“Where to Start as a New CCBHC: Lessons from a First Round CCBHC Grantee”

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Today’s Speakers

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Supporting CCBHCs and Driving Transformational Change

- Comprehensive consulting firm specializing in transformational change to prepare providers for the value-based healthcare marketplace
- Has worked with more than 800 providers, including more than 45 current CCBHCs participating in the initial SAMHSA pilot
- Leverages state-of-the-art analytical tools to achieve meaningful outcomes:
  - Increase access
  - Expand clinical services and capacity
  - Workforce management and staff retention
  - Demonstrate value
Central Nassau Guidance & Counseling Services
A Certified Community Behavioral Health Clinic
Serving the Long Island community since 1972
“△” = Main HQ / Core-Service Sites

Red circles show a small sampling of Residential and Mobile service sites

(CN houses 250+ individuals in supported housing and delivers mobile outreach/care at over 150 sites across Nassau and Suffolk County, from the border with Queens to central Suffolk County.)
## CN Guidance Offers Continuum of Behavioral Health Services

- CCBHC: Integrated Outpatient Treatment Services
- Personalized Recovery Oriented Services (PROS)
- The Wellness Center (on-site primary care)
- Assertive Community Treatment
- Residential Services (Congregate Care, Apartment Tx, Supported, HUD)

- Health Home Care Management
- Mental Health Court Care Coordination
- Adult BH Home & Community Based Waiver Services
- Project FORWARD
- Project Connect (ER overdose transitional services)
- Project LinkAge (Geriatric home & community based services)
CN Guidance’s CCBHC Array of Services

- 24/7 Mobile Crisis
- Peer Supports
- Care Transitions – No 4 walls
- Targeted Case Management
- Integrated SUD & MH Outpatient Treatment
- Veterans’ Services
- Psychiatric Rehabilitation
- Tele-psychiatry
- Outpatient Detox / MAT
- Mobile AWS/MAT Services
- Health Monitoring/Onsite primary care
Certified Community Behavioral Health Clinics (CCBHCs) have an excellent opportunity to be helpful partners in the new integrated healthcare system if they can display the following specific **values**:

1. **Be Accessible** (Provide fast access to all needed services) in house and out of the office (Non 4 Walls).
2. **Be Efficient** (Provide high quality services at lowest possible cost).
3. Be Connected (Have the ability to share core clinical information electronically).
4. Be Accountable (Produce information about the clinical outcomes achieved).
5. Be Resilient (Have ability or willingness to use alternative payment arrangements).
Making the CCBHC Conversion a Reality!

"The Heavy Lift"

What it will take to meet the criteria for CCBHC Status
Core Requirements

• **Program Requirement 1: Staffing** ("Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic’s patient population.")

• **Program Requirement 2: Availability and Accessibility of Services** ("Availability and accessibility of services, including: crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient’s ability to pay or a place of residence.")
Core Requirements

• **Program Requirement 3: Care Coordination**  (“Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

  • (i) Federally-qualified health clinics (and as applicable, rural health clinics) to provide Federally-qualified health clinic services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.
  • (ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.
  • (iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment clinics, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.
  • (iv) Department of Veterans Affairs medical clinics, independent outpatient clinics, drop-in clinics, and other facilities of the Department as defined in section 1801 of title 38, United States Code.
  • (v) Inpatient acute care hospitals and hospital outpatient clinics.”

What This Means for You
Program Requirement 4: Scope of Services ("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.
- (ii) Screening, assessment, and diagnosis, including risk assessment.
- (iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- (iv) Outpatient mental health and substance use services.
- (v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- (vi) Targeted case management.
- (vii) Psychiatric rehabilitation services.
- (viii) Peer support and counselor services and family supports.
- (ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.")
Making the CCBHC Conversion a Reality!

**opportunity**

*noun*  
op·por·tu·ni·ty  
\ä-par-ˈtu-nə-tee, -ˈtyū-

**Simple Definition of OPPORTUNITY**

: an amount of time or a situation in which something can be done

**Full Definition of OPPORTUNITY**

*plural* op·por·tu·ni·ties

1: a favorable juncture of circumstances <the halt provided an opportunity for rest and refreshment>

2: a good chance for advancement or progress

Source: http://www.merriam-webster.com
Benefits of Being a CCBHC

What are the biggest benefits to being a CCBHC?

- Preparing for VBP - reporting outcomes and values
- Greater access to care - increased over 42%
- Integration of care - no wrong door
- Recruiting talent
- Data-driven care
- Offering enhanced services – peer, psych rehab
- Services delivered in the community
- Transformational thinking
- Improved workflows & efficiencies
Get Yourself Ready

- Management buy in/ownership
- Transformational change on all levels
  - Change in organizational work flows
  - Managing resistance to change
  - Operational shift
- Be prepared to shift your thinking
What to Tackle First

What should new grantees look at first?

- MTM Readiness Survey: create comprehensive work plan
- Strategy to “buy or build” core services
- Weekly Meetings: leadership, management and compliance to get buy in
- Project management software: track tasks and responsibilities
- Onboarding plan for staffing patterns
- Capacity projections
- Space requirements
- Review cash flow to implement: increase line of credit?
- Frank discussion with IT vendor: can they meet reporting requirements? By when?
- Develop plan for manual chart extraction
- Ability to manage transformational change - train management
- Develop collaborative agreements & set up meetings to introduce CCBHC concept to community
- Workforce development needs
Implementation Teams

Implementation Process Teams Interaction Chart

Implementation Team
Team Duties:
Operationalize training, resources, and technology for the pilot and the final implementation process, as per the Implementation Matrix Timeline.

Scramble Team
Team Duties:
Respond quickly to any challenges that arise for staff once the pilot or final implementation timeframe has begun.

Monitoring/Eval. Team
Team Duties:
Evaluate the success of the change piloted or implemented by the implementation team.

Organizational Staff

Has Sufficient Progress of the Desired Change been attained?

Challenges Response

Is there a challenge to be addressed?

Source: MTM Services
Workflow

Embed Data Requirements Into Workflow

• Clinical
• IT
• Business Intelligence
• Billing/Claims Based data
Defining Workflow

Workflow:

– The flow of work through operations both clinical and non-clinical, where work is comprised of three components: *inputs* are *transformed* into *outputs*.

– The activities, tools, and processes needed to produce or modify work, products, or services. More specifically, clinical workflow encompasses all of the 1) activities, 2) technologies, 3) environments, 4) people, and 5) organizations engaged in providing and promoting health care.

Source: U.S. Department of Health and Human Services
What is Workflow?

• Workflow is the sequence of:
  – Physical and/or mental tasks performed by various people over time and through space
    • It can occur at different and/or multiple levels (e.g., one person, between people, across organizations)
    • It can occur sequentially and/or simultaneously

Source: U.S. Department of Health and Human Services
Operationalizing Workflows

• Inter-organizational workflow:
  – Workflow between a physician and a community pharmacy, or
  – Between an emergency department physician and a CCBHC to share information about a patient.

• Clinic-level workflow:
  – Flow of a physician, nurse or patient through physical space, and
  – The flow of information, in paper or electronic formats, among people at a practice or clinic to collect the quality measures.

Source: U.S. Department of Health and Human Services
Work flows in different ways

• Intra-visit workflow:
  – Workflow during a patient visit, which involves the workflow of the visit (e.g. assessing the metabolic needs, asking for a problem list, then do history and physical, then prescribe treatment)

• Cognitive workflow – the workflow in the mind:
  – Perception, clinical decision making, and response execution
  – A clinician might be thinking: “listen for any significant acute problems and deal with those first. Also, investigate my concern about trauma. If I don’t hear any, focus on the chronic problems.”

Source: U.S. Department of Health and Human Services
# CNG Workflow for BMI

## CCBHC Workflow: Preventive Care & Screening: Body Mass Index Screening and Follow Up

All clients over the age of 18 must have a BMI value recorded, no older than 6 months.

If not WNL a follow up plan is documented, no older than 6 months.

<table>
<thead>
<tr>
<th>How does this start?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A report will indicate that a client needs their BMI calculated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI takes Height &amp; Weight of client to record BMI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapist &amp; Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI records Vital Signs in the Vital Signs form (for the prescriber) and then documents their services completely, in the Health Monitoring form.</td>
</tr>
</tbody>
</table>

MI can also do some of the follow up plans: *Provide Education* *Referred to Dietitian, Nutritionist, OT, PT, PCP, Exercise Physiologist, MI Profession, Surgeon* *Exercise Counseling* *Nutrition Counseling* |

<table>
<thead>
<tr>
<th>Other Treatment Team Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Assistant performs and documents a follow up plan.</td>
</tr>
</tbody>
</table>

If further escalation is indicated or requested, then the MA refers to the therapist/care coordinator/TCM/PCP/SN for action & documents.
BMI Outcomes

CCBHC Metric: WCC-BH
BMI for Children/Adolescents

Compliance Trend
Current Compliance Rate

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Know Your Measures

- Process measures – used to determine if the providers are following the protocol defined in the measure

- Outcome measures – used to determine if the protocol is having the desired effect based on a clinical measure, such as a lab or vital sign
## First 3 Quarters Testing Results

<table>
<thead>
<tr>
<th>Description</th>
<th>Measure Name</th>
<th>NY Min</th>
<th>NY Max</th>
<th>CNG’s DY1-Q1</th>
<th>CNG’s DY1-Q2</th>
<th>CNG’s DY1-Q3</th>
<th>Sparkline</th>
<th>Description</th>
<th>Measure Name</th>
<th>NY Min</th>
<th>NY Max</th>
<th>CNG’s DY1-Q1</th>
<th>CNG’s DY1-Q2</th>
<th>CNG’s DY1-Q3</th>
<th>Sparkline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Initial Evaluation (Adults)</td>
<td>I-EVAL</td>
<td>&lt; 10 days</td>
<td>3</td>
<td>2.1</td>
<td>1.5</td>
<td></td>
<td></td>
<td>SRA for Children</td>
<td>SRA-BH-C</td>
<td>5%</td>
<td>100%</td>
<td>100.0%</td>
<td>91.9%</td>
<td>99.0%</td>
<td></td>
</tr>
<tr>
<td>Time to Initial Evaluation (Children)</td>
<td>I-EVAL</td>
<td></td>
<td>12.2</td>
<td>10.2</td>
<td>5.7</td>
<td></td>
<td></td>
<td>SRA for Adults</td>
<td>SRA-A</td>
<td>54%</td>
<td>99%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>90.9%</td>
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</tr>
<tr>
<td>BMI Assessment and Intervention</td>
<td>BMI-SF</td>
<td>28.7%</td>
<td>68.2%</td>
<td>18.6%</td>
<td>60.0%</td>
<td>73.0%</td>
<td></td>
<td>Depression Screening &amp; Follow-up</td>
<td>CDF-BH</td>
<td>12%</td>
<td>73%</td>
<td>11.0%</td>
<td>16.6%</td>
<td>73.6%</td>
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<tr>
<td>BMI Assessment and percentile Calculation for Children</td>
<td>WCC-BH</td>
<td>28.7%</td>
<td>68.2%</td>
<td>0.0%</td>
<td>34.8%</td>
<td>35.2%</td>
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<td>Depression Remission at 12 Months (Index Visits)</td>
<td>DEP-REM-12</td>
<td>N / A</td>
<td>65</td>
<td>92</td>
<td>156</td>
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<tr>
<td>Tobacco Assessment &amp; Intervention</td>
<td>TSC</td>
<td>72.6%</td>
<td>98.5%</td>
<td>62.5%</td>
<td>96.2%</td>
<td>94.7%</td>
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<td>Deaths by Suicide</td>
<td>SUIC</td>
<td>N / A</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Assessment &amp; Intervention</td>
<td>ASC</td>
<td>48.9%</td>
<td>99.9%</td>
<td>88.9%</td>
<td>60.9%</td>
<td>92.7%</td>
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<td>Suicide Attempts</td>
<td>SU-A</td>
<td>N / A</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Housing Status</td>
<td>HOU</td>
<td>95%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Housing Status</td>
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**Know Your Measures**
Outcome Measure: PHQ-9 Scores

Initial & Most Recent PHQ Scores

50.82% overall decrease
Lessons Learned

What are some of your lessons learned?

• Sustainability, sustainability, sustainability…
• Reporting requirements - test and improve workflows quarterly
• Do you have the infrastructure to do this? Can you share costs with other CCBHCs?
• Ability to manage resistance to change & burnout - prepare management first!!!
• Challenge every assumption that everything works…inspect what you expect
• Invest in Business Intelligence & Data Analytics Software
• Invest in a good EMR – must have access to your data
• Invest in HIT and QI talent - to know, understand and manage your measures
• Continuous financial projections and forecasting
• Build relationships with other CCBHCs – don’t do this alone
• Become data driven
Would you do it again?

If you had to do it over again........
What’s Next

What’s next for CN Guidance as you move into year 2?

- Population health management – moving needle on outcome measures
- Executing sustainability plan
- IPA relationships
- Positioning for value based payment
Questions
Reach Out with Questions

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