. Counties can also partner with the state to help identify and support the best providers in their areas to become CCBHCs delivering crisis services. Second, at the local level, counties and regional entities should reach out to any existing CCBHC grantees in their area and become familiar with their services, to help build the CCBHC role into the county crisis continuum and help them get connected to existing crisis services. Over time, it is most valuable when counties/regions and the emerging CCBHCs within those regions can come together to plan for statewide development in a collaborative partnership that is mutually advantageous.

NEXT STEPS FOR CCBHC GRANTEES

CCBHC grantees, especially those with no access to the PPS, are often struggling so hard to determine how to meet the basic CCBHC certification requirements that it's hard for them to invest in developing the relationships that might contribute to the initiation and expansion of PPS resources for crisis services in their states. Nonetheless, it is important to remember that the same long-term advantages for states and counties also apply to the CCBHCs, even though there may be many challenges en route. A valuable next step is to partner as effectively as possible with the state and with county or regional entities, to demonstrate value as a partner and leader in your local crisis system. (This is especially valuable in large urban counties or cities.) Meet regularly with other CCBHCs in your region and/or state, to come to the table with state leaders and county/regional entities as helpful partners in figuring out how to achieve the end goal. Although, at the

beginning of this process, other providers may be better funded for crisis services, in the long run helping the state to develop and use the PPS for as much crisis infrastructure as possible (through DCOs, for example) can lead to so much ongoing, sustainable resource expansion that it is worth the effort to stay at the table with the state to get it right. Finally, encourage other providers in the state to step in to become CCBHCs and offer peer support; the challenges are likely to be worth the effort, and, most importantly, the CCBHCs are much more effective clinically and financially when there is statewide coverage, especially for crisis services.

NEXT STEPS FOR CRISIS SYSTEM PROVIDERS AND PARTNERS

Approach the emergence of CCBHCs within your state and local crisis systems as a benefit for both your own services and for the entire community. Make every effort to avoid a sense of competition (e.g., "Why is the CCBHC getting those PPS resources and not us?") Instead, partner with your CCBHC to help build the continuum of crisis services, and develop DCO relationships whenever feasible to reap the advantages of better data sharing (at minimum) and access to funding (potentially). Many crisis partners, like first responders and EDs, can benefit significantly from the crisis access that CCBHCs provide. Other crisis services benefit from having a partner to help manage flow and access to continuing care. Most importantly, as crisis providers and partners, do your best to help both your county/regional entities and your state learn how CCBHCs contribute as valuable partners to the overall crisis system, so the potential for improved and expanded services benefits as many people as possible, including those who receive services from you.

Resources

General resources and expert support

CCBHC-E National Training and Technical Assistance Center

CCBHC State Training and Technical Assistance Center

CCBHC Success Center

National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit

2024 CCBHC Impact Report

Section I

A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth

National Guidelines for Child and Youth Behavioral Health Crisis Care

County Funding Opportunities to Support Community Members Experiencing a Behavioral Health Crisis

Section II

CCBHC Community Needs Assessment Toolkit

Crisis Resource Need Calculator

CCBHC Contracting and Partnerships Toolkit for CCBHC Expansion Grantees

Certified Community Behavioral Health Clinics, Peer-delivered Services and Peer-operated Agencies: Opportunities for Collaboration and Expansion

Peer Support Services in Crisis Care

Organizational Self-assessment tool for Integrating Peer-delivered Services in CCBHCs

National Suicide Prevention Lifeline Requirements

NENA Suicide/Crisis Line Interoperability Standard

Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response, March 2021

Section IV

Centers for Medicare and Medicaid Services Updated PPS Guidance

Section VI

Quality Measurement in Crisis Services

Michigan Department of Health and Human Services CCBHC Handbook

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Appendix 1: Additional Criteria Directly Related to Crisis Services That Are Found Outside Sections 2.C and 4.C of the SAMHSA CCBHC Crisis Services Requirements

The **Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Certification Criteria (revised March 2023)** address crisis service provision largely described in the two major crisis service criteria sections: Criteria 2.C: 24/7 Access to Crisis Management Services, and Criteria 4.C: Crisis Behavioral Health Services. Appendix 1 highlights 18 additional criteria directly related to crisis services that are found outside sections 2.C and 4.C, throughout the full criteria.

Crisis-related CCBHC Requirements Effective March 2023

Criteria 2.B: General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation

2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, **at the time of first contact, whether that contact is in person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs.** That preliminary triage may occur telephonically. **If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.**

- If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made.
- If the triage identifies routine needs, services will be provided and the initial evaluation completed within 10 business days.
- **For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed.**

2.b.3 People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. **If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if necessary**. If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.

Criteria 2.C: 24/7 Access to Crisis Management Services

2.c.1 In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.

2.c.2 A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.

2.c.3 Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).

2.c.4 In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.

2.c.5 Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations.

Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.

2.c.6 Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.

Note: See criterion 3.a.4 where precautionary crisis planning is addressed

Criteria 2.E: Provision of Services Regardless of Residence

2.e.1 The CCBHC ensures no individual is denied behavioral health care services, **including but not limited to crisis management services**, because of place of residence, homelessness, or lack of a permanent address.

2.e.2 The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. **The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence**. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking noncrisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote client monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical...

Criteria 3.A: General Requirements of Care Coordination

3.a.4 The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. **To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.**

Criteria 3.C: Care Coordination Partnerships

3.c.2 The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). **These include tribally operated mental health and substance use services including crisis services that are in the service area**. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.

3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, **provide opportunities to identify individuals in need of services (i.e. 988)**, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts.

Program Requirement 4: Scope of Services

Authority: Section 223 (a)(2)(D) of PAMA

The statute requires the published criteria to include criteria with respect to the following:

"Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

I. **Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization. ..."**

Criteria 4.A: General Service Provisions

4.a.1 Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k **the following required services: crisis services;** screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.

Criteria 4.C: Crisis Behavioral Health Services

4.c.1 The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so.

Certifying states must request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.

PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:

- **Emergency crisis intervention services:** The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC) systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.
- **24-hour mobile crisis teams**: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan.

- **Crisis receiving/stabilization**: The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs.

  The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.

Note: See program requirement 2.C regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.

Criteria 4.D: Screening, Assessment, and Diagnosis

4.d.1 The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services.

Note: See program requirement 3 regarding coordination of services and treatment planning.

4.d.2 Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.

4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum:

1. Preliminary diagnoses
2. The source of referral
3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved
4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications
6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful
7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications
8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors
9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence
10. Assessment of need for medical care (with referral and follow-up as required)
11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services
12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice)

Criteria 4.J: Peer Supports, Peer Counseling, and Family/Caregiver Supports

4.j.1 The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; **peer-run crisis respites; warmlines; peer-led crisis planning;** peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support.

Appendix 2: Confidentiality Requirements Related to Crisis Services

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT — CONFIDENTIALITY APPLICABLE TO ALL HEALTH CARE SERVICES

Crisis services are considered as treatment under the Health Insurance Portability and Accountability Act (HIPAA).

Treatment means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a client; or the referral of a client for health care from one health care provider to another (45 CFR 164.5010). Treatment can only be provided to an individual client.

Treatment, by design, is broadly defined. Protected health information (PHI) about a prospective client may be disclosed for referrals to a health care provider. Treatment also covers the coordination or management of health care among providers or a third-party "related service." Related services can include social, rehabilitative or other services associated with health care. In the case of crisis systems, a non-healthcare related service such as temporary housing is only made available to people as it meets some aspect of a crisis need (e.g., the crisis is related to a health care condition such as mental illness or substance use disorder [SUD]).

Minimum necessary disclosure does not apply to treatment.

Authorizations are not needed to use or disclose PHI for treatment purposes.

Clients have the right to request restrictions on how a covered entity will use and disclose PHI about them for treatment, health care operations and payment. However, a covered entity is not required to agree to a client's request for restriction, but it is bound by any restrictions to which it agrees (45 CFR 164.522(a)).

42 CFR PART 2 — CONFIDENTIALITY RELATED TO SUBSTANCE USE DISORDER TREATMENT

42 CFR Part 2 confidentiality requirements only apply to "covered entities," which are health care providers, organizations or programs that hold themselves out as providing SUD diagnosis, treatment or referral to treatment. 42 CFR Part 2 regulations do not apply SUD treatment by health care organizations that do not advertise themselves publicly as SUD care providers. This includes emergency rooms, primary care practices and mental health service providers that do not advertise treatment of SUD.

Covered entities are required to obtain client consent to share information regarding SUD treatment but not treatment of other conditions, except for the following medical emergencies as described in 42 CFR Part 2.51:

42 CFR Part 2.51 Medical emergencies

(a) General rule. Under the procedures required by paragraph (c) of this section, client identifying information may be disclosed to medical personnel to the extent necessary to:

(1) Meet a bona fide medical emergency in which the client's prior written consent cannot be obtained; or

Persons providing consent under 42 CFR part 2 can provide very broad consent such as "sharing my treatment information with any healthcare crisis services provider in any crisis or emergency situation"

(2) Meet a bona fide medical emergency in which a part 2 program is closed and unable to provide services or obtain the prior written consent of the client

ONC AND CMS INTEROPERABILITY RULES (INFORMATION BLOCKING)

Confidentiality requirements were passed as part of the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Final Rule, specifically referred to as the Interoperability and Patient Access final rule (CMS-9115-F). It was finalized in 2020 and has only now been implemented.

This rule prohibits information blocking, which is a practice by a health care provider, health information technology (HIT) developer or health information exchange/network (HIE/HIN) (referred to subsequently herein as 'the actor') that, except as required by law or specified by the secretary as a reasonable and necessary activity, is likely to interfere with, prevent or materially discourage access, exchange or use of electronic health information.

Whereas the HIPAA Privacy Rule permits, but does not require, covered entities to disclose health care information in most circumstances, the information blocking rule requires the actor to provide access, exchange or use of health care information unless prohibited by law or covered by one of the exceptions. There are eight exceptions, but only two are generally pertinent to crisis care situations.

1. **Privacy exception:** It will not be information blocking if "respecting an individual's request not to share information" applies (if the following requirements are met):

    i. The individual makes the request orally or in writing without any improper encouragement or inducement by the actor.

    ii. The actor documents the request within a reasonable period. The final rule does not require a specific form of documentation and indicates that a note in the certified electronic health record (EHR) or similar notation is sufficient. To exercise the privacy exemption, the client's request to not share electronic health information (EHI) must be documented in the record.

2. **Preventing harm exception:** It will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a client or another person. Under this exemption, an actor may exclude notes of any type that may cause harm to the client or others should the client have access. However, the rule specifically states that psychological distress does not meet the definition of harm (Torous, 2020). The rule requires "substantial harm," meaning life-threatening or physical harm.

SUMMARY — TAKING ALL THREE RULES TOGETHER

Health care providers, including those who hold themselves out to the general public as providing SUD treatment, and including crisis services providers, *must* exchange information upon a treating provider request or for making a referral, even in the absence of client consent, unless they have it documented in their treatment record that the client has requested that information not be shared, in which case they still *may* share the information.

Health care providers holding themselves out to the public as treating SUD *must* share treatment information with requesting providers with whom the client has consented to share that information. They *must* share information even absent consent if there is a bona fide medical emergency in which the client's prior written consent cannot be obtained.

Appendix 3: Considerations for Meeting Rural Crisis Needs

Rural regions face unique barriers to mental health and substance use crisis care access. Low population density and expansive geography spreads resources thin. Residents may travel long distances to services, if any exist nearby. Stigma and cultural disconnects with outsider providers can impede utilization. CCBHCs are well-suited to expand rural crisis access by leveraging their embedded community presence and flexible, comprehensive model, or through DCO arrangements with more local providers or community-based services. Even small rural CCBHCs can make significant impacts with thoughtful localization.

UNDERSTANDING RURAL REALITIES

To tailor appropriate solutions, CCBHCs must grasp rural realities, including:

- Extreme provider shortages: Many counties have one mental health professional per 1,000 square miles or more. Recruitment is very difficult. Hospital systems may be experiencing perpetual crisis.
- Transportation obstacles over long distances on poorly maintained roads. Walk-in services may be impossible. Transportation is a significant strain on law enforcement, and there are limitations as to where and how far they may transport people.
- Delays obtaining backup from law enforcement and emergency medical responders who are spread thin.
- Health care and social services infrastructure concentrated in distant urban hubs, with only a patchwork of local crisis service providers.
- A culture that values self-reliance, discouraging help-seeking behavior. Stigma is amplified in close-knit towns.
- Economic factors like poverty, unemployment and uninsured status limit affordability of any care.
- Digital divide: limited broadband or access to technology for telehealth capabilities.

CORE SERVICE DELIVERY

Despite profound challenges, CCBHCs can creatively ensure rural communities have access to someone to contact, someone to respond and a safe place for help in crisis. With information from the needs assessment as to available resources and barriers, a patchwork of crisis services may be unified by building a dedicated CCBHC team and comprehensive care pathways. Grant funding allows a level of creativity in developing and implementing the service array; once certified and clear on what evidence-based practices are being used, those services and related administrative costs can be built into PPS rates.

- Establishing crisis call access can leverage technology like statewide lines with chat/text and telehealth to bridge distance. Warm transfers to local CCBHCs for mobile response are optimal.
- For mobile crisis, regional on-call teams may be needed to cover expansive areas. CCBHCs can equip law enforcement with tablets to initiate virtual assessments when in-person response is far. Quick handoffs to CCBHC staff for disposition planning and symptom stabilization help divert unnecessary hospitalizations and legal system involvement. Telehealth enables psychiatry consults.

- Under the updated criteria, CCBHCs must have crisis walk-in capacity during regular and evening hours. CCBHCs can also coordinate with hospitals to designate beds and procedures for mental health and substance use crises.
- The PPS payment methodology allows for broader use of trained staff that are usually not reimbursable in fee-for-service, where payment is limited to licensed providers.
- The PPS payment methodology can cover training and remote clinical supervision and consultation support for trained paraprofessionals and traditional local rural responders, such as sheriffs and clergy who are willing to learn additional crisis response skills.

County/state takeaway: Larger sites are more likely to enjoy economies of scale. Smaller rural sites are more likely to experience more intense pressure to meet requirements. Fidelity models don't always appeal to rural sites in the way that they would to sites in more urban areas. Measurement needs to take these dynamics into account.

PARTNERING

Cost and resource sharing expands collective coverage. To bolster capacity, rural CCBHCs can leverage partnerships:

- Share crisis call centers, mobile teams, residential crisis beds and on-call staff with other regional CCBHCs. Work across catchment areas by developing collaborative agreements to enable the nearest mobile response team to respond — just as an ambulance would be deployed — and determine follow-through once contact has been achieved.

County/state takeaway: When defining catchment area, allow flexibility and fluidity.

- Consider an array of disciplines as first responders, shored up by requirements to engage a mental health professional within a specific period (e.g., within three hours). This both enables rapid response and reduces strain on the mobile response team.
- Collaborate with critical access and community hospitals for medical clearance, lab work, observations and telepsychiatry.
- Equip primary care to provide basic medication management and counseling, with CCBHC referral relationships.
- Engage human service organizations, churches, shelters, community centers and schools for space, referrals and health education. Mobile response teams may not be immediately well-received, but community leaders can serve as champions for crisis services, increasing the social acceptability of needing and accessing care.
- Train recovery coaches and community health workers to fill support roles and cultural gaps. For example, embedding care coordinators in jails who are dually trained in crisis screening and getting releases can eliminate the need for mobile team deployment to the jail. Further, embedded staff then possess capabilities for an immediate intervention when needed, potentially avoiding re-incarceration. Develop joint release of information to key players, including peers.
- Remember that community and communication channels are mission critical. Often, barriers are resolved with a direct phone call between crisis services partners.

Rural collaboration requires flexibility about "turf" and openness to creative solutions.

VIRTUAL CARE

Availability does not always equate to accessibility. Hybrid models that employ telehealth and mobile health technology can alleviate rural distance barriers:

- Phone, chat and video crisis lines offer immediate support anywhere with cellular service, including from within a police vehicle.
- A CCBHC may issue electronic tablets to law enforcement personnel, which provide immediate connectivity to crisis personnel via audio call, video call or an app. Tablets can be left with the person in crisis to ensure continued access to help. Additionally, having a tablet readily available in the police vehicle provides a direct, private link to services for an officer experiencing crisis themself — often a valuable benefit to a participating agency.
- Web-based screening, self-help resources and support groups make help accessible from home. Tablet and phone apps allow remote symptom monitoring and recovery coaching.

Virtual tools expand the impact of limited rural workforce and connect crisis services counterparts and clients. Digital literacy support helps reluctant adopters. *It is critical to note, however, that virtual tools do not replace the requirement to have an in-person response, if necessary.*

Appendix 4: State Visioning Exercises

(Developed for the CCBHC State Technical Assistance Center State Learning Collaborative, 2024)

INTRODUCTION

During this learning community we will be exploring ways each state can establish a three- to five-year action plan to align CCBHCs and their crisis systems. Each state's plan will begin with developing a vision for an integrated system to be achieved over the next three to five years. The vision and three- to five-year plan will be anchored to concepts in the **Roadmap to the Ideal Crisis System** (Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, 2021) and account for the unique structure, design, payment and performance levers within each state to integrate the CCBHC model into the crisis system.

The visioning exercise document is organized into four parts, to help each state team conceptualize their vision for the design of the best behavioral health crisis system to fit their state, and the best way to fit the services and funding advantages of CCBHCs receiving prospective payment within that design.

PART 1: CRISIS SYSTEM STRUCTURE AND ACCOUNTABILITY

A community crisis system is more than an array of services. It's an organized set of processes designed to provide a comprehensive and accessible continuum of best practice crisis response to a designated population covered by all payers.

1. In your state, what is your vision for how crisis system design is matched to designated populations (by multi-county region, county, ZIP codes, catchment areas, etc.)?

2. Within each allocated community/population/geography, in your vision, what entities in your state should be accountable to the state for the performance of the crisis system and coordination of all crisis services for that population? Examples might be the state directly, regional entities, counties, lead providers and managed care organizations.

3. Within each allocated community, do you have a vision for the service array and capacities (type and scale) — including technology for service delivery, measurement and care coordination — that you want to be available in your state for every individual, family and community?

PART 2: POTENTIAL ROLES FOR CCBHCS IN THAT STRUCTURE

CCBHCs are not only required to directly provide, or formally collaborate with, state "sanctioned" crisis services. They are also intended to play a role in their communities as leaders and partners in behavioral health system design, including crisis system design.

1. In your state, is part of your vision that, in *each* designated population or service area described above, there will be one or more CCBHCs receiving prospective payment that will be playing a role in the system?

2. If so (or if not), in your state vision, what role would you like them to play? Examples might be:

   - We want them to work as leaders or partners in their assigned communities to help coordinate all the crisis services.
   - We want them to each be responsible for the mobile crisis in their catchment areas.
   - We want them to be responsible for crisis walk-in and rapid continuing crisis follow-up in their area.
   - We want them to take the lead in organizing Air Traffic Control.

Note that they may do other things as well; this is just your vision of what you would like CCBHCs to be responsible for in each community's *crisis* system.

3. If there are multiple CCBHCs (and perhaps multiple other service providers who are not CCBHCs) in your designated population areas, what is your vision of how the CCBHCs will collaborate (rather than compete) with each other and with other service providers, so they have complementary roles? This is likely to include DCO and non-DCO relationships.

PART 3: FINANCING THE CRISIS SYSTEM

Financing crisis systems requires state and local coordination of multiple types of funding to meet population needs. Limited unmatched state dollars should be used to leverage other types of funding (e.g., federal Medicaid match, other third-party payers, local funding, health system contributions) as much as possible. Prospective payment system (PPS) funding for CCBHCs provides federal match for many "non-billable" direct and indirect costs that would otherwise be paid for with unmatched funds.

1. In your state, what is your vision for how crisis systems in each designated community/population/geography eventually will be funded to scale?

2. Within your envisioned "community crisis system" array of services and capacities, what services and capacities would most benefit from having a funding source to support non-billable direct and indirect costs? What is your vision of how to best support those costs?

3. Of the above non-billable costs, what do you envision would be best covered (in whole or in part) by CCBHC prospective payment to CCBHC(s) in each designated community?

PART 4: MONITORING, MANAGING AND IMPROVING PERFORMANCE

State behavioral health authorities are ultimately responsible for designing, implementing and operating high-performance crisis systems in all communities, even though they do not directly fund most of the services. Therefore, maximizing the state's ability to perform this function is an important part of a successful vision.

1. In your state, what is your vision for how the entities responsible for community crisis systems (and their service delivery partners) in each designated community/population/geography will be monitored (through reporting on key crisis system outcomes), managed, supported and incentivized to continuously improve performance? Who will collect data? How will appropriate metrics be identified and collected? How will data be reported at both the state and local levels and used to improve performance in each community and statewide?

2. What is your vision of how CCBHCs in each area can be positioned and PPS funded to contribute most effectively to the above processes? This may include alignment with already-required CCBHC metrics, alignment with state certification and investment of a PPS into continuous quality improvement technology and population management infrastructure.

3. What is your vision of how the CCBHC PPS methodology the state uses — *if applied with consistency statewide* — can also provide tools for improving system performance, including crisis performance? One example is building performance incentive payments into your PPS design.

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