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 <u>FIRST</u> 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.

☐ C.1.a Self-referral
☐ C.1.b Referred by physical health care providers
☐ C.1.c Referred by other behavioral health providers
☐ C.1.d Referred by courts/involuntary or assisted outpatient treatment order
☐ C.1.e Referred by schools or other child service providers
☐ C.1.f Referred by family
☐ C.1.g Referred by crisis service providers
☐ C.1.h Referred by hospitals
☐ C.1.i Referred by emergency departments
☐ 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".

☐ C.2.a. Expansions or additions to the CCBHC building
☐ C.2.b. Renovations to existing CCBHC facilities
☐ C.2.c. Improvements to facility safety features
☐ C.2.d. Other changes: [Text box]
○ 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.

☐ Clients' homes
☐ Hospitals
☐ Emergency departments
☐ Restaurants, coffee shops
☐ Shelters
☐ Social service organizations (e.g., Medicaid, housing agencies)
☐ Schools
☐ Parole offices
☐ Courts, jails, police stations or law enforcement offices
☐ Libraries
☐ Other community locations (please describe): [Text box]

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.

☐ Crisis services
☐ Screening, assessment, and diagnosis
☐ Outpatient mental health
☐ Outpatient SUD services
☐ Person- and Family-Centered Treatment Planning Services
☐ Psychiatric Rehabilitation Services
☐ Peer Support Services
☐ 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.

- ☐ Mental health clinicians
- ☐ Substance use disorder clinicians
- ☐ Case managers
- ☐ Consumers/clients
- ☐ Client family members
- ☐ Psychiatrists
- ☐ Primary care providers
- ☐ 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?

- ☐ CCBHC leadership (e.g., executive director, medical director)
- ☐ 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
☐ Data dashboard(s)
☐ Electronic prescribing
☐ Electronic exchange of clinical information with external providers
☐ Clinical registry
☐ State operated health information exchange
☐ Privately operated health information exchange
☐ Patient portals
☐ Other health information technology (please describe): [Text box]

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	☐	☐	☐	☐
D.7.a. Rural health clinics	☐	☐	☐	☐
D.7.a. Primary care providers	☐	☐	☐	☐
D.7.a. Urgent care centers	☐	☐	☐	☐
D.7.a. Emergency departments	☐	☐	☐	☐
D.7.b. Inpatient psychiatric facilities	☐	☐	☐	☐
D.7.b. Psychiatric residential treatment facilities	☐	☐	☐	☐
D.7.b. Substance use disorder residential treatment facilities	☐	☐	☐	☐
D.7.c. Medical detoxification facilities	☐	☐	☐	☐
D.7.c. Ambulatory detoxification facilities	☐	☐	☐	☐
D.7.c. Post-detoxification step-down facilities	☐	☐	☐	☐
D.7.c. Hospital outpatient clinics	☐	☐	☐	☐
D.7.c. Medication-assisted treatment providers for substance use	☐	☐	☐	☐
D.7.d. Schools	☐	☐	☐	☐
D.7.d. School-based health centers	☐	☐	☐	☐

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

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	☐	☐	☐	☐	[Text box]
D.8.a.2. Receives notification of emergency department visit	☐	☐	☐	☐	[Text box]
D.8.a.3. Receives notification of residential facility admission or discharge	☐	☐	☐	☐	[Text box]
D.8.a.4. Receives notification of use of crisis services	☐	☐	☐	☐	[Text box]
D.8.a.5. Receives notification of care from primary care providers	☐	☐	☐	☐	[Text box]
D.8.a.6. Receives notification of care from other community behavioral health providers	☐	☐	☐	☐	[Text box]
D.8.a.7. Receives notification of client interactions with criminal justice system	☐	☐	☐	☐	[Text box]
D.8.a.8. Receives notification of referral appointment	☐	☐	☐	☐	[Text box]

attendance (e.g., client attends appointment with primary care provider to which they were referred) D.8.a.9. Receives notification of other types of care transitions (please describe transition type): [Text box]	☐	☐	☐	☐	[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:**			
	CCBHC	**DCO**	**Business hours**	**Outside business hours**	**Added in the past 12 months**	**Does not provide**
E.1.a. Crisis Behavioral Health Services [ASK if E1A =1]	☐	☐	☐	☐	☐	☐
24-hour mobile crisis teams	☐	☐	☐	☐	☐	☐
Emergency crisis intervention	☐	☐	☐	☐	☐	☐
Crisis stabilization	☐	☐	☐	☐	☐	☐
E.1.b. Screening, Assessment, and Diagnosis [ASK if E1B =1]	☐	☐	☐	☐	☐	☐
Mental health screening, assessment, diagnostic services	☐	☐	☐	☐	☐	☐
Substance use disorder screening, assessment, diagnostic services	☐	☐	☐	☐	☐	☐
E.1.c. Person- and Family-Centered Treatment Planning Services	☐	☐	☐	☐	☐	☐
E.1.d. Outpatient Mental Health and/or Substance Use Disorder (SUD) Services [ASK if E1D =1]	☐	☐	☐	☐	☐	☐

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

Waist circumference screening	☐	☐	☐	☐	☐	☐
Blood pressure screening	☐	☐	☐	☐	☐	☐
Blood sugar testing	☐	☐	☐	☐	☐	☐
Other: [text box]	☐	☐	☐	☐	☐	☐
E.1.i. Intensive Community-Based Mental Health Services for Armed Forces and Veterans	☐	☐	☐	☐	☐	☐
[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.	☐	☐	☐	☐	☐	☐
E.1.j. Other required CCBHC services (please describe):	☐	☐	☐	☐	☐	☐
1. Click here to enter additional service.	☐	☐	☐	☐	☐	☐
2. Click here to enter additional service.	☐	☐	☐	☐	☐	☐
3. Click here to enter additional service.	☐	☐	☐	☐	☐	☐

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? ☐ Yes ☐ 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.

☐ Staffing
☐ Availability and accessibility of services
☐ Care coordination
☐ Scope of services
☐ Quality and other reporting
☐ 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? ☐ Yes ☐ 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
☐ Risk stratification
☐ Report cards
☐ 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)
☐ Quality measures required for the demonstration
☐ Other quality measures (not 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 threhshold 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 servies 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
☐ Somewhat close to projected number of visits
☐ Not at all 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"