
Evaluation of the Extension to the Certified Community Behavioral Health Clinic Demonstration Year One Survey Template

1. Our records indicate that the name of your CCBHC is [AUTOFILL CCBHC NAME]. Is this correct? [Y/N]
[ASK 1A IF 1=N]
1a. Please provide the correct CCBHC name here: [TEXTBOX]

Section A. Certified Community Behavioral Health Clinic (CCBHC) structure In this section, we would like to learn about how your CCBHC is organized.

A.1. Please enter the physical address of your CCBHC here: [Text box]

A.2.a. How many locations does your organization have? [Text box]
[ASK A2b if A2a ≥ 1]

A.2.b. Please enter the physical address of each location that offers CCBHC services: [Text box]

A.3. What is the name and job title of the *primary person* completing this survey?

Name: [Text box]

Job title: [Text box]

A.4.a. Which of the following best describes the type of treatment provided by this clinic prior to CCBHC certification? Select one.

Primarily substance use disorder services

Primarily mental health services

Mix of mental health and substance use disorder services

Primarily physical health services

Other (please describe): [Text box]

A.4.b. Which of the following best describes the type of treatment provided by this clinic currently? Select one.

Primarily substance use disorder services

Primarily mental health services

Mix of mental health and substance use disorder services

Primarily physical health services

Other (please describe): [Text box]

A.5.a. Is your CCBHC accredited? Yes No

[ASK A5a IF A5=1(YES)]

A.5.b. Please select the current accreditation of this CCBHC:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- National Committee for Quality Assurance
- Healthcare Facilities Accreditation Program

- The Joint Commission
- Council on Accreditation (COA)
- Other (please describe): [Text box]

A.6.a. Has your CCBHC also received a CCBHC Expansion (CCBHC-E) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA)? Yes No

[ASK A6B IF A6A = 1 (YES)]

A.6.b. What year did your CCBHC FIRST receive a CCBHC Expansion grant? [Drop down menu]

Section B. Certified Community Behavioral Health Clinic (CCBHC) staffing

In this section, we would like to learn about how your CCBHC is staffed.

B.1. How many FTE of the following types of staff did your clinic hire as a result of CCBHC certification?

B.1.a Adult psychiatrist(s) [Text box]

B.1.b Child/adolescent psychiatrists [Text box]

B.1.c Nurses [Text box]

B.1.d Licensed staff including psychologists, clinical social workers, counselors, and marriage and family therapists [Text box]

B.1.d Substance abuse specialists [Text box]

B.1.e Peer specialist(s)/recovery coaches [Text box]

B.2.a. Have any of the following staff positions gone completely unfilled for two months or longer during the past twelve months?

- Adult psychiatrist(s)
- Child/adolescent psychiatrists
- Nurses

Licensed staff including psychologists, clinical social workers, counselors, and marriage and family therapists

- Substance abuse specialists
- Peer specialist(s)/recovery coaches

[ASK B2B IF B2A=1(YES)]

B.2.b. If so, please describe why (for example, has a position been difficult to fill?): [Text box]

B.3.a. Has your clinic been trying to add more of the following types of staff during the past twelve months?

- Adult psychiatrist(s)
- Child/adolescent psychiatrists
- Nurses

Licensed staff including psychologists, clinical social workers, counselors, and marriage and family therapists

- Substance abuse specialists
- Peer specialist(s)/recovery coaches

[ASK B3B IF B3A=1(YES)]

B.3.b. If so, please describe why (for example, has the clinic added new or expanded availability of services?): [Text box]

Section C. CCBHC accessibility

Questions in this section will help us understand how clients access services at your clinic.

C.1. How are clients referred to CCBHC services? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> C.1.a Self-referral | <input type="checkbox"/> C.1.f Referred by family |
| <input type="checkbox"/> C.1.b Referred by physical health care providers | <input type="checkbox"/> C.1.g Referred by crisis service providers |
| <input type="checkbox"/> C.1.c Referred by other behavioral health providers | <input type="checkbox"/> C.1.h Referred by hospitals |
| <input type="checkbox"/> C.1.d Referred by courts/involuntary or assisted outpatient treatment order | <input type="checkbox"/> C.1.i Referred by emergency departments |
| <input type="checkbox"/> C.1.e Referred by schools or other child service providers | <input type="checkbox"/> C.1.j Other (please describe): [Text box] |

C.2. Has your clinic made any changes to the physical space of the clinic in the past twelve months to comply with CCBHC service requirements? Check all that apply or select "None".

- | | |
|---|--|
| <input type="checkbox"/> C.2.a. Expansions or additions to the CCBHC building | <input type="checkbox"/> C.2.c. Improvements to facility safety features |
| <input type="checkbox"/> C.2.b. Renovations to existing CCBHC facilities | <input type="checkbox"/> C.2.d. Other changes: [Text box] |
| | <input type="radio"/> None |

C.3.a. Does your CCBHC offer services in locations outside of the clinic? Yes No

[ASK C3B IF C3A=1(YES)]

C.3.b. Where are services provided? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Clients' homes | <input type="checkbox"/> Schools |
| <input type="checkbox"/> Hospitals | <input type="checkbox"/> Parole offices |
| <input type="checkbox"/> Emergency departments | <input type="checkbox"/> Courts, jails, police stations or law enforcement offices |
| <input type="checkbox"/> Restaurants, coffee shops | <input type="checkbox"/> Libraries |
| <input type="checkbox"/> Shelters | <input type="checkbox"/> Other community locations (please describe): [Text box] |
| <input type="checkbox"/> Social service organizations (e.g., Medicaid, housing agencies) | |

C.4.a. Does your CCBHC offer any services via telehealth? Yes No

[ASK C4B IF C4A=1(YES)]

C.4.b. What CCBHC service types are available via telehealth? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Crisis services | <input type="checkbox"/> Person- and Family-Centered Treatment Planning Services |
| <input type="checkbox"/> Screening, assessment, and diagnosis | <input type="checkbox"/> Psychiatric Rehabilitation Services |
| <input type="checkbox"/> Outpatient mental health | <input type="checkbox"/> Peer Support Services |
| <input type="checkbox"/> Outpatient SUD services | <input type="checkbox"/> Intensive Community-Based Mental Health Services for Armed Forces and |

- Targeted Case Management
- Primary Care Screening and Monitoring

- Veterans
- Other (please describe): [Text box]

C.4.c. What method does your clinic use to provide CCBHC services via telehealth? Check all that apply.

- Video conference
- Mobile applications
- Telephone
- Other (please describe): [Text box]

C.4.d. Are CCBHC services offered by telehealth available to all CCBHC clients or only specific populations? All clients Specific populations (please describe): [Text box]

C.5.a. Does your clinic provide services in languages other than English? Yes No

C.5.b. Does your CCBHC offer translation services to clients? Yes No
[ASK C5C IF C5B=1(YES)]

C.5.c. How are translation services delivered? Please check all that apply: Staff or contract interpreter Multilingual staff Other (please describe): [Text box]

C.6.a. Does your CCBHC offer open access or same-day scheduling? Yes No
[ASK C6B IF C6A=1(YES)]

C.6.b. For which service types is open access or same-day scheduling available?

- Crisis behavioral health services
- Screening, assessment, and diagnosis
- Outpatient mental health
- Outpatient SUD services
- Targeted Case Management
- Primary Care Screening and Monitoring
- Person- and Family-Centered Treatment Planning Services
- Psychiatric Rehabilitation Services
- Peer Support Services
- Intensive Community-Based Mental Health Services for Armed Forces and Veterans

C.7. Does your CCBHC offer childcare to clients during appointments? Yes No

C.8. In the past twelve months, what has your CCBHC done to increase access to care? [Text box]

C.9. What specific activities has your CCBHC implemented to increase access to care for children/youth and their families as a result of the demonstration? [Text box]

C.10. What challenges have your CCBHC faced related to increasing access to care under the demonstration in the last twelve months? [Text box]

C.11. How many NEW clients (i.e., individuals who have not received services from your CCBHC before) has your CCBHC served in the past twelve months? [Text box]

Section D. CCBHC care coordination

The following questions will help us understand how client care is coordinated at your clinic.

D.1. Who is generally involved in developing and updating a comprehensive treatment plan? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Mental health clinicians | <input type="checkbox"/> Client family members |
| <input type="checkbox"/> Substance use disorder clinicians | <input type="checkbox"/> Psychiatrists |
| <input type="checkbox"/> Case managers | <input type="checkbox"/> Primary care providers |
| <input type="checkbox"/> Consumers/clients | <input type="checkbox"/> Other (please describe): [Text box] |

D.2. How are client and family preferences for care elicited and documented? Please describe: [Text box]

D.3.a. Does your CCBHC provide on-site primary care services (in addition to primary care screening and monitoring)? Yes No
[ASK D3B IF D3A=1(YES)]

D.3.b. Does your CCBHC have a primary care clinician on staff or under contract? Yes No
[ASK ALL RESPONDENTS D3C-E (no skip logic)]

D.3.c. Does your CCBHC routinely document the name of clients' external primary care provider(s) in client health records? Yes No

D.3.d. Is your CCBHC also a federally qualified health center (FQHC)? Yes No

D.3.e. Is your CCBHC a FQHC look-alike? Yes No

D.4.a. What electronic health record system does your CCBHC use? [Text box]

D.4.b. Does your CCBHC's EHR generate electronic care plans? Yes No

D.4.c. Does your CCBHC's EHR include physical health records? Yes No

D.4.d. Does your CCBHC's EHR generate the quality measures required for the demonstration? Yes No
[ASK D4E IF D4D = 1 (YES)]

D.4.e. Are the quality measures generated by your CCBHC's EHR easily and quickly accessible to your CCBHC? Yes No
[ASK D4F if D4E = 1 (YES)]

D.4.f. To whom are the quality measures generated by your CCBHC's EHR available?

- | | |
|--|--|
| <input type="checkbox"/> CCBHC leadership (e.g., executive director, medical director) | <input type="checkbox"/> Quality officers/managers |
|--|--|

Frontline clinical staff

Other (please describe): [Text box]

D.4.g. In what format are the quality measures generated by your CCBHC's EHR available (e.g., electronic only, printable PDF)? Please describe: [Text box]

D.5.a. Please tell us about the other health information technology (HIT) your CCBHC uses. Check all that apply.

Electronic clinical decision support tools

State operated health information exchange

Data dashboard(s)

Privately operated health information exchange

Electronic prescribing

Patient portals

Electronic exchange of clinical information with external providers

Other health information technology (please describe): [Text box]

Clinical registry

D.6.a. Has your clinic altered its HIT systems or EHR in the past twelve months as a result of the demonstration? Yes No

[ASK D6B IF D6A=1(YES)]

D.6.b. Please describe the HIT or EHR alterations made in the last twelve months: [Text box]

D.7. Does your CCBHC have relationships with any of the following types of external facilities or providers? For each, indicate the type of relationship or that there is no relationship. Formal relationships might involve a MOU or letter of agreement between two organizations.

	DCO	Formal relationship	Informal relationship	No relationship
D.7.a. Federally qualified health centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.a. Rural health clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.a. Primary care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.a. Urgent care centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.a. Emergency departments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.b. Inpatient psychiatric facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.b. Psychiatric residential treatment facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.b. Substance use disorder residential treatment facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.c. Medical detoxification facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.c. Ambulatory detoxification facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.c. Post-detoxification step-down facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.c. Hospital outpatient clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.c. Medication-assisted treatment providers for substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.d. Schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.d. School-based health centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.7.d. Child welfare agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.d. Therapeutic foster care service agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.e. Juvenile justice agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.e Adult criminal justice agencies/courts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.e. Mental health/drug courts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.e. Law enforcement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.f. Indian Health Service or other tribal programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.f. Indian Health Service youth regional treatment centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.f. Department of Veterans Affairs treatment facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.g. Homeless shelters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.g. Housing agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.g. Suicide/crisis hotlines and warmlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.g. Residential (non-hospital) crisis settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.h. Employment services and/or supported employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.h. Older adult services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.h. Other social and human service providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.h. Consumer operated/peer service provider organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7.i. Other (please describe):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.8. How does your CCBHC learn of clients' care transitions, such as hospitalizations or discharges? Check all that apply.

	Phone, fax, or email	Automatic alert from health information exchange (HIE)	Manual monitoring of HIE	Electronic notification via linked electronic health record systems	Other (please describe method)
D.8.a.1 Receives notification of hospital admission or discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.2. Receives notification of emergency department visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.3. Receives notification of residential facility admission or discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.4. Receives notification of use of crisis services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.5. Receives notification of care from primary care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.6. Receives notification of care from other community behavioral health providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.7. Receives notification of client interactions with criminal justice system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]
D.8.a.8. Receives notification of referral appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[Text box]

attendance (e.g., client attends appointment with primary care provider to which they were referred) [Text box]

D.8.a.9. Receives notification of other types of care transitions (please describe transition type): [Text box]

D.8.b. Are care transition notifications received: for most clients for only some clients for very few clients?

D.9. Does your CCBHC provide support or services for the 988 crisis hotline? If yes, please describe: [Text box]

D.10. What other initiatives is your CCBHC engaged in to improve care coordination (for example, Medicaid health homes, integration of primary and behavioral health care)? Please describe: [Text box]

E. CCBHC scope of services

In this section, we would like to learn about the services your clinic provides, the extent of their availability, and whether your clinic was providing them prior to certification.

E.1. Which of the following services does your CCBHC or designated collaborating organization(s) (DCO(s)) currently provide?
For each service, please indicate the following:
 1. If the service is provided by your CCBHC or a DCO
 2. The time of day/week the service is available.
 3. If the service was added in the past 12 months.

	Provided by:		Available:		Added in the past 12 months	Does not provide
	CCBHC	DCO	Business hours	Outside business hours		
E.1.a. Crisis Behavioral Health Services [ASK if E1A =1]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24-hour mobile crisis teams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency crisis intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis stabilization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.b. Screening, Assessment, and Diagnosis [ASK if E1B =1]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health screening, assessment, diagnostic services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use disorder screening, assessment, diagnostic services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.c. Person- and Family-Centered Treatment Planning Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.d. Outpatient Mental Health and/or Substance Use Disorder (SUD) Services [ASK if E1D =1]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Outpatient mental health counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient SUD treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivational interviewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual cognitive behavioral therapy (CBT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group CBT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online CBT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialectical behavioral therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First episode/early intervention for psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multi-systemic therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assertive community treatment (ACT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forensic ACT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence-based medication evaluation and management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication-assisted treatment for alcohol and opioid use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community wraparound services for youth/children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialty mental health/SUD services for children and youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.e. Psychiatric Rehabilitation Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[ASK if E1E =1]						
Medication education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skills training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychoeducation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community integration services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness management and recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supported education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.f. Peer Support Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[ASK if E1F=1]						
Peer support services for consumers/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer support services for families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.g. Targeted Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.h. Primary Care Screening and Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[ASK if E1H=1]						
Testing for hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Triglyceride testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Waist circumference screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood sugar testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: [text box]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.i. Intensive Community-Based Mental Health Services for Armed Forces and Veterans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[IF E1I_PROVIDED="CCBHC" OR "DCO", ASK E1I_ACTIVITIES]						
Please describe any specific activities or services that are targeted to members of the Armed Forces or Veterans: Click here to enter description.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.1.j. Other required CCBHC services (please describe):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Click here to enter additional service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Click here to enter additional service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Click here to enter additional service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.2. If your CCBHC has made any changes to the scope of services provided in the past twelve months, please briefly explain why you made them. Click here to enter text.						

F. CCBHC quality and other reporting

Questions in this section will help us understand your clinic's efforts to monitor and improve care.

F.1.a. Does your CCBHC have a process in place to monitor its ongoing compliance with the CCBHC certification criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No [ASK F1B if F1A = 1 (YES)]
F.1.b. Please describe how your CCBHC monitors its compliance with the certification criteria: [Text box]
F.1.c. Has your CCBHC been unable to fulfill any of the following component(s) of the certification criteria at any point during the demonstration? Select all that apply.
<input type="checkbox"/> Staffing <input type="checkbox"/> Scope of services <input type="checkbox"/> Availability and accessibility of services <input type="checkbox"/> Quality and other reporting <input type="checkbox"/> Care coordination <input type="checkbox"/> Organizational authority, governance and accreditation
[ASK F1D if F1C = 1]
F.1.d. Why was your CCBHC unable to meet this/these component(s)? Please describe: [Text box]
F.2.a. Does your state conduct ongoing monitoring of CCBHCs' compliance with the certification criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No [ASK F2B if F2A = 1 (YES)]
F.2.b. How does your state conduct ongoing monitoring of CCBHCs' compliance with the certification criteria? [Text box]

F.3. Please list any current Continuous Quality Improvement projects underway as a result of the demonstration and the length of time they have been implemented. [Text box]

F.4.a. In the past 12 months, has your CCBHC used any of the quality measure data collected as part of the demonstration to change clinical practice? Yes No

[ASK F4B IF F4A=1(YES)]

F.4.b. Please describe what quality measure(s) your efforts to change clinical practice were based on and the nature of the changes to your clinical practice:

Measure 1: [textbox]; Changes to clinical practice: [textbox]

Measure 2: [textbox]; Changes to clinical practice: [textbox]

Measure 3: [textbox]; Changes to clinical practice: [textbox]

Any other measures: [textbox]; Changes to clinical practice: [textbox]

F.4.c. Did your CCBHC find all of the quality measures required for the demonstration relevant and useful for monitoring demonstration performance? Yes No

[ASK F2D if F2C = 0 (NO)]

F.4.d. Which measure(s) did your CCBHC not find relevant or useful and why? Please describe. [Text box]

F.5.a. Does your CCBHC use tools such as data dashboards, report cards, risk stratification to monitor and/or improve quality of care?

Yes No

[ASK F5B IF F5A = 1 (YES)]

F.5.b. What tools does your CCBHC use? Check all that apply:

Data dashboards

Report cards

Risk stratification

Other (please describe):

[ASK F5C IF F5B = Data dashboards OR Report cards]

F.5.c. Describe the types of information captured and presented by your CCBHC's data dashboard(s) or report cards (check all that apply):

Appointment statistics (appointments kept, no-shows)

Other quality measures (not required for the demonstration)

Quality measures required for the demonstration

Other: [Text box]

F.5.d. Can your CCBHC's data dashboards or report cards be viewed by all staff? Yes No

F.5.e. Describe how the information captured in your CCBHC's data dashboard(s) or report cards is used: [Text box]

F.6.a. Is your CCBHC eligible to receive Quality Bonus Payments from the state for achieving certain quality measure benchmarks or

improvements under the demonstration?

[ASK F6B IF F6A = 1 (YES)]

F.6.b. Has the opportunity to receive Quality Bonus Payments changed clinical practice at your CCBHC? Yes No

[ASK F6C IF F6B = 1 (YES)]

F.6.c. What aspect of the Quality Bonus Payments motivated changes to clinical practice at your CCBHC? Check all that apply.

- Bonus payment amounts
- The quality measures used to award payments
- The quality measure performance threshold used to award payments
- Comparing performance to other CCBHCs in your state
- Other (please describe):

G. CCBHC Costs

In this section we would like to know more about your CCBHC’s experience with the prospective payment system (PPS).

G.1. Please indicate if the PPS allowed your CCBHC to cover the costs of any of the following (select all that apply):

- Services not previously reimbursed under your Medicaid state plan (please indicate which services): [Text box]
- Staff or staff types not previously supported by traditional Medicaid or other reimbursement mechanisms (please indicate which staff types): [Text box]
- Access improvements (e.g., open access scheduling, transportation). Please describe these improvements: [Text box]
- Data collection or quality improvement activities (e.g., data dashboards). Please describe these efforts: [Text box]
- Other activities to support the CCBHC model” (e.g. training, staff meetings)
- Other activities not previously supported by traditional Medicaid or other reimbursement mechanisms (please describe): [Text box]

G.2.a. We would like to understand if the PPS rate for your CCBHC has been adequate to cover the costs of implementing the CCBHC model. Please indicate if the PPS does not fully cover the costs of providing the following services for clients enrolled in Medicaid:

- Crisis behavioral health services
- Screening, assessment, and diagnosis
- Outpatient mental health
- Outpatient SUD services
- Targeted Case Management
- Primary Care Screening and Monitoring
- Person- and Family-Centered Treatment Planning Services
- Psychiatric Rehabilitation Services
- Peer Support Services
- Intensive Community-Based Mental Health Services for Armed Forces and Veterans
- Other (please describe): [Text box]

G.2.b. Please indicate if the PPS does not fully cover the cost of the following activities to support the CCBHC model for clients enrolled in Medicaid:

- Services not previously reimbursed under your Medicaid state plan (please indicate which services): [Text box]
- Staff or staff types not previously supported by traditional Medicaid or other reimbursement mechanisms (please indicate which staff types): [Text box]
- Access improvements (e.g., open access scheduling, transportation). Please describe these improvements: [Text box]
- Data collection or quality improvement activities (e.g., data dashboards). Please describe these efforts: [Text box]
- Other activities to support the CCBHC model” (e.g. training, staff meetings)
- Other activities not previously supported by traditional Medicaid or other reimbursement mechanisms (please describe): [Text box]
- Other (please describe): [Text box]

G.3. To what extent did the actual number of visits during the year deviate from the projected number of visits used to set the PPS rate for the previous demonstration year? Select one response.

The actual number of visits in the previous demonstration year was:

- Very close to projected number of visits Not at all close to projected number of visits
 Somewhat close to projected number of visits Unsure

G.4. What challenges has your clinic experienced with the PPS, if any? [Text box]

H. COVID-19 Pandemic

In this section we would like to learn more about how the COVID-19 pandemic affected your CCBHC.

H.1.a. What steps did your CCBHC take to continue providing CCBHC services during the COVID-19 pandemic? Check all that apply.

- Expanded availability of individual telehealth services (e.g. virtual medication management, individual psychotherapy appointments)
 Expanded availability of group telehealth services (e.g., virtual 12 step or SMART Recovery meetings, virtual group therapy)
 Expanded availability of services provided outside of the clinic (e.g., meeting clients in outdoor locations)
 Other (please describe): [Text box]

[ASK H1B if H1A = 1]

H.1.b. Have the changes your CCBHC made as a result of the pandemic remained in place?

- Yes, all of them Yes, some of them No

[ASK H1C if H1B = 2 (YES, some of them)]

H.1.c. Which changes has your clinic maintained? [Text box]

H.2. Did the number of clients your CCBHC provided services to change in the first year of the COVID-19 pandemic?

- Number of clients increased Number of clients decreased No change

H.3. What was the impact of the COVID-19 pandemic on your provision of CCBHC services during the demonstration? For example, did your CCBHC discontinue certain services or lose staff? Please describe: [Text box]

Section I. Sustainability

In this section, we would like to learn about your clinic's plans for sustaining the CCBHC model.

I.1.a. Is your clinic planning to sustain the CCBHC model after demonstration funding ends? Yes No

[ASK I2B if I1A = 1 (YES)]

I.1.b. Does your CCBHC currently have a formal sustainability plan in place? Yes No

I.1.c. How does your clinic plan to sustain the model after demonstration funding ends (for example, seeking a CCBHC Expansion grant or using other Medicaid funding)? Please describe: [Text box]

[ASK I1D if I1A = 1 (YES)]

I.1.d. Are there components of the CCBHC model that you do not plan to sustain after demonstration funding ends (for example, certain state service requirements, quality measure reporting, staffing requirements)? Please describe which components and why if so: [Text box]

J.1. Please use the space below to provide any additional information that you think would help us understand your clinic's experience implementing the CCBHC model. If you do not have additional information to add, please click next to complete the survey.

[Text box]

Thank you for your responses to this survey! To change any of your answers, please click "Back". To complete the survey, click "Next"