Checklist

Part 1: Attachments

_____ Attachment 1: State's Compliance with CCBHC Certification Checklist
_____ Attachment 2: Medicaid Statement
_____ Attachment 3: Participating CCBHC's List
_____ Attachment 4: Signed Statement that state will pay for services at the established rate
_____ Attachment 5: Description of Scope of Services

Part 2: Program Narrative

_____ Narrative

Part 3: Prospective Payment System Methodology Description

_____ Completed required forms

PART 2: PROGRAM NARRATIVE

A. Solicitation of Input by Stakeholders

The Oregon Health Authority (OHA) has actively engaged in planning and outreach activities with various stakeholders throughout Oregon to appropriately prepare for the Certified Community Behavioral Health Center (CCBHC) demonstration project. This process has been intentional, striving to assure meaningful representation from a variety of stakeholders, including providers, consumers, family members, policy makers, health plans, and tribes. Oregon continues to align with the Triple Aim of Healthcare reform (Institute for Healthcare Improvement): better health, better care and lower costs for all Oregonians. OHA believes successful implementation of CCBHCs will contribute to meeting these goals. The following represents a description of outreach activities and how they contribute to the state's readiness for full demonstration project implementation in 2017.

Achieving input throughout the grant period

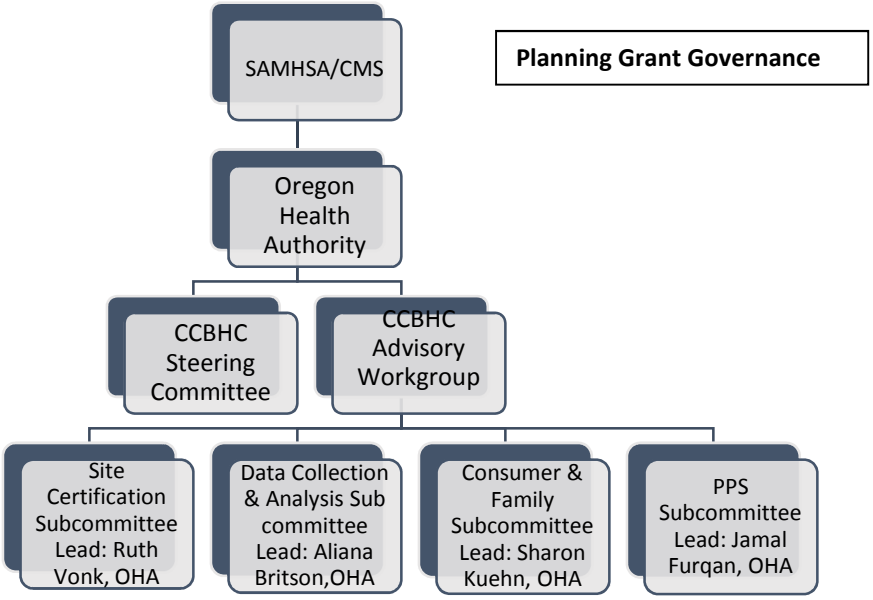
CCBHC Stakeholder Advisory Workgroup: OHA began outreach to engage stakeholders in Oregon's CCBHC design planning process in December 2015. This included phone calls, email, letters and personal invitations to assure broad representation from the healthcare industry and consumer voice would be well represented throughout the duration of the planning grant activities. OHA hosted a preliminary Stakeholder Advisory Meeting in January 2016, which was attended by 31 individuals. Fifty percent of those participating identified as consumers or family members of consumers. In an effort to encourage broad participation, individuals were able to attend in person in or call in by telephone. To assure communication with those unable to participate, discussion notes are posted online at http://www.oregon.gov/oha/bhp/Pages/CCBHC-Advisory-Group.aspx. The Advisory Stakeholder Group has convened monthly throughout the planning grant period to provide input on the CCBHC design model in Oregon, raise key questions, as well as provide information sharing. Over the course of the planning grant, consumer and family member participation has varied from 25% to 50% at the CCBHC Stakeholder Advisory Workgroup meetings. While Stakeholder Advisory membership is limited by invitation, meetings are open to the public and CCBHC applicants were automatically added to the communications roster beginning in June.

CCBHC Steering Team: Given the short project timeline, OHA established a steering team composed of key members of the Stakeholder Advisory Workgroup, which is inclusive of consumer and family representatives. The steering committee meets approximately every three weeks, and is charged with communicating provider concerns and interests, raising questions, and providing guidance around key decision points which may arise between monthly advisory workgroup meetings.

CCBHC Planning Grant Governance: The activities conducted as part of the CCBHC planning grant have been largely driven by the aforementioned groups. An additional, more specific set of sub-committees was developed to dive deeper into specific planning grant issue areas. Members of the Stakeholder Advisory Group were offered the opportunity to serve on one or more of four subcommittees. Each subcommittee is led by an OHA staff member who facilitates

communication and tracks any recommendations or decisions made by the group. These include:

1. **Data Collection and Analysis:** Launched in June, this subcommittee focuses on identifying the data collection needs and appropriate tools to gather this information to demonstrate that the project is meeting the identified goals.
2. **Prospective Payment System:** One of the first two subcommittees to form, this group became active in February and focuses on identifying questions and resources regarding payment methodology.
3. **Consumer and Family Engagement:** Launched in July, this subcommittee focuses on assuring that consumer voice is represented at all levels of the CCBHC initiative.
4. **Certification:** Launched in February, this group hosted early design planning and process calls as they pertained to the CCBHC application and site certification process.



In February 2016, OHA created an email address for the CCBHC process to facilitate two-way communication between providers, consumers, and other interested parties with project staff. This email, ccbhc.grant@state.or.us, has been a useful tool. Further, OHA launched the CCBHC website (http://www.oregon.gov/oha/bhp/Pages/Community-BH-Clinics.aspx) and delivery subscription service in February, 2016. By July, the subscription service reported over unique subscriber email addresses.

Additional CCBHC Stakeholder Engagement: In March 2016, OHA conducted a survey of providers throughout the state regarding their interest in becoming CCBHCs. The OHA made the survey available via Survey Monkey. A link was posted on the Oregon CCBHC website and also distributed to tribal representatives and multiple OHA managed list-servs. The survey was open from March 23, 2016 through April 1, 2016. Approximately seventy-five organizations responded to the survey. Of the respondents:

- 32 organizations indicated that they were "very interested in becoming a CCBHC"
- 36% indicated that they were "ready" or "mostly ready" to meet CCBHC criteria
- 72% had accessed the National Council's readiness tool, which was posted on the Oregon CCBHC website.
- 58% had completed or partially completed the readiness tool.
- Fewer than 10% of respondents identified as FQHCs or Tribal Clinics.

Modeled after SAMHSA's Technical Assistance (TA) calls, the OHA began hosting regular TA calls in March. Between March and October calls were conducted approximately every two weeks to address any questions stakeholders, interested community partners, or prospective CCBHCs would like to ask. Open to the public, the calls were hosted by the CCBHC project director and team, and were announced through advisory group meetings, emails to CCBHC applicants, as well as posted on the CCBHC website. Discussion notes from select calls are available online.

Finally, the OHA hosted several statewide meetings to engage all interested parties in planning and preparation for the CCBHC Application. In April, a two-day planning meeting was held which addressed the needs assessment process, organizational qualifications, philosophy and standards (including Trauma Informed Care, Outside the Four Walls, Cultural Competence, and Evidence-Based Practices), service requirements and design elements, care coordination, financial design, and data and quality management. Input was garnered from consumers in particular to assure that their voices were heard and represented in the CCBHC design. In May and August, training was provided to address applicant progress toward certification and continue to immerse statewide partners in the philosophy and design of the CCBHC demonstration project.

Outreach, Recruitment and Engagement of Population of Focus

As noted previously, the OHA has made concerted efforts to engage consumers and family members of consumers from throughout the state in the CCBHC planning process. Participants have included Peer Recovery Mentors (both mental health and substance abuse), adults who identify as having severe mental health concerns, and family members of adults and children with significant behavioral disorders. Oregon has been on the forefront of developing and providing peer-delivered services. As a result, participants also represent several peer-delivered service organizations as well as traditional behavioral health organizations that incorporate peer-delivered services. Early participation of consumers and family members in the Stakeholder Advisory group was 50%, and then varying from 25 – 50%.

Peer, consumer and family representatives are key members of the Consumer and Family Subcommittee. While this subcommittee took a bit longer to launch, their insight to the planning and implementation of the CCBHC initiative is crucial. A consumer and family specialist also serves on the Certification team. The Consumer and Family Subcommittee has built upon information gathered through a series of Behavioral Health Town Halls that were held throughout the state in early 2015. The Town Halls, which were attended by approximately 55-consumers and their family members, a foundation was laid that noted the positive growth of

peer delivered services, and access to supported employment programs, while gaps remained in overall service access, integration, service coordination, and quality of care. By the end of the planning grant cycle, the Consumer and Family Subcommittee had developed a list of nine recommendations designed to strengthen peer supports, person-centered, and family-centered care during the implementation period.

In April 2016, OHA hosted a Design Summit which included an array of service provider representatives, but specifically engaged consumers so that their voice could be included in the planning process. A key outcome of this summit was the development of a Ten Question Guidance Survey which was intended to assist organizations in determining their readiness to apply for CCBHC status. Of note was the inclusion of an organization's willingness to address issues of importance to consumers. Specifically, organizations were to assess whether they had a core commitment and service orientation, including trauma informed, outside the four walls approaches, to address the needs of OHP members with serious mental illness, serious emotional disturbance, and substance use disorders.

Coordination with Other Agencies

The OHA has been diligent in its work to coordinate work with other agencies operating in the state that may have interest in the CCBHC initiative. These have included the Veterans Administration, tribal governments, insurance providers and Care Coordinating Organizations (CCO).

The OHA has worked to be inclusive and transparent with key partners and organizations from the outset. Prior to submitting the planning grant application, the OHA convened a stakeholder meeting to review the state's proposed approach to the grant application and solicit feedback from stakeholders. Based on their initial support, the OHA continued with the application. Representatives from the following organizations were invited to participate:

- Behavioral Health Directors for Coordinated Care Organizations
- Association of Community Mental Health Programs
- Oregon Prevention, Education and Recovery Association
- National Alliance on Mental Illness– Oregon Chapter
- Oregon Residential Provider Association
- Addictions and Mental Health Planning and Advisory Council
- Oregon Consumer Advisory Council
- Children's System Advisory Committee
- Oregon Primary Care Association (FQHCs)
- Indian Health Services and Tribal 638 health clinics

The OHA has reached out to the Veteran's Administration from the outset of planning. The Director of the Oregon Department of Veteran's Affairs was invited to all stakeholder meetings. Active involvement with the Veteran's Administration began in August with engagement from site specific leadership. While CCBHCs are asked to develop relationships with their local

veteran's services, OHA is developing a statewide MOU with the Veteran's Administration that covers all CCBHCs.

There are nine federally recognized tribes in Oregon that provide IHS funded physical and behavioral health services, as well as one urban Indian physical and behavioral health provider, which is also a FQHC. Tribal participation in early stakeholder meetings and conversation was limited. To address specific tribal concerns, two OHA staff members were included in the May quarterly tribal meeting to discuss the CCBHC planning grant activities. Since the CCBHC application deadline was close to closing at this time, the OHA re-opened the application specifically for tribes from June 9, 2016 to July 8, 2016. While none of the tribes decided to pursue CCBHC certification, CCBHCs throughout the state are committed to care coordination with tribes to ensure full service provision for any tribal member.

B. Certification

The OHA has carefully crafted a certification process for CCBHC's that supports our Triple AIM of better health, better care, and lower costs for all Oregonians. The process has included statewide outreach to assure the best access throughout the state based on needs assessed at the state and local level, technical assistance and training for providers, a clear process for application and review and certification, and steps to assure that evidence-based practices are used.

Oregon's vision for delivery system transformation is to deliver the right care, at the right time and right place. Through the CCBHC demonstration program, the OHA is building upon existing and emerging health system infrastructures that have been central to the State's transformation progress to strengthen physical and behavioral health care delivery in behavioral health settings. Specifically, the OHA is leveraging experience with the Patient-Centered Primary Care Home Program (PCPCHP), the OHA Behavioral Health Home Learning Collaborative, and the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Pilot. Overall health system capacity has been expanded through the application of broader interdisciplinary team-based care, care coordination and developing new sites of care.

The OHA has successfully developed and implemented the Patient-Centered Primary Care Home Program (PCPCH), Oregon's version of the "medical home model" of primary care organization and delivery. The program identifies primary care homes, promotes their development, and encourages Oregonians to seek care through recognized primary care homes. More than 560 clinics have been recognized as a PCPCH since the program began in 2011; of these, 27 are also FQHCs.

The OHA is leveraging its PCPCH experience to develop the Behavioral Health Home (BHH) model. In 2015, a stakeholder advisory committee was convened to develop standards for BHHs. An overarching goal of this process is to focus on whole-person care and highlight collaboration between primary and behavioral health care as opposed to creating two competing models. The committee developed the BHH model with over 40 specific measures

which provide a framework for integrating physical health services into behavioral health care settings. At this time there is no BHH recognition from the state akin to PCPCH recognition. To align this work with the CCBHC demonstration, organizations applying to become a CCBHC in Oregon must meet 9 Oregon Standards for CCBHCs which have adapted from the BHH model in addition to the federal CCBHC standards. The standards, referred to as the Oregon CCBHC Standards are:

1. **Telephone and Electronic Access** - CCBHC provides continuous access to behavioral health advice by telephone.
2. **Performance and Clinical Quality** – CCBHC tracks one quality metric from the core or menu set of PCPCH Quality Measures. See appendix A for list of measures.
3. **Provision of Services** – CCBHC reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation.
4. **Coordination and Integration with Primary Care** – CCBHC has primary care services onsite at least 20 hours a week and has a process to insure patients can access primary care services during the hours onsite primary care is not available.
5. **Organization of CCBHC Information** – CCBHC maintains a health record for each consumer that contains at least the following elements: problem list, medication list, medication list, allergies, basic demographic information, preferred language, and updates this record as needed at each visit.
6. **Specialized Care Setting Transitions** - CCBHC has a written agreement with its usual hospital providers or directly provides routine hospital care.
7. **Care Coordination** – CCBHC demonstrates that members of the health care team have defined roles in care coordination for consumers and tell each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care.
8. **End of Life Planning** – CCBHC has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from them.
9. **Language and Cultural Interpretation** – CCBHC offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice.

Application and Review Procedures: The OHA was prepared to certify up to 30 CCBHC's throughout the state, with the intent of CCBHCs being accessible in urban, rural and frontier counties. The OHA began offering training and technical assistance to providers as early as March. Certification is provided at the organizational level, with each organization identifying any satellite sites.

Phase 1 – Development of temporary rule: The OHA established Temporary Administrative Rules which gave the state authority to certify CCBHCs. The rule later became permanent. See Appendix B.

Phase 2 - Application: The OHA launched an electronic application for potential CCBHCs to begin the path toward CCBHC certification. All clinics interested in participating in the demonstration were required to submit applications by May 25, 2016. The OHA added an application specific to Tribal Clinics, and their deadline was extended to July 8, 2016.

Phase 3 – Site Visits & Communications: Applications were received from 22 organizations throughout the state. Upon receipt of the application, OHA staff completed phone interviews with the applicants, scheduled the initial site visit, and provided a list of additional information to be gathered. The site visit structure is based on the OHA's current process for PCPCH site visits. The site visit provided an opportunity for the OHA to verify that the clinic is meeting all of the necessary criteria as well as an opportunity for technical assistance in areas where the clinic may need practice facilitation or other supports. The site visit team is comprised of:

- A Compliance Specialist, who is the primary contact for the clinic before the site visit, and assists the clinics with scheduling and preparing for the site visit. The role of the CS is to review documentation to verify the clinic is meeting the standards attested to in its BHH/CCBHC application. During the site visit the CS interviews front office staff, quality improvement teams and clinic leadership. The CS also conducts a chart review with a clinician or other clinic staff member;

- A Practice Enhancement Specialist to observe and verify the functionality of attested to BHH/CCBHC standards during the site visit, and provide technical assistance to the clinic. The PES disseminates tools and strategies for clinical transformation to the BHH/CCBHC and serves as a practice coach during the demonstration program;

- A Consumer/Family Specialist assesses consumer governance of the CCBHC transformation, provides consultation regarding recruitment and meaningful participation of consumers and family members of consumers.

Phase 3 – Site Improvement Plans and Response: Based on the site visit, Oregon's CCBHC Project Director coordinated with the certification team to prepare a written report (site improvement plan) for each CCBHC applicant. The site improvement plans directly aligned with the SAMHSA criteria as well as the Oregon CCBHC standards and was intended to address any inadequacies, or to move the organization closer to the level of readiness required by the OAR 049-062 to be included in the demonstration application. Site visits were conducted throughout summer 2016, with follow up and site plans completed by mid-October, 2016. Applicants were provided a timeline in which to complete and submit their Site Improvement Plans. Complete responses led to applicants being identified as eligible to be certified. Each CCBHC applicant received follow up from the Project Director regarding follow up to the individualized site improvement plans as well as status of certification. See Appendix C for a Work Flow Chart of the Certification Process.

CCBHC's: Fourteen organizations have completed applications and met initial standards to become CCBHCs, representing 16 of Oregon's 36 counties. These include four urban organizations, five rural organizations, and five frontier organizations

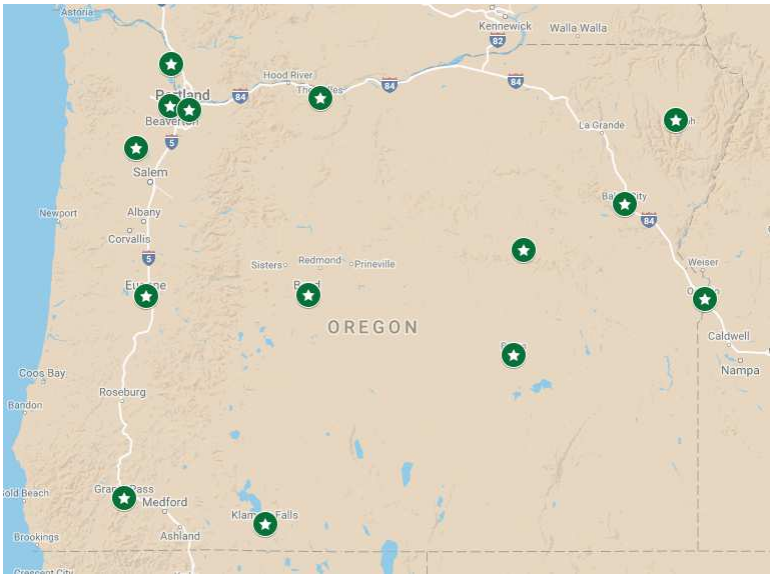


Figure A: Map of Oregon CCBHC locations, including satellite clinics. Locations are color coded by CCBHC organization affiliation.

Counties containing Oregon CCBHCs vary widely in population, from 6,814 people to 766,135. The highest populations are found in Multnomah and Washington counties (home to the Portland Metro area), as well as Lane County (home to Eugene, OR, the second largest city in the state). The lowest populations are found in Grant, Harney, and Wallowa counties, which all have populations under 10,000 people. Figure B indicates the population distributions per county.

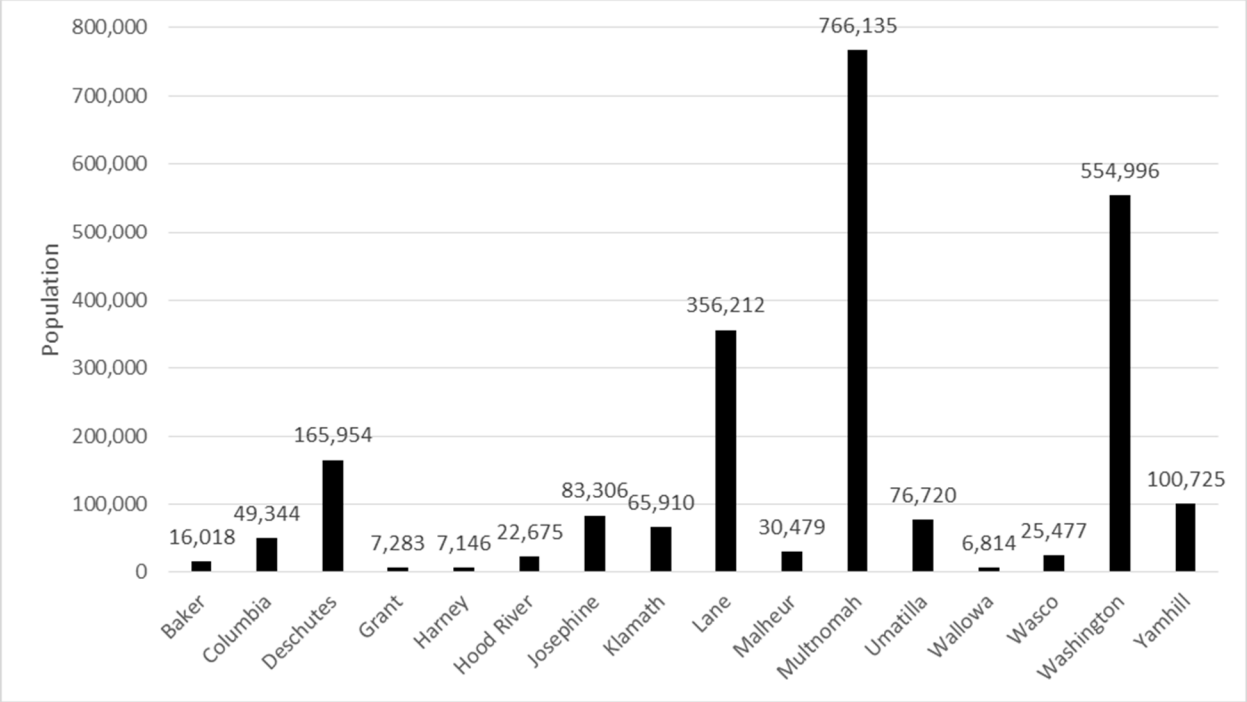


Figure B. Population of Counties that contain a CCBHC. From 2013 US Census data. www.census.gov

Population density (Figure C) varies widely for counties containing a CCBHC, with Harney County having the lowest population density (0.7 people per square mile) and Multnomah County having the highest population density (1,704.9 people per square mile). The Portland

Metropolitan Area, which is Oregon's largest urban center, includes Multnomah and Washington counties. By contrast, Baker, Grant, Harney, Malheur, and Wallowa counties all have population densities under 10 people per square mile, and are all located in Oregon's eastern desert.

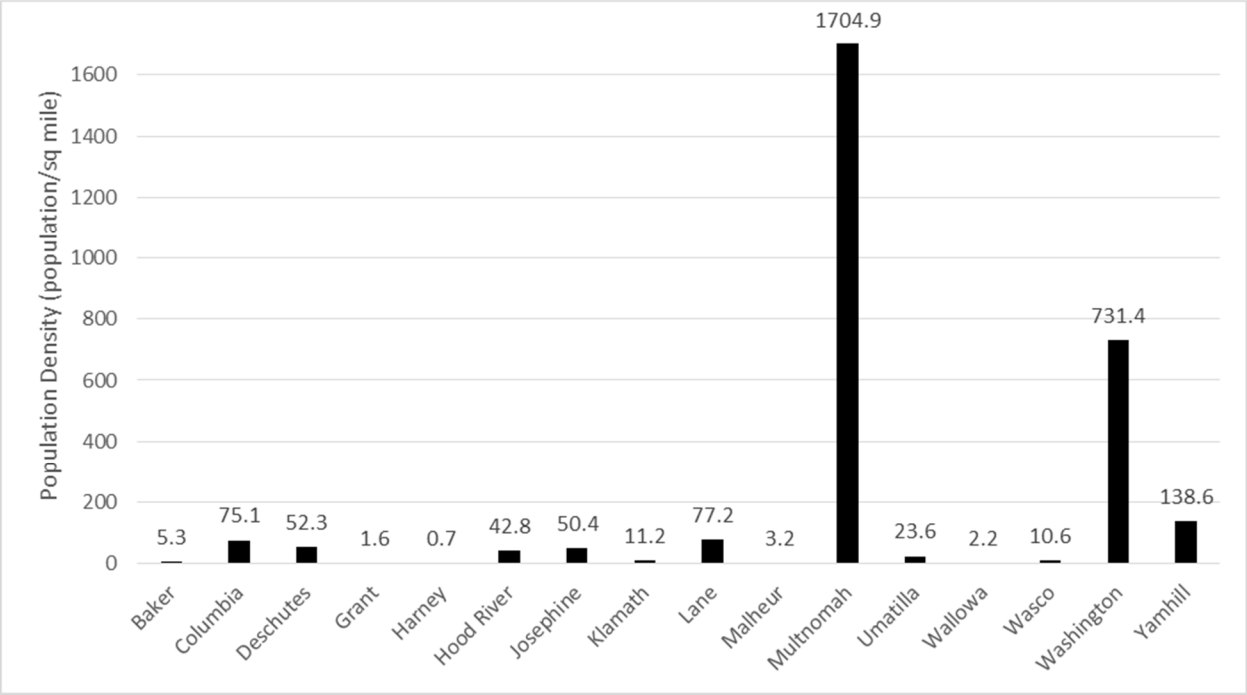


Figure C. Population density (per square mile) for counties containing a CCBHC. Data from 2010 Oregon Population and Housing Report.

Other indicator data differs significantly across the 16 counties. County growth rates vary from -4% to 8%. The growth rate was highest for Deschutes County, which is home to Bend, OR, and for Multnomah and Washington counties, which are rapidly growing and experiencing significant housing shortages. In 2014, Oregon's poverty rate was 16.1% (Oregon Center for Public Policy). Nine of the 14 CCBHCs are located in counties which exceed the state poverty level, with the lowest in Washington County (11%) and highest in Malheur County (29%). Finally, the unemployment rate was lowest in Hood River (5.3 %) and Washington Counties (9.6%), and highest in Josephine County (15.2%). Figure D provides a visual of this data.

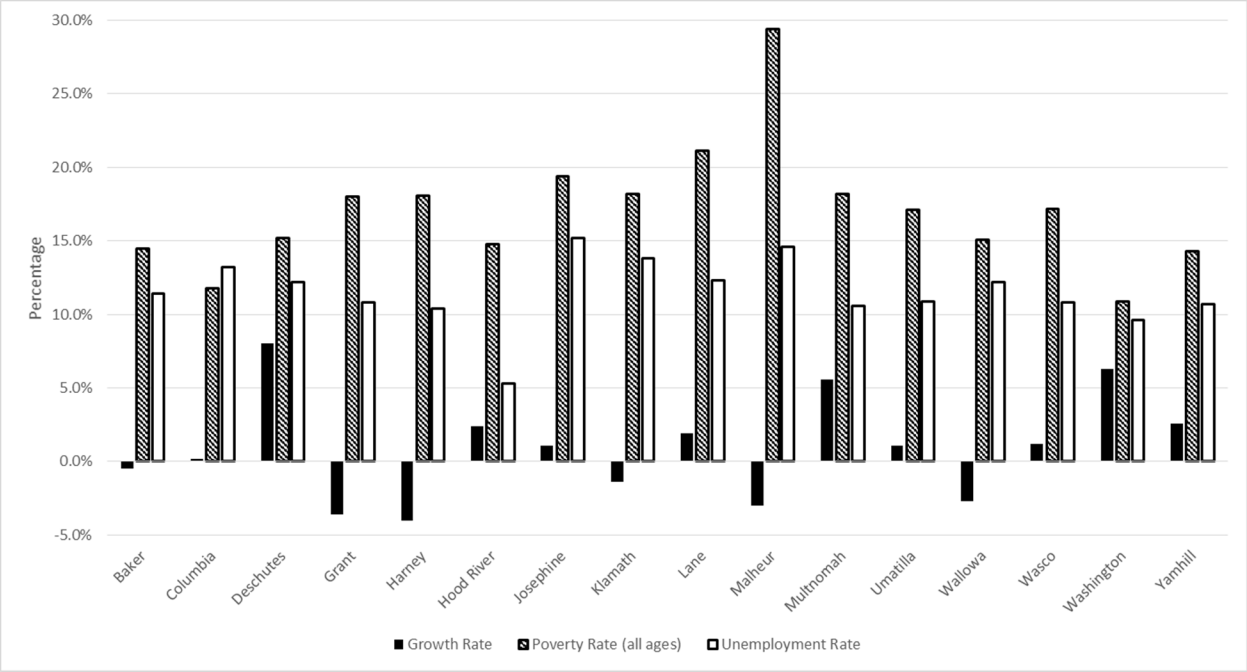


Figure D. Poverty, Growth & Unemployment. Data from 2013 US Census data.

Approximately 59% of Oregon's CCBHCs will be located in an MUA. While the vast majority of the CCBHCs located within an MUA serve a rural population, two CCBHCs located within a MUA serves an urban population. A list of CCBHC's indicating county, rural or urban, and MUA designation is provided in **Attachment 3.**

State Facilitated Cultural, Procedural, and Organizational Changes to CCBHC's Leading to High Quality, Person-Centered, Evidence-Based, Accessible Services: The OHA considers the planning and sees the implementation of the CCBHC model as a transformational initiative that brings a higher standard of care across the state. Every step taken is a step forward. Said one applicant on a recent consultation call, "…it's just about being better."

To support organizations on their journey to become CCBHCs, the OHA has engaged in a strategic planning process. Of key importance has been engagement with consumers and families. From the beginning, OHA staff have reached out to consumer community leaders to provide input into what they value and want in terms of quality and types of care. Further, each applicant organization is engaged with a consumer advisory board in which the guidance is to allow consumers and family members a genuine and meaningful role in the development and implementation of the CCBHC.

Planning for and becoming a demonstration state for the CCBHC also aligns with Oregon's Behavioral Health Strategic Plan for 2015-2018. CCBHC planning has built upon the statewide process to develop the Behavioral Health Strategic Plan which included a variety of Town Halls throughout the state. Key goals for the strategic plan that tie directly to the CCBHC initiative include:

1. Health equity exists for all Oregonians within the state's behavioral health system.
    a. Promote health equity and eliminate avoidable health gaps and health disparities in Oregon's behavioral health care system.
    b. Target and treat common chronic health conditions faced by people with severe and persistent mental illness, substance use disorders and co-occurring disorders.

2. People in all regions of Oregon have access to a full continuum of behavioral health services.
    a. Increase equitable access to prevention, treatment and recovery services and supports, which are culturally and linguistically appropriate, in underserved areas of the state.
    b. Expand access to crisis services in all areas of the state.
    c. Expand statewide access to medication assisted treatment.

3. The behavioral health system promotes healthy communities and prevents chronic illness.
    a. Ensure all Oregonians have access to prevention and early intervention programs that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels.
    b. Increase the availability of physical health care professionals in behavioral health care settings.
    c. Develop and enhance programs that emphasize prevention, early identification and intervention for at-risk children and families.
    d. Strengthen the prevention, screening and treatment of the psychological, physical and social impacts of early childhood and lifespan trauma.

The strategic plan also places a significant emphasis on the inclusion of consumers, peer-delivered services, and movement toward a Recovery Oriented System of Care. The alignment of the strategic plan with the CCBHC initiative assures legislative and policy support at the highest levels, while providing a consistent message for improvement and quality care at the service and community levels.

To facilitate these improvements, the OHA has provided a variety of supports both for applicants and for stakeholders. These have included an open and inclusive planning process that assures inclusion of diverse voices. The OHA engaged a consultant, Dale Jarvis and Associates, to provide direct support for agencies as they moved toward CCBHC readiness. This has included face to face technical assistance in different areas of the state, TA webinars that addressed policy and procedures, cost reporting, behavioral health mapping and other aspects of conducting a community needs assessment. The OHA also hosted a statewide Learning Collaborative event in May to assist organizations in understanding all of the elements of the CCBHC. Face to face events included training on specific populations (veterans), services (substance abuse and care coordination), cultural competence (readiness and resources), and models of care including Trauma Informed Care and Multi-Disciplinary Service Teams.

CCBHC Needs Assessment Process: The CCBHC Needs Assessment process has been an evolving and collaborative process, including local providers and the OHA. In Fall 2015, as part of the planning process for the state's behavioral health system, State Senator Sara Gelser and the OHA hosted a series of seven Town Hall meetings across the state. A total of 613 people attended, approximately 550 of whom were consumers of behavioral health services. Themes presented at the town halls were consistent: Systemic challenges that included lack of access, lack of specific resources statewide, and poor coordination; and the need for holistic supports including housing, transportation and work. Consumer suggestions to address concerns included increased crisis prevention and the development of behavioral health homes or "one-stop-shops."

The OHA has developed a behavioral health mapping tool that is designed to create a snapshot of population indicators, as well as behavioral health needs and unmet needs across the state and by county. CCBHC applicants were provided a needs assessment template and directed to the behavioral mapping tools for their counties to help complete their county level assessments (http://www.oregon.gov/oha/amh/Pages/bh_mapping.aspx). In addition to the preliminary population data, behavioral health needs and utilization, applicants were instructed to assess additional needs related to racial equity/disparity, transportation barriers, criminal justice backgrounds, developmental disabilities, veteran's status or other concerns specific to their community. These county specific assessments were used to plan CCBHC services by county, and then integrated into the statewide needs assessment and recommendations.

Various resources were brought together to assess need across the state of Oregon. Resources utilized include the preliminary 2015 Behavioral Health Mapping Profiles for each county in Oregon to assess statewide need, the 2015 results from the MHSIP surveys targeting adults and children, and a series of Behavioral Health Town Hall meetings held across the state in 2015. The preliminary data associated with the Behavioral Health Mapping Profiles quantified the size of unmet need in Oregon, while the MHSIP surveys track consumer satisfaction of those already receiving care. Finally, the Town Hall meetings provide a more in depth look into statewide and region specific issues in mental health care. Additionally, each CCBHC was required to complete a needs assessment for their service area based on the behavioral health mapping profile for their respective county/service area and any additional data available to the region. Individual CCBHCs identified local issues and populations that they wish to target, with rural/frontier clinics often citing transportation, traveling clinicians, and telehealth as an area for expansion and urban clinics often mentioning expanding services to those who live below the poverty line and increasing multicultural services. Telehealth and telemedicine were cited as means to address workforce shortages for rural clinics. Furthermore, many individual CCBHCs mentioned expanding services for veterans, expanding interpretive services, and increasing trainings for cultural sensitivity and veteran's issues. Many clinics also either currently offer or will expand their service hours beyond regular Monday-Friday 9am-5pm business hours. The needs assessment indicates many in Oregon would benefit from improved access to quality mental health resources, but that regional variation will require a multi-faceted approach to meeting the mental health needs of Oregonians.

Though unmet need and resources vary widely across Oregon, by performing local needs assessments each CCBHC was able to identify local solutions that will help alleviate the need for behavioral health services in their service areas. Due to Oregon's unique position in certifying 14 CCBHCs across the state, OHA believes the individual CCBHC clinics will be able to work collaboratively within the system to improve access and quality statewide.

Evidence-Based Practices: Oregon was an early adopter of evidence-based practices as a required element of state funded behavioral health services. The Health Evidence Review Commission reviews medical evidence in order to prioritize health spending in the Oregon Health Plan and to promote evidence-based medical practice statewide through comparative effectiveness reports, including Coverage Guidances, health technology assessments and evidence-based practice guidelines. The commission uses a transparent public process to ensure that its decisions are made in the best interest of patients and taxpayers while considering input from providers and members of the public, including those affected by the conditions discussed. Some of the current mental health EBPs that Oregon has particular investment in and provides support for centers of excellence include:

- Assertive Community Treatment
- Supported Employment
- Children's Wraparound/System of Care
- Trauma Informed Care
- Collaborative Problem Solving
- Parent Child Interaction Therapy
- Early Assessment and Support Alliance

Many other EBPs are implemented without direct support from the state office. Oregon has focused on assuring that some of the high cost specific population EBPs like Assertive Community Treatment are available in all areas of the state without requiring that those services are available in all programs. In light of this approach, the list of EBPs focuses on those practices that are applicable to a wider population at reasonable costs. The following are those practices identified that Oregon requires CCBHCs to provide:

- Peer Delivered Services
- Cognitive Behavioral Therapy
- Motivational Interviewing
- Recovery Supports
- Co-occurring Disorder Treatment

Guidance to CCBHC's regarding Organization Oversight that includes Consumers, Persons in Recovery, and Family: The OHA provided all organizations with the direct language from SAMHSA listed in the Program Requirements, Section 6b. At a minimum, each organization must be able to assure that they have a governing board in which at least 51% of the members being family members, consumers, or persons in recovery from a behavioral health disorder.

Further, the overall board should represent the demographic factors of the region served, such as race, gender, ethnicity, ability, age, and sexual orientation. Large, established organizations were provided alternative methods to meet this requirement while maintaining meaningful representation on the governing board. Specifically, an organization could create a Consumer Advisory Board in which one or more members also served as a voting member of the governing board.

C. Data Collection and Reporting

Data Collection and Reporting Capacity, Quality Reporting Requirements and Demonstration Evaluation Reporting Requirements: The state of Oregon currently has two major databases that relate to behavioral health claims and data, including the Materials Management Information System (MMIS) and Measures and Outcomes Tracking Systems (MOTS). Through MMIS the state can access all Medicaid claims (both paid and denied) submitted by each individual CCBHC, identify which service was provided through billing codes, cost of service, reimbursement, dates of service, which consumer was served, pharmacy claims, and more. The Oregon MMIS is configured to reimburse providers at their cost based encounter rate. PPS reimbursements will occur through the standard MMIS claims adjudication process, with all claims, provider, and recipient data being stored in the MMIS data warehouse. Oregon anticipates using the CCBHC specific encounter procedure code when it becomes available. Through MOTS the state is able to track multiple demographic variables for consumers such as race, ethnicity, gender, marital status, education, veteran status, living arrangements, number of dependents, insurance status, tribal affiliation, and employment status as well as mental health details such as diagnosis, mental health level of care, assessment of functioning, substance abuse issues (including age at first use and frequency of use), number of arrests, and positive alcohol/drug tests for both Medicaid and non-Medicaid consumers. Oregon also collects annual data using the Mental Health Statistics Improvement Program (MHSIP) survey, Youth Services Survey for Families (YSS-F), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This data would also be available for the state or Oregon to track and report on quality metrics.

Data Collection Systems: Oregon utilized its existing behavioral health fee schedule to create a cross-walk to the nine CCBHC Demonstration categories of services. This crosswalk was made publicly available to prospective CCBHCs to allow them to query their electronic health records and IT systems, and determine the amount, cost, and scope of CCBHC services they were already providing. The CCBHC Demonstration Service Crosswalk will also be a clear and concise billing document for CCBHCs during the demonstration year.

In preparation for data reporting for the CCBHC Demonstration program. The Oregon Health Authority supported the CCBHC applicants in submitting baseline data from the 2015 calendar year (Jan 1st, 2015 to Dec 31st 2015) for the 9 clinic-lead required measures. Both the SAMHSA data webinars provided by Truven Health and regular (weekly to every other week) meetings with a Level 3 OHA Research Analyst dedicated to preparing the state of Oregon for CCBHC data collection were used to assist clinics in a trial run of data collection, and to troubleshoot issues

that arose in order for clinics to be prepared for the demonstration program. Through this process we were able to identify and find solutions for many potential problem areas that would have greatly impacted accurate data reporting, including a timeline reporting issue for the measure DEP-REM-12 and issues with important mental health billing codes commonly used in Oregon that were not incorporated into the Clinic-Lead required measures. Having worked through these issues with the clinics and with guidance from SAMHSA, Oregon was able to incorporate slight modifications to the clinic-lead required measures that will increase the accuracy of data reporting for our CCBHCs.

Out of the 14 CCBHC applicants, 10 (71 %) reported some form of baseline data. Of the 4 clinics that did not submit baseline data, the majority cited having switched to an improved EHR during 2015 as the primary impediment for data submission. All 10 clinics that reported were able to report caseload characteristics. However, the number of clinics able to report baseline data for each measure varied depending on the metric (Table 1).

For the measures that the clinics were unable to report, and for clinics that were not able to report baseline data, plans have been submitted to the OHA detailing development and timelines for the ability report by demonstration program start date. Multiple CCHBC applicants conveyed that the process of submitting baseline data was very useful for helping them understand and troubleshoot the CCBHC reporting requirements for clinics, and to think about how to improve their current data systems for reporting and quality improvement. To assist the CCBHCs in continuous quality improvement, the state will submit an annual data report back to the CCBHCs that will allow the clinics to see the average rates and ranges for all measures (both clinic- and state-lead), as well as the rates for all other clinics so that each CCBHC can identify high performing clinics for each measure. This will be submitted with the intention of encouraging the CCBHCs to coordinate with each other for the goal of continuous quality improvement.

Table 1. Clinic-Lead Measures: Overview of baseline results for all reporting clinics by measure

Measure	Number of Clinics Reporting	Average for Total Population	Range
I-EVAL- Metric #1	8	61%	28% to 84%
I-EVAL- Metric #2	7	11.5	1.0 to 18.6
BMI-SF	2	75%	64% to 86%
WCC-BH	2	36%	21% to 50%
TSC	3	50%	33% to 61%
ASC	3	51%	8% to 96%
SRA-BH-C	1	100%	
SRA-A	1	100%	
CDF-BH (ages 18-64)	3	37%	1% to 69%
DEM-REM-12	0	ND	ND

Table 2. State-Lead Measures: Overview of baseline results by measure		
Metric	Average	Range
FUM 7 day	76%	67%-100%
FUM 30 day	87%	79%-100%
FUA 7 day	20%	0%-42%
FUA 30 day	46%	22%-100%
PCR-BH	12%	0%-23%
ADD-BH	81%	60%-100%
IET-BH Initiation	43%	33%-54%
IET-BH Engagement	22%	14%-31%

To test state-level data systems, Oregon attempted to calculate baseline data for all measures using our MMIS and MOTS databases. As of the time of submission, we are able to report on 5 of the 13 required measures (Table 2). Data for the two state-lead survey measures (PEC and Y/FEC) are currently collected and reported at the state level each year, but survey results have not been identified by clinic in the past. The state is preparing to reach out to 300 consumers from each clinic for the survey measures each demonstration year, and identifying those consumers by CCBHC to be able to report on those measures. Oregon projects that the state will also be able to provide data on the additional 6 measures not presented here by November 2016, as they are currently being added to our reporting system.

Data Access: The evaluators will be able to make data requests from the OHA for any data needs associated with MMIS, MOTS, MHSIP, YSS-F, and CAHPS for any Medicaid consumers in Oregon. Data can be provided in a variety of formats: Excel, MS Access, Text, SPSS, SAS, and others as requested. Due to the time it takes for data to be processed and verified in these systems, it is encouraged that the Evaluator wait 6 months after the end of a Demonstration Year before requesting data.

D. National Evaluation

Description of Participation in TA Data Collection Calls (particularly as it pertains to the selection of a comparison group).

The OHA has been an active participant in both national and state level planning. Since May, the OHA has participated in state level TA data collection calls. After May, SAMHSA released a list of state and clinical measures and hosted eight webinars, of which the OHA attended 100%. Throughout these webinars, the OHA staff tracked and submitted questions, and then scheduled office hours with Truven on August 25, 2016. Truven was able to respond to all of the Oregon specific questions in the meeting, which lasted over an hour.

The meeting with Truven led to the development of a FAQ sheet for Oregon. Of note, Oregon has restrictions on how behavioral health can bill, including not allowing some codes that are allowable in other states. Oregon has been permitted to add codes to accommodate this variance.

Discussions also included how to select an appropriate comparison group. OHA staff believe that the Evaluator will have an easier time finding a comparison group if he or she selects clinics

from which to pull claims data. However, the population of Oregon varies widely from county to county, and therefore we recommend that any clinics or claims selected by the evaluator to compare with any CCBHC be either within the same county, or the same population grouping (Table 3) as the CCBHC.

Table 3. Counties by Population Size

Population Size	**Counties**
<10,000	Wheeler, Sherman, Gilliam, Wallowa, Harney, Grant, Lake
10,000-50,000	Morrow, Baker, Crook, Jefferson, Curry, Hood River, Tillamook, Wasco, Union, Malheur, Clatsop, Lincoln
50,000-100,000	Columbia, Coos, Klamath, Polk, Umatilla, Josephine, Benton,
100,000-300,000	Yamhill, Douglas, Linn, Deschutes, Jackson
>300,000	Clackamas, Marion, Lane, Washington, Multnomah

Describe How Group Discussions Impacted or Influenced Plans and Data Use. The OHA suggests that either Federally Qualified Health Centers (FQHCs) that focus on providing behavioral healthcare or Community Mental Health Programs (CMHPs) would provide good comparison groups for the CCBHCs. The mission of FQHCs is already aligned with the requirements of the CCBHC program in that they are non-profit organizations, serve underserved populations, offer services regardless of a person's ability to pay, offer sliding-fee scales, and offer comprehensive services. The CMHPs would be an excellent choice as some of Oregon's CCBHCs are already CMHPs. Selecting CMHPs not currently part of the CCBHC program would likely provide the most direct comparison to the clinics participating in the CCBHC program. CMHPs are required to be responsive to the needs of the local community and provide a variety of services aligned with the CCBHC program including 24 hour crisis services, family and peer support services, transportation support, and coordination services among criminal and juvenile justice systems.

Table 4. Recommended Comparison Clinics by County and County Population Size

Population Size	County	Clinic Name	Type
<10,000	Lake	Lake County Mental Health Center	CMHP
	Baker	Mountain Valley Mental Health Programs	CMHP
	Clatsop	Clatsop Behavioral Healthcare	CMHP
	Crook	Crook County Mental Health	CMHP
	Curry	Curry Community Health	CMHP
	Lincoln	Lincoln County Mental Health Program	CMHP, FQHC
10,000-50,000	Tillamook	Tillamook Family Counseling Inc.	CMHP
	Benton	Benton County Mental Health Program	CMHP, FQHC
	Coos	Waterfall Clinic, Inc.	FQHC
	Coos	Coos County Mental Health	CMHP
	Polk	Northwest Human Services	FQHC
50,000-100,000	Polk	Polk County Behavioral Health	CMHP
100,000-300,000	Jackson	La Clinica Del Valle Family	FQHC

	Jackson	Jackson County Health and Human Services	CMHP
	Linn	Linn County Health Services	CMHP
	Clackamas	Clackamas County Mental Health	CMHP, FQHC
	Lane	Lane County Behavioral Health Services	CMHP, FQHC
	Marion	Marion County Behavioral Health	CMHP
	Multnomah	Central City Concern	FQHC
	Multnomah	Multnomah County FQHC Clinics	FQHC
	Multnomah	Native American Rehabilitation Association of the NW	FQHC
	Multnomah	Neighborhood Health Center	FQHC
	Multnomah	Multnomah County Mental Health and Addiction Services	CMHP
	Washington	Virginia Garcia Memorial Health Center	FQHC
>300,000	Washington	Washington County Health and Human Services	CMHP

OHA staff recommend that the evaluator keep in mind that behavioral health clinics in Oregon are not allowed to use the G-codes that have been specified in the clinic-lead measures BMI-SF, TSC, ASC, CDF-BH, and DEP-REM-12. CCBHC certified clinics have been instructed to code the G-codes into their EHRs for reporting purposes. However, potential comparison clinics have been given no such directive. It may behoove the Evaluator to contact potential comparison clinics at the beginning of Demonstration Year 1, or earlier if possible, in order to ask comparison clinics to code the G-codes into their EHRs for reporting purposes and to ensure comparability of these metrics between comparison groups and CCBHCs

Discussion of IRB: The approval of Oregon's Public Health Institutional Review Board is not required for OHA to collect and report on process and/or outcome data for the CCBHC project, and therefore IRB approval does not apply to the CCBHC project.

E. Impact of Demonstration Program in Oregon

Goals and Explanation of process for selecting these goals. OHA selected two of the four goals to address project impact of CCBHCs in Oregon.

1. Provide the most complete scope of services required in the CCBHC Criteria to individuals that are eligible for medical assistance under the State Medicaid program;
2. Improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program.

The OHA project leadership first coordinated with the CCBHC Steering Team to discuss the goals, recommending the first two goals. The goals were then communicated via email to the CCBHC Stakeholder Advisory Workgroup and were then discussed and selected during the February 17th Stakeholder Advisory Workgroup Meeting. Oregon selected Goal 1 and Goal 2, as they best align with ongoing initiatives within the state while underscoring the purpose of the CCBHC activities in Oregon.

List Specific Measures that will show Impact: For Goal 1, the OHA will measure the number type of services offered by each CCBHC. By tracking both total claims and claims per consumer for each clinic by category we will be able to reliably determine how service types have expanded throughout the course of the CCBHC demonstration program. The types of services to be tracked are:

- Crisis
- Screening, assessment, and diagnosis, including risk assessment
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning
- Outpatient mental health and substance use services
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk
- Targeted case management
- Psychiatric rehabilitation services
- Peer support and counselor services and family supports

The billing codes used to track each category can be found as part of the Oregon CCBHC Demonstration Service Crosswalk (See Appendix D).

For Goal 2, the OHA will track of the number of clinicians (in FTE) employed by each clinic and the number of staff that will be added as a result of the needs assessment process. The number of staff employed by each CCBHC will directly affect availability of services and an increase of staff will translate into an increase an availability of services. OHA will also track the number of Medicaid consumers served through billing claims, as an increase in the number of consumers served will show an increased access and participation in services. Finally, OHA will also collect baseline data on the Clinic-lead required data reporting metric Initial Time to Evaluation (I-EVAL), as this metric will be able to show changes in access to service over time as it tracks the proportion of consumers who receive and initial evaluation within 10 days.

Baseline Data:

Goal 1: Provide the most complete scope of services as described in the Criteria to individuals eligible for medical assistance under the state Medicaid program.

Metric: Number and type of services currently offered.

To identify the number and type of services offered, we pulled all claims (paid and denied) for each CCBHC applicant from the 2015 calendar year (1/1/2015- 12/31/2015) that used the billing codes identified on the PPS crosswalk, plus one extra code H2011: Crisis intervention service (classified under Crisis Services). Data was obtained for all but two applicants, who had not separated previous claims out by service location and were only certifying a subset of locations

for the CCBHC program. This issue will be resolved by the start of the demonstration program, and future data will be able to be collected for all clinics.

Each billing code in the PPS crosswalk has been categorized into one of the following categories:

- CRISIS = Crisis mental health services
- SADRA = Screening, assessment, and diagnosis, including risk assessment
- PCTP = Patient-centered treatment planning
- OMHSUS = Outpatient mental health and substance use services
- PCSM = Outpatient clinic primary care screening and monitoring
- TCM = Targeted case management
- PRS = Psychiatric rehabilitation services
- PEER = Peer support and counselor services and family supports

The OHA has gathered data for each of the above specific services. The following two figures represent all claims by service type and clinic.

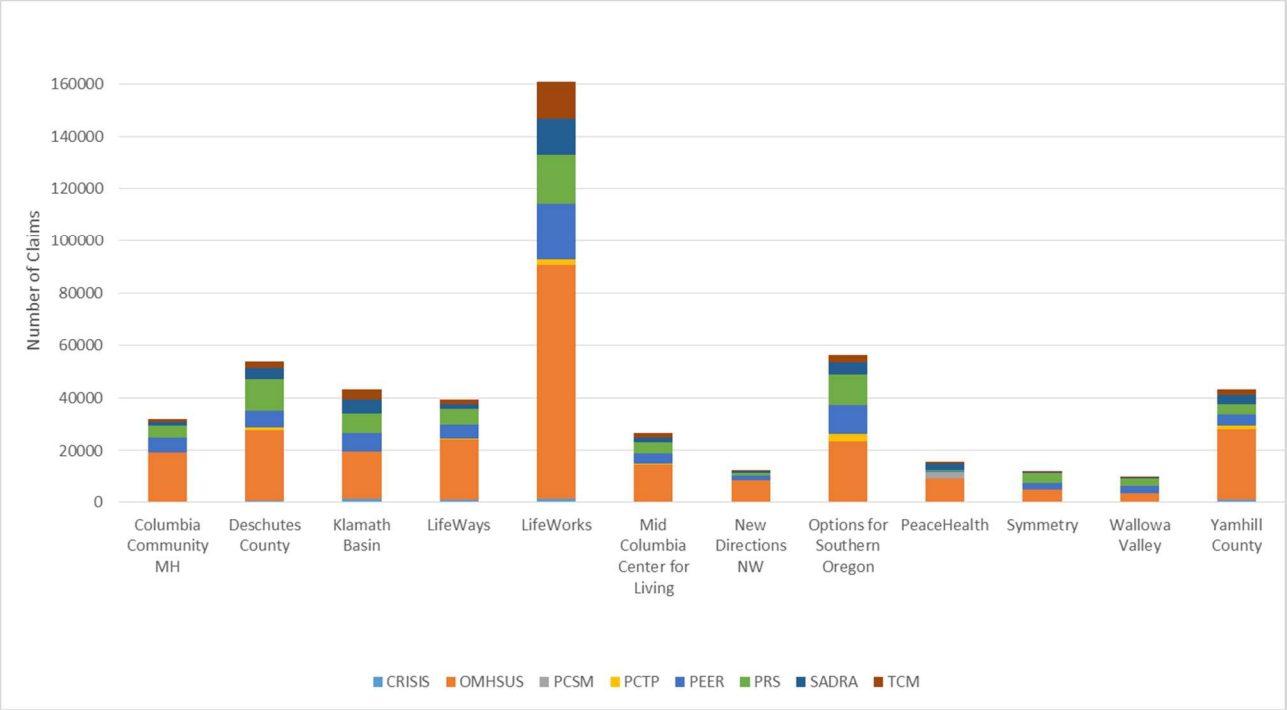


Figure 6. All Claims broken down by service type and clinic

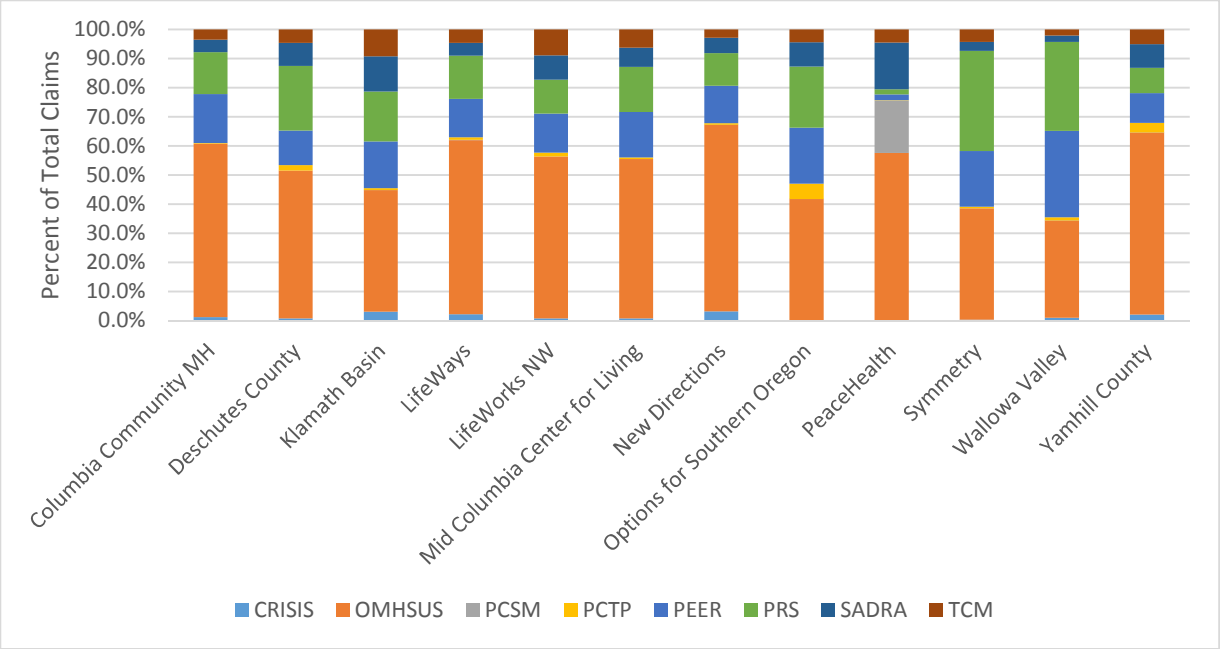


Figure 7. Percent of claims by service type, broken down by clinic

Crisis: In terms of specific services by provider, we are able to identify these as well. All 12 clinics for which data could be obtained provided crisis services in 2015. A total of 6,031 crisis service claims were made in 2015 from the 12 clinics, and crisis services made up approximately 1.3% of a clinic's total number of claims on average.

Outpatient Mental Health Services: All 12 clinics for which data could be obtained provided outpatient services, with a total of 267,342 outpatient service claims made in 2015. On average, outpatient services accounted for 51.6% of a clinic's total number of claims.

Primary Care Screening and Monitoring: Only 7 of out of 12 clinics for which data could be obtained currently billed for primary care screening and monitoring, with a total of 2,940 claims made in 2015. On average, 1.5% of a clinic's total number of claims were related to primary care screening and monitoring in 2015.

Patient Centered Treatment Planning: All 12 of the CCBHC applicants for which data could be obtained offered patient centered treatment planning, with a total of 8,552 claims made in 2015. On average, these services account for 1.3% of a clinic's total number of claims.

Peer Support: All of the 12 CCBHC applicants for which data could be obtained billed for peer support services, with a total of 71,888 claims made in 2015. On average, peer support claims accounted for 15.0% of a clinic's total claims in 2015.

Psychiatric Rehabilitation Services: All 12 of the CCBHC applicants for which data could be obtained billed for psychiatric rehabilitation services with a total of 76,930 claims made in 2015. On average, 16.9 % of a clinic's total claims were related to psychiatric rehabilitation.

Screening, Assessment, and Diagnosis: All 12 CCBHC applicants for which we were able to obtain data provided screening, assessment, and diagnosis services, with a total of 39,868 claims in 2015. On average, 7.2% of a clinic's total claims were related to screening, assessment, and diagnosis.

Targeted Case Management: All 12 of the CCBHC applicants for which we could obtain data provided targeted case management services, with a total of 32,025 claims made in 2015. On average, 5.1% of a clinic's total claims were related to targeted case management.

Table 5. Number of Claims by Service Type

	Category							
	CRISIS	OMHSUS	PCSM	PCTP	PEER	PRS	SADRA	TCM
Columbia Community MH	388	19022	0	52	5365	4605	1359	1149
Deschutes County	439	27294	0	959	6421	11941	4226	2515
Klamath Basin	1327	18143	2	259	7011	7407	5250	4032
LifeWays	853	23516	23	345	5207	5813	1736	1821
LifeWorks NW	1270	89486	0	2158	21511	18686	13507	14352
Mid Columbia Center for Living	196	14589	0	153	4135	4127	1768	1673
New Directions NW	394	7990	1	71	1606	1392	666	356
Options for Southern Oregon	121	23323	50	2945	10787	11815	4686	2494
PeaceHealth	17	9072	2859	4	315	274	2540	719
Symmetry	35	4701	0	60	2346	4228	369	535
Wallowa Valley	94	3149	1	106	2794	2883	205	200
Yamhill County	897	27057	4	1440	4390	3759	3556	2179

Goal 2: Improve availability of, access to, and participation in, services described in Criteria to individuals eligible for medical assistance under the state Medicaid program.

Metric: Number of Medicaid patients served in 2015

In 2015, approximately 404,000 Medicaid consumers were seen at the clinics currently applying to be part of the CCBHC Demonstration program.

Metric: Number of staff by clinic and number of staff to be added as a result of the needs assessment.

The needs assessment estimated the number of staff currently employed by each clinic (reported in cost report) and the number of staff each clinic plans to hire in order to meet unmet need in their service area (reported from needs assessment). Projections are reflected in Table 6.

Table 6. Staffing by CCBHC Applicant

Provider Name	# of Staff (FTE)	# of Staff to be added (FTE)	% staffing increase
Cascadia	221.6	23.8	10.7
Columbia Community Mental Health	117.0	35.0	29.9
Community Counseling Solutions	13.0	2.2	16.8
Deschutes County	158.0	12.9	8.2
Klamath Basin	113.0	37.5	33.2
LifeWays	259.0	234.4	90.5
LifeWorks NW	251.0	31.0	12.4
Mid Columbia Center for Living	122.0	25.7	21.1
New Directions Northwest	26.0	1.6	6.0
Options for Southern Oregon	172.0	21.8	12.7
PeaceHealth	160.0	0.0	0.0
Symmetry Care	23.0	5.0	21.7
Wallowa Valley	28.0	6.0	21.4
Yamhill County	162.0	24.4	15.1

Metric: I-EVAL scores for each clinic

SAMHSA requires that CCBHCs track the metric Time to Initial Evaluation (I-EVAL) as part of the CCBHC demonstration program. We requested that clinics submit baseline data for I-EVAL for the 2015 calendar year. Eight of the 14 clinics reported I-EVAL for 2015. On average, in 2015 61% of all new clients had received an initial evaluation within 10 business days (range of 28% to 84%), and the mean number of days a client had to wait until receiving an initial evaluation was 11.5 (range of 1 to 18.6 days).

Data Collection, Documentation, Outcome Tracking, and Analysis: The metrics described above will be collected annually, corresponding to the dates of the demonstration year. The metrics for Goal 1 will be calculated by pulling all submitted claims from each clinic for the demonstration year from the MMIS database and categorizing them based on the categories defined in the Oregon Demonstration Services Crosswalk. A sum of claims for each category would be provided for each clinic. For Goal 2, Oregon will be able to track the number of Medicaid consumers served at each CCBHC during the demonstration year through billing claims pulled from the MMIS database and the number of Outreach claims during the demonstration year by pulling all claims utilizing the billing codes H0023 and H2021 from the MMIS database. To track number of clinical staff hired, Oregon will contact the CCBHCs and ask for the number of clinical staff hired over the course of the demonstration program. I-EVAL will be submitted to Oregon by each CCBHC as part of regular reporting for the demonstration year. Oregon will be able to compile and track yearly outcomes and compare with baseline data to be able to see improvements as a result of Oregon participating in the CCBHC program.

Projected Impact on Target Population:

Goal 1: Because Oregon already offers a complete array of outpatient services, patient centered treatment planning services, peer support services, psychiatric rehabilitation services, screening, assessment and diagnosis services, and targeted case management services, Oregon will focus on other categories of service, especially primary care and outreach, to advance Goal #1. By participating in the CCBHC program, Oregon will be able to add primary care services to seven clinics participating in the program. Oregon has implemented additional standards for CCBHC's, requiring that primary care services are offered onsite at least 20 hours a week and that a clinic also has a process to insure patients can access primary care services during hours that onsite primary care is not available.

Goal 2:

Metric - Number of Medicaid Consumers: As part of the needs assessment process, each clinic projected how much they would be able to expand their services as part of the CCBHC project. This process resulted in a projected 20-30% increase in availability of services, which is approximately 8,000 to 12,000 Medicaid consumers for these service areas, as a result of Oregon's participation in the CCBHC program.

Metric - Staffing: As part of the needs assessment process, each clinic calculated the number of staff it planned to hire in order to meet unmet need in Oregon, this process resulted in projected clinical staffing increases of a total of 231 FTE, or an average expansion of 15% for each clinic, in order to increase total services by 20-30% during the CCBHC project.

Metric - I-EVAL: Oregon's goal is to ensure that 100% of new clients receive an initial evaluation within 10 business days, as per SAMHSA's guidance, and by participating in the CCBHC program Oregon will be able to improve consumer access by increasing the number of clients who are able to receive an initial evaluation within 10 business days.