BRIEF

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Deborah Harburger
Sheila Pires
Suzanne Fields
Shannon Robshaw

The Institute for Innovation and Implementation
University of Maryland
School of Social Work

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Critical Barriers & Issues in the Criteria for Certified Community Behavioral Health Clinics (CCBHC) Related to Children, Youth, and Young Adults

The Protecting Access to Medicare Act of 2014 (PAMA)[i] was signed into law in April 2014 and includes efforts and funding to improve community behavioral health services through creation of CCBHCs. PAMA, through development of CCBHCs, is intended to increase use of evidenced-based practices, support integration of behavioral health and physical health services and improve access to quality care. Care coordination is included as a key CCBHC function. Specific criteria for CCBHCs were included in PAMA in six areas: (1) staffing, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and other reporting, and (6) organizational authority.

On October 19, 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), along with the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary of Planning and Evaluation (ASPE), awarded twenty-four states Planning Grants for Certified Community Behavioral Health Clinics. On December 1, 2016, eight states were awarded two-year demonstration grants beginning in January 2017. The eight states are: Minnesota, Missouri, New York, Nevada, Oklahoma, Oregon, and Pennsylvania.

This document summarizes critical barriers and issues within existing PAMA criteria related to serving children, youth and young adults with complex behavioral health needs and their families. The document recommends:

1. amendments to the criteria for consideration by federal and state agencies to strengthen CCBHCs to meet the unique needs of children, youth and young adults; and

2. implementation approaches for states to support effective care for children youth and young adults with behavioral health needs.

Issue #1: The CCBHC is required to provide care coordination, screening and assessment, treatment planning, and treatment services directly.

Criteria 2, 3, and 4 require the CCBHC to provide care coordination, screening and assessment, treatment planning, and treatment services directly, without consideration for other entities that may have greater population-specific expertise. There is an existing infrastructure across the country, supported by CMS and SAMHSA, which is providing population-specific, Medicaid-funded care coordination, assessments and treatment planning through health homes and care management entities, among others structures.

If the CCBHC is required to provide these functions and services, it will undo the infrastructure that has been developed without any guarantee of equal or better outcomes.

Similarly, there are provider organizations across the country that offer tailored treatment services to meet the specific needs of children, youth, young adults and families, including the provision of specific evidence-based and promising practices. The current requirement assumes that the CCBHC is capable of providing the majority of these services, which will greatly impact the availability of services in the community and ignores the extensive workforce development effort necessary to implement and sustain an evidence-based or promising practice (i.e. initial and ongoing training, coaching, and fidelity and outcomes monitoring).

[Note: The requirements associated with serving Members of the Armed Forces and Veterans are population-specific; it was likely similar concerns about expertise, existing infrastructure, and workforce capacity that resulted in the specific requirements for the Members of the Armed Forces and veterans.]

Recommendation: Amend the criteria to permit the CCBHC to contract with a Designated Collaborating Organization (DCO) with population-specific expertise to provide care coordination; comprehensive behavioral health screening and assessment, including risk assessments; person-centered and family-centered treatment planning; and/or, comprehensive outpatient mental health and substance use disorder services, including evidence-based practices and interventions for specific populations including:

- Children, youth, and young adults;
- Members of the Armed Forces and Veterans.

Issue #2: There are no specific service requirements for the CCBHCs serving children, youth, and young adults.

Criteria 4 does not establish specific requirements for the service array for children, youth, and young adults and their families (but does provide such requirements for Members of the Armed Forces and Veterans). The children's behavioral health arena has developed a core set of recommended services that should be available in a good and modern system for children. Support for the service array was issued in the 2013 Informational Bulletin issued by CMS and SAMHSA,[ii] which outlined home and community-based services proven effective for children and youth with serious behavioral health issues. The recommendations resulted from two federal demonstrations, which concluded that youth had better outcomes in the community when the traditional behavioral health service array was enhanced through the addition of the services and supports outlined in the May 2013 joint bulletin (see below). As a result, states and communities have made tremendous progress in developing this array for children and youth across the country.

The CCBHC requirements should ensure that services and interventions can happen in the school, home and community, rather than relying on traditional clinic-based services. The rate for these services should be incentivized to promote the provision of services where families are most comfortable and in the settings most accessible to them.

Recommendation: Establish specific requirements for CCBHCs serving children, youth and young adults to include providing (directly or through a DCO), at a minimum the following services, and incentivize the provision of services in the home, school and community-based settings:

- Intensive Care Coordination using a high quality Wraparound practice model;
- Parent/Family and Youth Peer Support Services, provided by individuals with lived experience;

- Intensive In-Home Services;
- Respite Services;
- Mobile Crisis Response and Stabilization Services;
- Flexible/Discretionary Funds (Customized Goods & Services); and,
- Trauma-informed, evidence-based practices to address mental health and substance use disorders, including co-occurring disorders, Autism Spectrum Disorder, and first episode psychosis.

Issue #3: The availability of a state-sanctioned, certified, or licensed crisis behavioral health service does not mean that there are consistent, minimum requirements these services.

There is significant variability across the country with regard to the design and operations of crisis responses systems. Some states may sanction or certify a particular provider of crisis behavioral health services but that does not mean that the provider has capacity to serve all necessary populations; is available 24 hours per day, 7 days per week; or has the ability to provide both crisis response and stabilization services: "Mobile Response and Stabilization Services looks different from state to state with variability dependent on the purchaser, the financing environment, and the population served."[iii] The CCBHC should not duplicate existing services but should address gaps in the crisis behavioral health service system within the geographic catchment area.

Recommendation: The CCBHC must meet all requirements set forth below if there is no state-sanctioned, certified, or licenses crisis service system; if there is a state-sanctioned, certified, or licensed crisis service system, the CCBHC must meet all requirements listed below that are *not* provided by the crisis service system:

- The ability to serve children, youth, young adults, adults, members and veterans of the Armed Forces and their families, and older adults;
- Partnership with local law enforcement, schools, and emergency departments;
- Crisis Hotline, available 24 hours per day, 7 days per week, continually staff by a trained and qualified specialist, able to triage the call to determine risk of harm and calibrate according to the level of threat, from immediate response through the mobile crisis team to a scheduled visit within 48 hours;
- Mobile crisis response teams who:
    - Are available 24 hours per day/7 days a week;
    - Provide face-to-face response in-home and community-based settings within 1 hour of initial crisis contact; [1]
    - Coordinate with law enforcement as needed for safety;
    - Deescalate the crisis;

[1] n.b. The criteria specify three hours, which is too long for most jurisdictions except the most remote, frontier environments; see Shannahan & Fields (2015), which states that the target response time is within one hour.

  - Assess for risk to self and others;
  - Identify crisis precipitants to assist in developing or revising an individualized crisis plan;
  - Provide mobile crisis intervention services, for up to 72 hours, providing immediate and direct clinical intervention (in-person or telephonically) and connections with the care coordinator to ensure follow-up regarding referrals to community services;
  - Facilitate access to CCBHC follow-up appointment with therapist within 24 hours of crisis response.
- Crisis stabilization, including in-home services and supports, referrals to services, and medication management, available for a period of weeks after the crisis.

Issue #4: The CCBHC is required to employ peer staff, not required to ensure access to peer staff.

Criteria 1.B requires that the CCBHC hire peer staff to be employed by the CCBHC. However, peer organizations (inclusive of family, consumer, and youth) have served as cornerstones of the behavioral health continuum and are among the leaders of national work on peer support. Peer support organizations hold local expertise in navigating behavioral health systems, which is furthered by their practice of hiring consumers and family members of participants who utilize the behavioral health services array. Although some communities may not have a peer organization with a significant presence in the service area, the requirement to hire the peer staff directly will undermine peer organizations by increasing competition for qualified staff, instead of contributing to ongoing stability.

A vast body of knowledge has been developed through these local and national networks of peer support organizations. These entities have a unique perspective and a deep knowledge base on hiring, training and retaining peers and family members to work as advocates and navigators within these service systems. By requiring CCBHCs to leverage these pre-existing networks where applicable, they will benefit from access to the experience and connections of the peer support workforce. Additionally, if peer support/family support workers are based in a peer support organization, the workforce will have access to specialized supervision related to their specific role. As a 2011 issue brief noted,

"When [family to family] peer support is provided within a non-family-run service agency, there may be a need to increase attention to the organizational culture to create a family-friendly work environment. For example, it is important for organizational leadership to be committed to the value of strong family partnerships and to create strategic alliances within family/professional teams at all administrative levels (e.g., pairing clinical residential director and PSP [peer support partner] supervisor)."[iv]

Recommendation: Require that peer staff employed by the CCBHC be connected to a consumer, family, or youth organization for support and permit CCBHCs to contract for their peer staff through a peer support organization (consumer, family, or youth).

Issue #5: The list of entities with which the CCBHC must coordinate is not comprehensive enough with regard to entities that support children, youth and families, and should be included to ensure comprehensive planning, treatment, and coordination.

Criteria 3C specifies a number of entities with which the CCBHC must coordinate and state that there are additional entities, including "social service agencies." However, there are several entities that

are of such critical importance to children, youth, and families that they should be stated explicitly in the requirements to ensure that every CCBHC across the country establishes and maintains these formal relationships.

Recommendation: In addition to those entities specified in §223(a)(2)(C), require that CCBHCs coordinate care with

- Psychiatric Residential Treatment Facilities;
- Partial Hospitalization/Day Treatment/Intensive Outpatient Treatment Programs;
- Behavioral Health Diagnostic Facilities;
- Consumer, family, and youth/young adult peer support organizations;
- Programs and services for families with young children, including Infants & Toddlers; Women, Infants and Children (WIC); Home Visiting Programs; and Early Head Start/Head Start;
- State child- and family-serving agencies, including behavioral health, developmental disabilities, juvenile justice, Medicaid, child welfare, and education.

Issue #6: The CCBHC is required to be responsible for the intensive community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, but is not required specifically to be responsible for the care of their family members.

Although the CCBHC is required to serve all individuals who seek care, there are specific requirements associated with providing services to certain members of the U.S. Armed Forces and veterans. However, these requirements found in Criteria 4.K do not extend to the spouses and dependent children of the members and veterans. As SAMHSA noted, "Military families have a culture and unique behavioral health needs that may not be understood within the greater community."[v] It is imperative that the CCBHC's specialized services to support members of the U.S. Armed Forces and veterans be extended to their spouses and dependent children as well.

Recommendation: Require the CCBHC to be responsible for intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans *and their families,* to include spouses and dependent children.

Issue #7: The CCBHCs are not required to have a balanced number of board members representing the lifespan nor are they required to have both consumer *and* family member representatives on their board.

Criteria 6 requires certain representatives on the CCBHC Board. The board should be reflective of the populations served by the CCBHC and, therefore, the members should be representative of the entire lifespan. Additionally, all consumer positions on the board should not be filled with adult consumers but should represent family members caring for or with experience in caring for a child with behavioral health challenges, youth/young adults, and adult consumers.

Recommendation: Require CCBHCs to have a balanced number of board members representing a range of ages (young child, adolescent/young adult, adult, older adult) for both the consumer/family representatives and the non-consumer members, ensuring there is balanced expertise on the board.

[i] Protecting Access to Medicare Act of 2014, P.L. 113-93. Available at https://www.gpo.gov/fdsys/pkg/PLAW-113publ93/html/PLAW-113publ93.htm

[ii] Mann, C. & Hyde, P.S. (May 7, 2013). Joint Bulletin: Coverage for Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions. Centers for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration. Available from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[iii] Shannahan, R. & Fields, S. (2015). *Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services.* Baltimore, MD: The Technical Assistance Network for Children's Behavioral Health.

[iv] Obrochta, C; Anthony, B., Armstrong, M., Kalil, J., Hust, J., & Kernan, J. (2011). *Issue brief: Family-to-family peer support: Models and evaluation.* Atlanta, GA: ICF Macro, Outcomes Roundtable for Children and Families, p.3

[v] Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Veterans and military families*. Available from the SAMHSA website: http://www.samhsa.gov/veterans-military-families.

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