Evaluation of the Oregon Certified Community Behavioral Health Clinic (CCBHC) Program

Final Report

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Acronyms Used in the Report

ACS	American Community Survey
ACT	Assertive Community Treatment
APM	Alternative Payment Mechanism
BHC	Behavioral Health Committee
BHH	Behavioral Health Home
BIPOC	Black/African American, Indigenous, and People of Color
CBO	Community-Based Organizations
CCBHC	Certified Community Behavioral Health Clinic
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
CDPS	Chronic Illness and Disability Payment System
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CIHS	Center for Integrated Health Solutions
CMHP	Community Mental Health Program
CMS	Centers for Medicare and Medicaid Services
DCO	Designated Collaborating Organization
DHS	Department of Human Services, Oregon
ED	Emergency Department
EHR	Electronic Health Record
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
GBHAC	Governor's Behavioral Health Advisory Council
HCPSC	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
LBGTQ+	Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), and Others
MA	Medical Assistant
MHSIP	Mental Health Statistics Improvement Program
MOUD	Medication for Opioid Use Disorder
M/SUD	Mental and Substance Use Disorders
OAR	Oregon Administrative Rules
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OHPB	Oregon Health Policy Board
OHSU	Oregon Health & Science University
OLS	Ordinary Least Squares
ORH	Office of Rural Health, Oregon Health Authority
PCPCH	Patient-Centered Primary Care Home

POS	Place of Service
PPS	Prospective Payment System
PSU	Portland State University
RE-AIM	Reach, Evaluation, Adoption, Implementation, Maintenance
REALD	Race, Ethnicity, Language, and Disability
RTF	Residential Treatment Facility
QMHA	Qualified Mental Health Associate
QMHP	Qualified Mental Health Professional
REALD	Race, Ethnicity, Language and Disability
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SPMI	Serious Persistent Mental Illness
SUD	Substance Use Disorder
VA	Veterans Affairs

Executive Summary

Study Aims: The Oregon Health Authority (OHA) contracted with a team at the OHSU-PSU School of Public Health to conduct an evaluation of the Certified Community Behavioral Health Clinic (CCBHC) Program in 2022, to respond to the legislative mandate to evaluate whether CCBHCs: 1) increase access to behavioral health treatment for residents of this state; 2) provide integrated physical and behavioral healthcare; 3) offer services that result in improved health outcomes, lower overall healthcare costs and improved overall community health; and 4) reduce the cost of care for coordinated care organization (CCO) members. The evaluation team also addressed the sustainability and potential expansion of the CCBHC model and its role in future Oregon health systems reform and transformation. In keeping with OHA's strategic goal to eliminate health inequities by 2030, the evaluation used an equity framework in the evaluation design, seeking to understand the effect of the CCBHC program on populations that experience marginalization, historic and contemporary injustices, and systemic oppression.

Findings: The CCBHC program has met most of the legislative goals. The program **increased access to behavioral health treatment for residents statewide (4.3%)**; this is proportionately higher in rural and remote areas (23.4% and 18.3%, respectively) where substance use disorder treatment services have substantially increased. Racial and ethnic diversity of service users also increased, primarily by Hispanic/Latino/a/x service users. The prospective payment system (PPS) model enhanced service delivery "outside the four walls" of the CCBHC clinics, enabling CCBHCs to engage service users in non-clinic settings. While all CCBHCs engage and provide services to underserved populations, there is variation across the clinics in terms of implementation of culturally and linguistically responsive outreach and engagement strategies and services.

The CCBHC model has enabled clinics to move toward **providing integrated physical and behavioral healthcare**, particularly with increased telehealth services during the COVID-19 pandemic. Primary care use increased up to 3.2%, with Hispanic/Latino/a/x service users having generally higher increases. The integration of primary care increased service users' access to care and facilitated the delivery of holistic, person-centered care. Care coordination has been critical for connecting service users with limited resources to local specialty care and social services, but this has not been accomplished uniformly across all 12 CCBHCs. Some CCBHCs struggled to hire primary care providers and/or maintain a patient panel sufficient to support Oregon's requirement for provision of 20 hours per week of primary care services.

The CCBHCs **offer services that result in improved individual and community health outcomes.** Improvements in treatment experience were found for CCBHC service users, as well as decreases in mental health emergency department and inpatient utilization (14.1% and 22.4%, respectively); both are considered positive treatment outcomes that lead to improved overall community health and also offset overall costs. Improved treatment experience was found for Black/African American adults and children, as well as Hispanic/Latino/a/x and American Indian/Alaskan Native children. The PPS model supported positive individual and community health outcomes as it enabled CCBHCs to offer non-traditional service delivery to reach service users who otherwise might not have accessed services. Service users reported positive experiences with CCBHCs and also identified community barriers to care, including limited access to behavioral health services, high cost, and inadequate transportation. CCBHCs strengthened their partnerships in the community by collaborating with community-based organizations (CBOs) and participating in community health events. However, many community members and CBOs were not aware of the unique attributes of CCBHCs as compared to other behavioral health clinics.

CCBHCs' activities result in cost savings in some service areas (up to 16.1% for hospital inpatient services) but **do not reduce the overall costs of care** or **the cost of care for CCO members**. In Oregon's historically underfunded behavioral health system, an increase in cost per person (up to 14.9%) likely reflects unmet service needs. This underinvestment in behavioral healthcare in Oregon, including insufficient hospital inpatient capacity, limits the ability of CCBHCs to reduce the overall cost of care. In addition, cost assessments must account for the value of the investment; the CCBHC model has increased access to care and facilitated cross-sector collaboration and greater engagement with CBOs, which supports individual and community health in ways that may not be accounted for in cost analyses.

CCBHCs have the potential to **play a meaningful and central role in Oregon health systems reform and transformation**. Future CCBHC sustainability and expansion efforts need to build the capacity of CCBHCs to provide greater access, improve coordination of care, and center equity. Several system-level factors were identified by key interested parties, clinic leaders, CBO representatives, and service users as barriers to sustainability and expansion. These include administrative burden, workforce shortages, lack of a robust data infrastructure system to identify health inequities and coordinate care, and challenges in identifying potential partners and building effective, mutually beneficial relationships.

Recommendations: The following are recommended to the Oregon Legislature and the Oregon Health Authority to advance the CCBHC program as part of improving Oregon's behavioral health system:

1. Develop strategies to ensure sustainable CCBHC funding while redirecting the focus of behavioral health from an emphasis on cost savings to provision of equitable, quality care to all Oregonians.
2. Expand the CCBHC program so that a CCBHC is located and supported in every Oregon county, to help ensure all Oregonians have access to essential behavioral health services.
3. Establish clearer standards for primary and behavioral care coordination and integration that enable CCBHCs to better provide whole-person care and services that meet the complex and multiple needs of diverse service users.
4. Engage advocates and community leaders to recommend actions for the development and implementation of culturally and linguistically responsive outreach and services.
5. Make investments in new or enhanced behavioral health workforce incentives (such as salaries, loan repayment, educational support, etc.) to augment the workforce in Oregon's CCBHCs.
6. Invest in the development and implementation of a health information exchange (HIE) to support coordination of care and identification of health inequities, building upon current initiatives such as the HIT Commons.
7. Streamline CCBHC reporting requirements to reduce administrative burden wherever possible and enhance the utility and relevance to clinics of metrics and data collected.
8. Identify opportunities to intentionally build upon or partner with other community-based initiatives, such as OHA's Regional Health Equity Coalitions and the Behavioral Health Resource Networks, to support CCBHCs in identifying potential partners and building effective, mutually beneficial local relationships, including with CCOs.
9. Continue and expand current technical assistance efforts to support CCBHCs to achieve statewide CCBHC goals and meet local needs identified by CCBHC clinic leaders and service users.
10. Elevate awareness of the CCBHC program in local communities and provide practical tools for communities to leverage the work of CCBHCs to address priority community health concerns.
11. Continue to evaluate the CCBHC program operations and performance, using community-centered participatory approaches to engage community members, service users, and advocates.
12. Commission ongoing research to understand how investments in the CCBHCs and behavioral health more broadly can have an impact on improving health outcomes and community health.

Background

The U.S. Congress passed the Excellence in Mental Health Act in 2014, which amended the Public Health Service Act to set forth criteria for the certification of federally qualified community behavioral health centers. It also amended Title XIX (Medicaid) of the Social Security Act to make such centers eligible for payments for services under Medicaid. Finally, it amended the Public Health Service Act to authorize the Secretary of Health and Human Services to award matching grants to states or American Indian tribes to expend funds for the construction or modernization of facilities used to provide community-based mental health and substance abuse services to individuals (U.S. Congress, 2014).

This legislation aimed to improve quality and access to behavioral health services through the creation of federal criteria for Certified Community Behavioral Health Clinics (CCBHCs). It authorized an eight-state demonstration program, funded by the single largest federal investment in community behavioral health in more than 50 years. Twenty-five million dollars in planning grants were awarded to states to assist with planning grant activities focused on the development of a CCBHC demonstration application (OHA, n.d.(a)). Oregon applied for a CCBHC planning grant, as the program aligned with the state's broader healthcare transformation efforts, enabling Oregon to further advance behavioral healthcare for Oregonians.

In 2015, Oregon was selected by the U.S. Department of Health and Human Services (HHS) as one of eight states to receive a planning grant to test new strategies to improve accessibility, quality, and outcomes of services provided in community mental health centers certified as CCBHCs. The Oregon Health Authority (OHA) subsequently submitted an application to the Substance Abuse and Mental Health Services Administration (SAMHSA) to be considered for participation in the 2017-2019 CCBHC Demonstration Program. In December 2016, Oregon was selected as one of eight demonstration states. The CCBHC demonstration was designed to provide whole-person care to individuals with behavioral health needs, including those with substance use disorder (SUD), serious behavioral health needs, and those with a dual diagnosis (i.e., behavioral health needs with comorbid SUD). CCBHCs integrate behavioral health and substance use disorder treatment with primary care services and address social determinants of health that can influence health outcomes. CCBHCs are required to serve anyone regardless of insurance status or ability to pay. The CCBHCs in Oregon are overseen by OHA. Twelve clinics were certified as CCBHCs when Oregon's demonstration program began on April 1, 2017 (OHA, n.d.(b)).

In 2021, the Oregon legislature directed OHA to evaluate whether CCBHCs:

1. Increase access to behavioral health treatment for residents of this state;
2. Provide integrated physical and behavioral healthcare;
3. Offer services that result in improved health outcomes, lower overall healthcare costs and improved overall community health; and
4. Reduce the cost of care for coordinated care organization members.
   From Legislative Fiscal Office Report on HB 5024 (2021).

OHA contracted with a team at the Oregon Health & Science University – Portland State University (OHSU-PSU) School of Public Health to conduct the evaluation to respond to the legislative directive. This evaluation was designed to address these four points retrospectively (e.g., did the CCBHC demonstration sites meet outcome expectations?) and prospectively (e.g., is the CCBHC model

sustainable in Oregon?) using a mixed methods approach informed by an equity framework. The evaluation team was also directed by OHA to address the sustainability of the CCBHC model, and the potential role of CCBHCs in future Oregon health systems reform and transformation.

Oregon's behavioral health system faces many well-documented challenges including inadequate data infrastructure and a lack of performance measures; lack of intensive residential treatment beds, particularly for children; workforce shortages; lack of coordination among state agencies and within the behavioral health system; and lack of consistent leadership and strategic vision for behavioral health (Secretary of State, 2020). Oregon currently does not have the capacity to adequately meet the needs of Oregonians with substance use disorders and substance misuse; there is a 49% gap in prevention, harm reduction, treatment, and recovery services, as well as insufficient culturally and linguistically responsive services and a lack of a diverse workforce that reflects the communities served (Lenahan et al., 2022). The consequences of these challenges are felt disproportionately among children, youth, and families with complex needs, as well as Black/African American, Indigenous, and People of Color (BIPOC) communities, Tribal communities, LGBTQ+ individuals, and other historically and currently underserved communities. These descriptors of communities reflect the language used in OHA's *Scope of Work* for this evaluation; thus, these terms are used throughout this report to reflect OHA usage.

The Behavioral Health Committee (BHC) of the Oregon Health Policy Board was established by House Bill 2086 in 2021 and began meeting in November 2021. The committee's purpose is to increase the quality of behavioral health services and transform Oregon's behavioral health system through improved outcomes, metrics, and incentives. The committee is supported by OHA's Office of Behavioral Health Services. The BHC is led by community members with lived experience whose perspectives provide input to advance the transformation of Oregon's behavioral health care system and help identify system improvements. The committee met regularly during 2022. Recent agenda items included defining "access themes" related to reducing need, reducing barriers, and increasing capacity for the behavioral health care system; physical and behavioral health integration; development of new/revised metrics; and a review of the Mental Health Statistics Improvement Program (MHSIP). Given the focus of this committee, it is relevant to this report as discussion of the future role of CCBHCs may be within the purview of this committee, and many of the themes in this report are reflected in BHC meeting agendas and summaries. CCBHC program staff presented to the committee in August 2022.

The majority of the CCBHC sites in Oregon are also community mental health programs (CMHPs). CMHPs are intended to "provide a system of appropriate, accessible, coordinated, effective, efficient safety net services to meet the mental health needs of the citizens of the community" (Oregon Secretary of State, n.d.). CMHPs are responsible for the planning and delivery of safety net behavioral health services under contract with a local mental health authority, operating within a specified geographic area (Oregon Secretary of State, n.d.). In addition to affordable therapy, CMHPs provide specialized and intensive services that are not available anywhere else or that are hard to find in private clinics. Oregon CMHPs primarily serve people with substantial behavioral health needs and people who are covered by the Oregon Health Plan (Oregon Medicaid). Some support is available for clients who are uninsured or underinsured; the number of uninsured clients a program can accept varies by county. In some counties, CMHPs accept private insurance plans and offer sliding-scale fees to people who meet clinical eligibility criteria but do not have Medicaid coverage.

The evaluation team completed a review of 44 community health reports published between 2016 and 2022 for communities with a local CCBHC; the review revealed that behavioral health is a priority

concern for these communities. Common barriers to access to behavioral health services included a lack of culturally and linguistically responsive services and a lack of insurance/concern about cost of services. Other barriers included long waits and lack of transportation. Common workforce concerns highlighted in these reports included behavioral health workforce shortages and the lack of a diverse workforce that reflects the communities served (a summary of this review is presented in Appendix 1).

Barriers to the effective delivery of behavioral health services in Oregon are interconnected. Oregon's behavioral health workforce shortage is a contributing factor to inadequate capacity to meet needs, particularly for communities of color who experience difficulties finding culturally and linguistically responsive care. The lack of providers and high turnover results in long waits for Oregonians in need of behavioral health services. While low wages contribute to behavioral health workforce shortages, Zhu et al. (2022) note that simply increasing wages is insufficient. Burnout was reportedly common among the workforce, given the nature of this work that involves high-stress work environments, higher acuity clients, large caseloads, and administrative burden. These factors contribute to difficulty in recruiting and retaining the workforce, with current behavioral health providers leaving community mental health for settings such as primary care and hospitals, which are perceived to have less stressful work environments, less administrative burden, and better compensation.

In October 2020, the Governor's Behavioral Health Advisory Council (GBHAC) released a report outlining priority recommendations to improve "access to effective behavioral health services and supports for all Oregon adults and transition-aged youth with serious mental illness or co-occurring mental illness and substance use disorders" (Governor's Behavioral Health Advisory Council, 2020). Recommendations included program changes that are responsive to and led by communities of color, Tribal communities, and people with lived experience; funding for continued operations and study of existing CCBHC demonstration sites; increased support for community restoration and an additional 16-bed residential treatment facility; a statewide crisis system; investments in the behavioral health workforce, including the creation of a behavioral health incentive fund for recruitment and retention of a diverse workforce and additional support for behavioral health workforce training; implementation and sustainability of culturally based practices; and revisions to the administrative rules to reduce provider administrative burden. Finally, the GBHAC also recommended investments in housing and housing supports.

Increasing access to behavioral health services in Oregon will require intentional effort to center equity. OHA has set a strategic goal to eliminate health inequities by 2030. The OHA/Oregon Health Policy Board (OHPB) definition of equity, updated in October 2020, is:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including Tribal governments, to address:*
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices.*

The Oregon Legislative Assembly in 2021 approved House Resolution 6 titled "Declaring Racism to be Public Health Crisis in This State" (Oregon Legislative Assembly, 2021). In its 2022 session, the Legislative Assembly approved House Bill 4052 titled "Relating to Equity; and Declaring an Emergency" (Oregon

Legislative Assembly, 2022), directing resources to improve the health outcomes of Oregonians affected by racism and fund robust culturally and linguistically specific intervention programs.

A 2021 Coalition of Communities of Color report highlights that many BIPOC individuals seek care outside the formal behavioral health system, opting to receive support from religious figures, traditional healers, and culturally specific community-based organizations (CBOs) (Coalition of Communities of Color, 2021). Lack of awareness about existing behavioral health services, lack of culturally and linguistically responsive services, and concerns about racism and discrimination are documented reasons that BIPOC individuals avoid seeking care from behavioral health clinics or other medical settings. In general, the two most common strategies to center equity include training the current workforce in cultural competency and diversifying the workforce. The Coalition of Communities of Color report highlights that health systems transformation should be led by BIPOC leaders and organizations; it offers additional recommendations directed to relevant organizations to invest in and yield resources and power to culturally specific leaders and organizations to co-create culturally and linguistically responsive outreach and services; collect, analyze, and make decisions based on disaggregated data on race, ethnicity, language, disability status, gender, and sexual orientation; partner with and compensate community leaders; invest in BIPOC behavioral health workers; train the current workforce; and embrace an inclusive understanding of wellness that recognizes multiple pathways to recovery rather than one centered on dominant Western models (Coalition of Communities of Color, 2021).

Taken together, these reports point to a behavioral health system that does not have adequate capacity to meet the behavioral health needs of Oregonians. Evaluation of the CCBHC program in Oregon must be understood within the context of Oregon's behavioral health system. While the CCBHCs are intended to improve access to integrated behavioral health, they may be limited by the larger behavioral health infrastructure and are influenced by the same barriers as the rest of the health system. The current context of behavioral health was described as follows in then-OHA Director Pat Allen's letter of resignation to Governor Brown of November 17, 2022:

> *Despite battling a global pandemic, OHA has shored up Oregon's behavioral health system and laid the foundation to expand services. By the end of 2022, OHA will have spent or obligated nearly $1.2 billion of the $1.35 billion Oregon lawmakers appropriated for the 2021-2023 biennium to transform the behavioral healthcare system. Today, every county has an organized network of providers who are working together to offer a full range of services to people with substance use problems – from harm reduction to treatment to housing. We have much ahead of us still at OHA. While we have demonstrated that we CAN deliver real health equity as we did in closing our COVID-19 vaccine gap, we have a long way to go to allocate and reallocate power and resources in a way that recognizes, reconciles, and rectifies the injustices and unfairness in our health systems.*

This overview of behavioral health in Oregon can also be placed in the larger federal context. The Biden-Harris Administration has a goal of improving behavioral health, which the HHS defines as "the promotion of mental health, resilience and well-being; the treatment of mental and substance use disorders (M/SUD); and the support of those who experience and/or are in recovery from these conditions, along with their families and communities" (SAMHSA, n.d.).

During his first State of the Union address in March 2022, President Biden announced a national strategy to prevent and treat mental and substance use disorders (White House, 2022). President Biden's *Strategy to Address Our National Mental Health Crisis* highlighted three commitments:

- Strengthen System Capacity: Expand the supply and diversity of the behavioral health workforce and ensure the full continuum of behavioral healthcare is available.
- Connect Americans to Care: Bridge the gap between services the system offers and people's ability to get the care they need.
- Support Americans by Creating Healthy Environments: Make "a whole-of-society effort," recognizing the importance of "culture and environment" in promotion, prevention, and recovery.

HHS will likely play an important future role in implementing and advancing the President's Strategy, which will no doubt have an impact on state-level complementary initiatives. Following the President's call to action, HHS examined further steps it could take to build upon these initiatives and transform the delivery of behavioral healthcare in the U.S. In September 2022, the HHS *Roadmap for Behavioral Health Integration* was published (ASPE, 2022). The *Roadmap* highlights integrated care and equity; it identifies eight major challenges to behavioral health integration: 1) structural support for siloed care, 2) stigma and mistrust, 3) limited adoption of technology, 4) inconsistent use of data and evidence, 5) insufficient investment in promotion and prevention, 6) insurance and financing limitations, 7) workforce challenges, and 8) inequitable engagement of underserved populations. All of these elements are relevant to the discussion that follows regarding Oregon's CCBHC program.

CCBHC Model in Oregon

The CCBHC model is defined by federal standards for CCBHC certification, which are supplemented by Oregon standards for CCBHCs. These are described below, as well as the CCBHC funding model. Finally, descriptive information about the Oregon CCBHCs and the communities they serve is provided.

Federal Standards for CCBHC Certification

The federal CCBHC standards mandate that states must certify that each CCBHC offers the following services, either directly or through a formal contract with a designated collaborating organization (DCO). The following services were required through the duration of the demonstration program and were paid for even if not included in a state's Medicaid plans (National Council for Behavioral Health, n.d.). Those marked * the CCBHC must directly provide; those marked ** may be provided by the CCBHC and/or DCO.

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization*
- Screening, assessment, and diagnosis including risk management*
- Patient-centered treatment planning*
- Outpatient mental health and substance use services*
- Primary care screening and monitoring**
- Targeted case management**
- Psychiatric rehabilitation services**
- Peer support, counseling services, and family support services**
- Services for members of the armed services and veterans**

- Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)

Oregon Standards for CCBHCs

Senate Bill 832 in 2015 directed OHA to develop standards for "achieving integration of behavioral health services and physical health services in Patient-Centered Primary Care Homes (PCPCH) and Behavioral Health Homes (BHH)." OHA relied upon the expertise of the PCPCH Standards Advisory Committee to advise in the development of integration standards. The committee developed the BHH model with over 40 specific measures to provide a framework for integrating physical health services into behavioral healthcare settings. Since there was no BHH recognition from the state comparable to PCPCH recognition, in order to align this work with the CCBHC demonstration, organizations applying to become a CCBHC in Oregon were required to also meet nine Oregon Standards for CCBHCs that were adapted from the BHH model (OHA, n.d.(c)).

The Oregon standards add additional requirements, notably 20 hours of onsite primary care services; the requirements are listed below (OHA, n.d. (c)):

- Telephone and Electronic Access: CCBHC provides continuous access to behavioral health advice by telephone.
- Performance and Clinical Quality: CCBHC tracks one quality metric from the core or menu set of PCPCH Quality Measures.
- 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.
- Coordination and Integration with Primary Care: CCBHC has primary care services onsite at least 20 hours a week and has a process to ensure patients can access primary care services during the hours onsite primary care is not available.
- Organization of CCBHC Information: CCBHC maintains a health record for each consumer that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, and updates this record as needed at each visit.
- Specialized Care Setting Transitions: CCBHC has a written agreement with its usual hospital providers or directly provides routine hospital care.
- 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.
- 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.
- 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.

Further specifications (OHA, n.d. (c)) on coordination and integration with primary care clarify that the 20 hours week of primary care offer services for physical health, disease prevention, and treatment; these may be contracted. Rural clinics with critical access shortages may be able to substitute a portion of the required 20 hours of on-site primary care using telehealth. CCBHCs must demonstrate evidence of collaborative provider relationships and care coordination for patients receiving primary care services

off-site during hours that primary care providers are not available at the CCBHC. Categories of primary care service include:

- Acute care for minor illnesses and injuries
- Ongoing management of chronic diseases including coordination of care
- Office based procedures and diagnostic tests
- Patient education, prevention, and wellness support services
- Care management, understood as individualized, person-centered planning and coordination to increase consumer participation and follow-up with all primary care screening, assessment, and treatment services

While there may only be a single CMHP within each specified geographic area, multiple CCBHCs may be co-located within the same geographic region. Like CCBHCs, CMHPs must provide care to service users regardless of ability to pay; however, CMHPs are not required to offer integration of behavioral and primary care services, nor are they mandated to provide patient-centered treatment planning, targeted case management, end of life planning, or peer support services (as CCBHCs are). CMHPs may offer services beyond what is mandated by OHA to meet the needs of their local geographic area.

CCBHC Funding Model

The Oregon CCBHC model uses a funding model based upon a daily Prospective Payment System (PPS) rate, which pays CCBHCs a fixed amount for each day that a Medicaid beneficiary receives CCBHC services. The payment is the same regardless of what services the beneficiary receives on that day. This rate is "cost-based," intended to cover the actual costs of operating the CCBHC. The rates in Oregon were developed using anticipated costs that clinics calculated and submitted to OHA. These initial rates have not been recalculated during the study period to adjust for any structural changes in the underlying cost basis but have been adjusted annually for the Medicare Economic Index (MEI).

Wraparound payments are only available for CCBHC services provided to Coordinated Care Organization (CCO) enrolled OHP members. CCBHCs receive many different types of payments from other payors for the provision of CCBHC services to CCO/managed care-enrolled members. These payments may include, but are not limited to, traditional claims payments (fee-for-service), capitation payments (per-member, per-month), case rate payments, and risk withhold payments. Oregon CCBHCs submit quarterly wraparound payment reports to OHA. These reports reflect the total of all paid claims for CCBHC services during the period and all payments received from CCOs, managed care plans, Medicare, and other payors. They also report all capitation payments, risk withholds, global payments, and other lump sums received for the CCBHC demonstration services. The upper limit of the clinic wraparound payment is calculated by counting the number of OHP individuals who received services each day multiplied by their PPS payment rate. The actual clinic wraparound payment is the difference between the upper limit and the value of payments received directly from payors for CCBHC services. When the payments received directly from payors match or exceed the upper limit, a clinic does not receive a wraparound payment in that period. This has happened in Oregon for several clinics over time.

The cost-based PPS rate gives clinics the flexibility to structure their services and financial management systems in a way that enables them to provide the full scope of services without having to bill for each of these services individually. CMS requires that CCBHCs participating in the demonstration program submit annual cost reports with details of their total operating costs.

The two-year federal demonstration program began April 1, 2017. There was an interruption of PPS payments in July and August 2019 after the two-year program ended and before federal funding was resumed. Counties agreed to reallocate resources from service elements to cover some of the costs during that time. Table 1, illustrating major funding milestones, was provided by OHA staff.

Table 1: Major Funding Milestones in CCBHC Program

Milestone	Date(s)
Federal CCBHC demonstration program begins	4/1/2017
Funding approved from General Fund and federal sources	2017-2019 biennium budget
Extension of federal funding #1	April 2019 to 6/1/2019
End of extension of federal funding #2	7/14/2019
OHA suspends PPS payments	7/1/2019 to 8/31/2019
Extension of federal funding #3	August 2019 to 9/13/2019
9 CCBHC's choose to reduce the County Financial Assistance Agreement to continue agreement through 11/30/2020	9/1/2019 to 11/30/2020
Extension of federal funding #4	9/26 to 11/21/2019
Extension of federal funding #5	11/21 to 12/20/2019
Extension of federal funding #6	12/20/2019 to 5/22/2020
Extension of federal funding #7	5/22/2020 to 11/30/2020
Extension of federal funding #8	12/21/2020 to 9/30/ 2023
Oregon E-Board provided $6 million from General Fund to pay State match of CCBHC expenses through remainder of biennium	1/1/2021

It is important to contextualize this funding timeline with the onset of COVID-19 in March 2020 and the resulting impact and social disruption.

CCBHC Sites

Twelve clinics participated in the initial two-year demonstration phase from April 1, 2017 to March 31, 2019. Three clinics left the demonstration at the end of the first demonstration period but returned to the program in 2021 and 2022. The CCBHC sites are listed in Table 2, grouped by the geographic designation (Urban, Rural, or Remote) of the Oregon Office of Rural Health (ORH) (Oregon Office of Rural Health, n.d.) and including locations, counties served, relevant CCOs, and CCBHC participation. Site numbers correspond with the mapped locations in Figure 1. Nine CCBHCs are also CMHPs (marked by an asterisk [*] in Table 2); LifeWorks NW, Cascadia Health, and Peace Health Medical Group are not CMHPs.

Table 2: Oregon CCBHC Sites

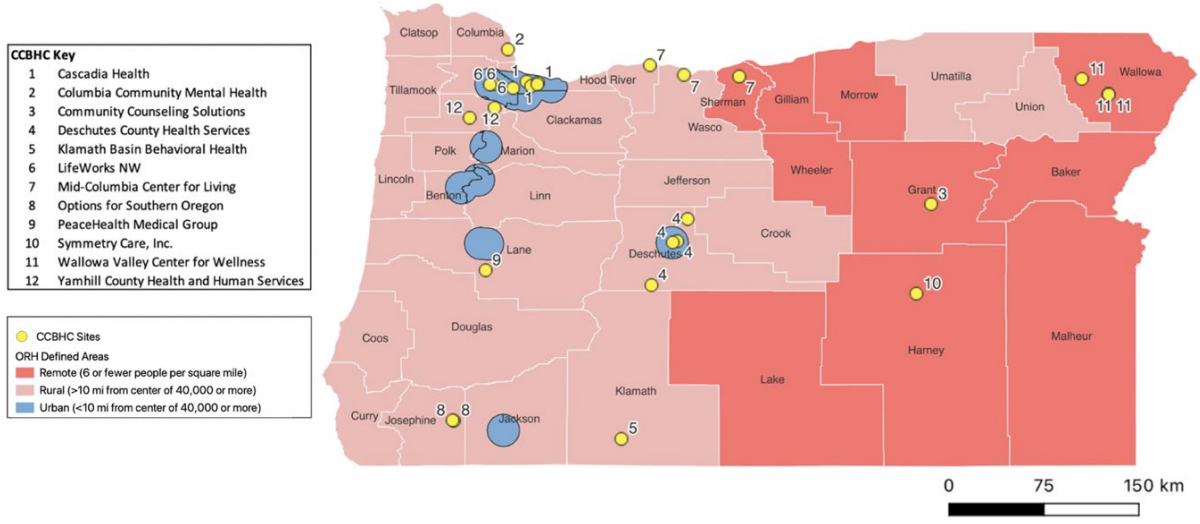
Site #	ORH Area	Clinic Name	CCBHC Locations	Counties Served	Relevant CCOs	CCBHC Participation
1	Urban	Cascadia Health	Portland (3 sites)	Multnomah	HealthShare of Oregon; Trillium Community Health Plan	Continuing
2	Rural	Columbia Community Mental Health *	St. Helens	Columbia	Columbia Pacific CCO	Continuing
3	Remote	Community Counseling Solutions *	John Day	Grant	Eastern Oregon Coordinated Care Organization	Exited 6/30/2019; returned 6/1/2022
4	Urban	Deschutes County Health Services *	Bend (2 sites)	Deschutes	PacificSource Community Solutions: Central Oregon	Continuing
4	Rural	Deschutes County Health Services *	La Pine, Redmond	Deschutes	PacificSource Community Solutions: Central Oregon	Continuing
5	Rural	Klamath Child and Family Treatment Center * (DBA Klamath Basin Behavioral Health)	Klamath Falls	Klamath	Cascade Health Alliance	Continuing
6	Urban	LifeWorks NW	Beaverton, Hillsboro, Portland (4 sites)	Multnomah, Washington	HealthShare of Oregon; Trillium Community Health Plan; Yamhill Community Care	Continuing
7	Rural	Mid-Columbia Center for Living *	Hood River, The Dalles	Hood River, Wasco	Pacific Source Community Solutions: Columbia Gorge	Exited 6/30/2019; returned 6/1/2021
7	Remote	Mid-Columbia Center for Living *	Wasco	Sherman	Eastern Oregon Coordinated Care Organization	Exited 6/30/2019; returned 6/2/2021
8	Rural	Options for Southern Oregon *	Grants Pass (2 sites)	Josephine	AllCare CCO	Continuing

9	Rural	PeaceHealth Medical Group, Oregon West Network	Cottage Grove	Lane	Pacific Source Community Solutions: Lane	Exited 6/30/2019; returned 7/1/2022
10	Remote	Symmetry Care Inc. *	Burns	Harney	Eastern Oregon Coordinated Care Organization	Continuing
11	Remote	Wallowa Valley Center for Wellness *	Enterprise, Wallowa (2 sites)	Wallowa	Eastern Oregon Coordinated Care Organization	Continuing
12	Rural	Yamhill County Health and Human Services *	McMinnville, Newberg	Yamhill	Yamhill Community Care	Continuing

* = CMHP

Figure 1 illustrates the geographic location of the CCBHC sites throughout the state of Oregon. ORH defines urban areas being less than 10 miles from a population center of 40,000 or more people, rural areas as being located greater than 10 miles from a population center of 40,000 or more people, and remote (ORH uses "frontier") areas as counties having 6 or fewer people per square mile (Oregon Office of Rural Health, n.d.).

Figure 1: Oregon CCBHC Sites



Source: Oregon Office of Rural Health, 2022

Centering Equity in the CCBHC Evaluation

According to Yearby (2020): "Structural racism is the way our systems (healthcare, education, employment, housing, and public health) are structured to advantage the majority and disadvantage racial and ethnic minorities. More specifically, it produces differential conditions between whites and

racial and ethnic minorities in the five key areas of the SDOH [social determinants of health], leading to racial health disparities." Leading with race recognizes that racism operates at the individual, institutional, and structural levels in the behavioral health system but does not mean that other identities are not recognized. This allows an intersectional exploration and acknowledges that within other dimensions of identity, such as gender, sexual orientation, ability, social class, and age, race inequities exist. Advancing health equity requires acknowledging the interconnectedness of oppression and explicit and intentional action to eliminate all areas of marginalization.

Based upon a review of equity frameworks in the published and grey literature, as well as OHA sources, the evaluation team created an equity framework for this evaluation to frame the analysis of the impact of CCBHCs on addressing behavioral health treatment for Oregon residents (Equitable Evaluation Initiative, n.d.; Oregon Health Authority, 2021b; W.K. Kellogg Foundation, 2021; Yearby, 2020). This approach, derived from OHA's emphasis in the evaluation scope of work on centering equity in this evaluation, reflects OHA's commitment to health equity at a system level, as well as a central theme of the CCBHC program. The overarching question for this evaluation is: What is the effect of the CCBHC model on different populations and underlying systemic drivers of inequity?

The specific questions that informed the design of data collection and subsequent analysis are:

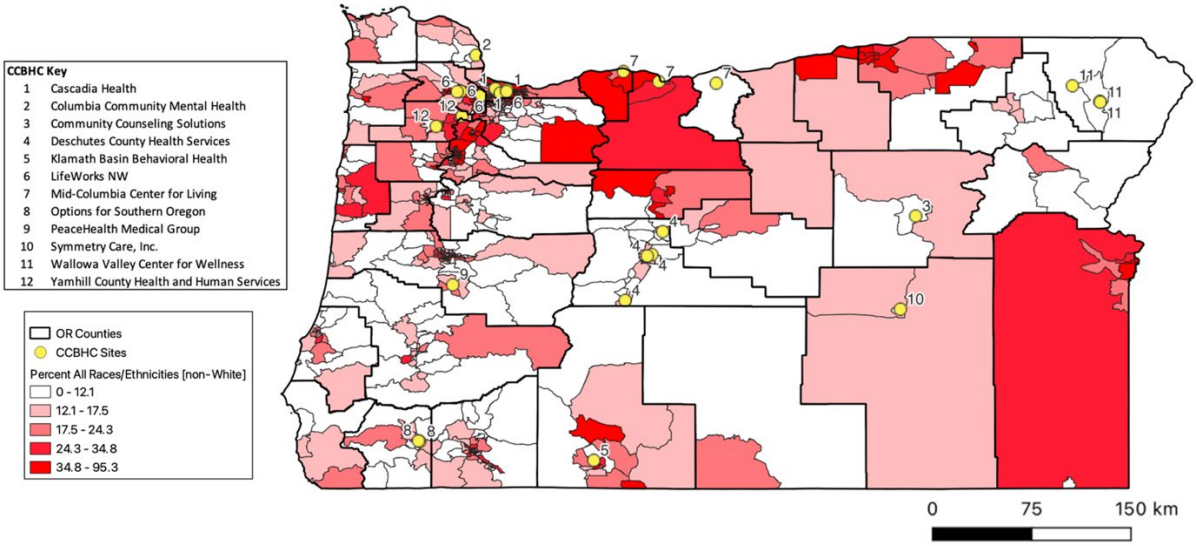
1. How do the CCBHCs define and identify communities that are experiencing health inequities in their service areas? How does this align with OHA's definition of equity?
2. How have community voices been invited into the development and operation of CCBHCs? How are they invited to provide feedback to the CCBHCs?
3. What are the outcomes for service users of accessing the CCBHCs? What were the community responses to the CCBHC program? Do the outcomes and responses vary by community?
4. What strategies could be modified or enhanced to ensure the needs of potential CCBHC service users are met?
5. What resources could be invested to enhance community collaborations and partnerships among CCBHCs and CBOs to ensure the needs of potential CCBHC service users are met?

This report is organized to respond directly to the legislative mandate and OHA scope of work; these questions informed the analytic process, development of recommendations, and discussion of the key findings, but are not necessarily answered explicitly.

In order to provide contextual background information to support the analysis that follows and highlight inequities, the following maps were prepared to illustrate population distributions by Oregon census tract, with the CCBHC sites identified on each map.

Figure 2 illustrates the aggregate self-reported racial/ethnic distribution of Oregon's population by census tract as defined by the 2020 5-Year American Community Survey (U.S. Census Bureau, 2022). The CCBHC sites are designated (as in Figure 1). Figure 2 provides evidence of the population concentrations of individuals self-reporting race/ethnicity relative to the location of the CCBHCs. Specific maps illustrating distribution by racial/ethnic group are presented in Appendix 2.

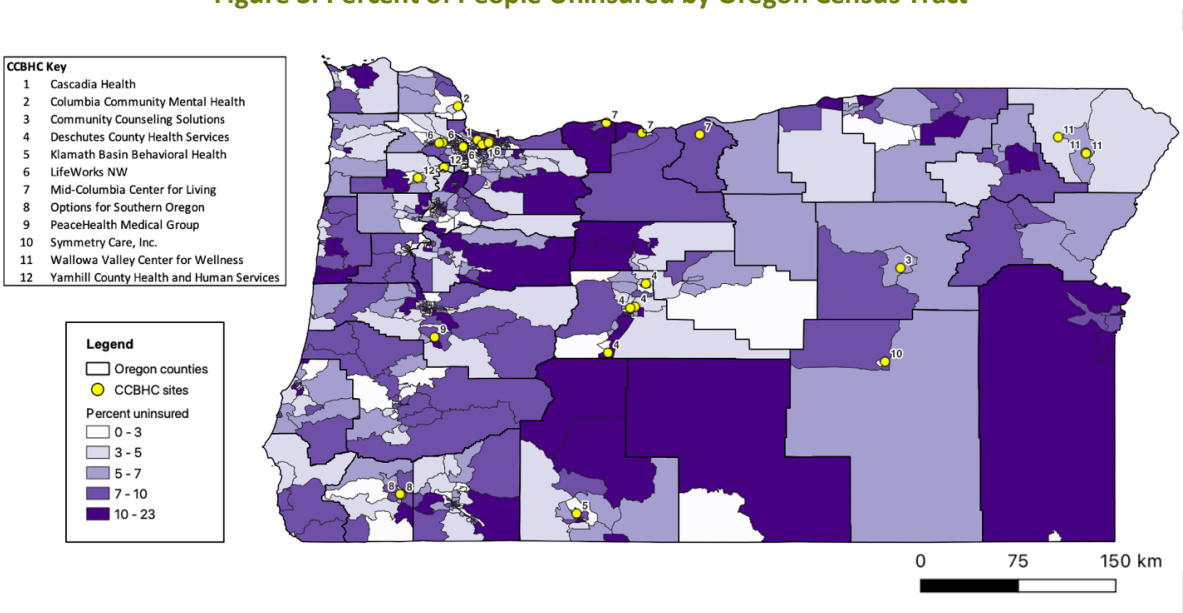
Figure 2: Self-Reported Racial/Ethnic Distribution of Oregon's Population



Source: Oregon Office of Rural Health, 2022

Figure 3 illustrates the percent of people uninsured by Oregon census tract. These data come from the Centers for Disease Control and Prevention's (CDC) Social Vulnerability Index, informed by data from the above-noted 2020 American Community Survey (CDC/ATSDR, 2022). This demographic group is important in terms of ability to access health services, recognizing that CCBHCs serve all individuals regardless of insurance status and acknowledging that a lack of insurance may limit ability to pursue referrals, inpatient services and/or specialty health services. Figure 3 provides evidence of the population concentrations of uninsured individuals relative to the location of the CCBHCs.

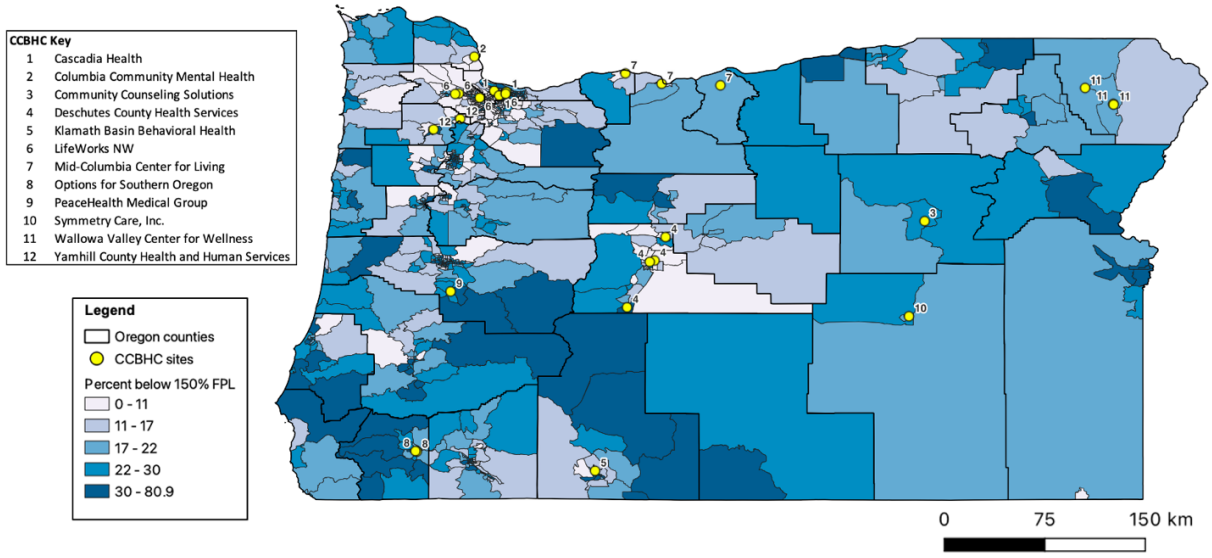
Figure 3: Percent of People Uninsured by Oregon Census Tract



Source: CDC/ATSDR, 2022

Figure 4 illustrates the percent of people living below 150% of the federal poverty level by Oregon census tract. Federal poverty levels are used to determine eligibility for certain programs and benefits, including Medicaid and Children's Health Insurance Program (CHIP) coverage and savings on health insurance. This is important in the context of the CCBHCs because CCBHCs must serve all individuals, regardless of their ability to pay. The CCBHC program thus poses a unique opportunity to expand behavioral health services for individuals with few economic resources who could not otherwise afford to seek care. Figure 4 provides evidence of the population concentrations of such individuals relative to the location of the CCBHCs.

Figure 4: Percent of People Living Below 150% of the Federal Poverty Level by Oregon Census Tract



Source: CDC/ATSDR, 2022

The use of language in this report must be acknowledged. All efforts have been made to use culturally-sensitive, human-centered language. However, some terms in current use incorporate words that may not center the human experience yet are part of accepted acronyms (such as "medication for opioid use disorder" (MOUD) and "substance use disorder" (SUD)); these words appear in this report as part of these terms or acronyms but other usage has been avoided. Similarly, some statutes referenced and quotes included in this report use "mental health" so that term is repeated; whenever possible, "behavioral health" is used in the narrative of this report. Direct quotes reflect what the respondent said and have only been edited for clarity, not substance. With respect to geography, the term "remote" is used to designate counties with 6 or fewer people per square mile; it should be noted that ORH continues to use the term "frontier" as its designation. Finally, OHA instructed the evaluation team to refer to those who access CCBHC services as "service user", which is used throughout this report, despite the fact that many OHA sources use the term "consumer".

Methodology

An overview of the methodology including detailed description of the evaluation framework, data collection strategies, methods, and analytic strategies is provided in Appendix 3. This was previously reported to OHA in October 2022. The primary data sources for the evaluation were:

- Focus groups and surveys with CCBHC service users (conducted between September 1 and October 4, 2022, with survey continuing until late October)
- Interviews with CCBHC clinic administrators and clinical leads (conducted between July 25 and August 16, 2022)
- Focus group and survey with community-based organizations representing multiple interests and sectors in communities served by CCBHCs (focus group conducted October 18, 2022, with survey continuing until early November)
- Interviews with interested parties that support, interact with, or advocate for, CCBHCs (CCOs, managed care organizations, elected officials, OHA leaders, and advocacy organizations) (conducted between October 3 and November 10, 2022)
- Analysis of individual level, de-identified MHSIP surveys of OHP members and OHP claims and eligibility data supplemented by Race, Ethnicity, Language, and Disability (REALD) demographic data (conducted between June and November, 2022)

All qualitative data collection protocols, including recruitment scripts (email or telephone), research information/consent sheets, and interview/focus group/survey protocols, were approved by the PSU Institutional Review Board (IRB) (IRB #227800-18) prior to the collection of any data from individuals. All quantitative data management protocols, including data security, were approved by the PSU IRB (IRB #227749-18) prior to any analysis of data.

Scope of this Evaluation

OHA specified that the scope of this evaluation addressed only the 12 original CCBHC sites based on the initial SAMHSA funding. Additional clinics funded under the SAMHSA CCBHC expansion grants were not included in the OHA scope of work. For the three CCBHC sites that temporarily left the program, the OHA liaison team directed that the two that were reinstated prior to June 2022 were to be included in all qualitative data collection; the one site that had a tentative (at the time) reinstatement date of July 1, 2022 was to be interviewed but no contact made with service users, since there were no service users with recent experiences. In order to provide consistent results, the quantitative analyses were limited to the nine sites that operated continuously as CCBHCs across the four years covered in this study.

Data collection for this evaluation took place between June and November 2022. The evaluation team drew upon additional information resources provided by OHA staff. During that time period, CCBHC program staff initiated various new mechanisms to support the CCBHCs; these are reflected in the evaluation when they were identified in interviews or meetings by CCBHC leaders or other interested parties, and when OHA staff provided documentation that could be used in this report.

Qualitative Design, Data Collection, and Analysis

The evaluation team drew upon interviews with clinic leaders, including administrators and clinical directors, and representatives from various organizations to identify challenges and opportunities for

sustained CCBHC implementation. Interested parties from OHA and elected officials who advocate for behavioral health in Oregon were also interviewed. The evaluation team attempted to gather further input from community-based organizations and service users via focus groups and a follow-up survey, but unfortunately the responses were minimal.

In the discussion that follows, qualitative quotes are named by the group and referenced by the de-identified code assigned to each respondent: Service User, Lead Administrator, Lead Clinical, Interested Party, and CBO Representative. Extended reports summarizing feedback, including quotes, are presented in three appendices (Appendix 4: CCBHC Service Users; Appendix 5: CCBHC Clinic Administrators and Clinical Leaders; Appendix 6: Interested Parties and Community-Based Organizations).

The evaluation team sought to apply the equity-centered evaluation framework throughout data analysis, yet limitations exist which prevented a full assessment of the CCBHC program's impact on health equity. The evaluation team acknowledges these limitations and their effect on this report; the limitations are addressed at relevant points in this report.

Each CCBHC was asked to identify a list of potential service users to participate in focus groups based on specific criteria, but the evaluation team was not informed of how closely each clinic adhered to those criteria. Additionally, there is the potential for sampling bias in the identification of service users for recruitment, as clinics could have selected service users known to have positive experiences while excluding service users with negative experiences (or those who went on to leave the CCBHC). While this possibility cannot be ruled out, most of the service users provided honest and candid feedback that encompassed experiences that were both positive and suggested room for improvement. Despite efforts to support participation of a large representative group of service users, the evaluation team was only able to gather responses through focus groups and surveys from 35 service users across 11 active CCBHCs. These findings are limited by the number of service users who participated in each focus group, as well as the individual contexts and characteristics of those service users.

Communities represented by the service users who participated in the focus groups included two LGBTQ+ individuals, one service user of Native American descent, and one veteran of the U.S. armed services; participant demographic data are limited only to those service users who chose to self-identify with a particular community. While the feedback of these service users is highlighted throughout this report and their experiences are centered as appropriate, the diversity of perspectives is limited and should be recognized as such. Future evaluation efforts are needed to illuminate the experiences of historically and currently underserved communities, including BIPOC communities, Indigenous and Tribal communities, LGBTQ+ individuals, those experiencing houselessness, and other historically and currently underserved communities. Future evaluations may benefit from longer recruitment periods, multiple opportunities for service user engagement (as time constraints meant that only a single focus group could be held per CCBHC), and coordinated recruitment efforts among OHA staff, CCBHC administrators, and local community partner leaders, in order to ensure sufficient and appropriate outreach is conducted to include these important community perspectives.

Despite OHA's explicit interest in the familial experience of children who receive services through the CCBHC, this report cannot speak to this. Efforts were made across multiple clinics to recruit focus group participants who are caregivers to children who have received CCBHC services; unfortunately, none attended the focus groups or responded to the survey.

The majority of service users who participated in a focus group resided in rural service areas; therefore, there is limited evidence to establish whether service users located in urban areas had markedly different experiences than those in rural areas. Further evaluation may be needed to explore whether urban and rurally located service users experience differences in access, services, or quality of care.

In addition, the evaluation team, working on a tight deadline, did not have time to build relationships to actively engage CBOs led by BIPOC or LGBTQ+ community members or federally recognized Tribal sovereign nations. To address this limitation, the evaluation team incorporated findings from the behavioral health report written by the Coalition of Communities of Color (2021).

Quantitative Design, Data Collection, and Analysis

OHA provided the evaluation team with Oregon Health Plan (OHP) claims and eligibility data from two years prior to, and four years after, the CCBHC program initiation (April 1, 2015 through March 31, 2021), as well as Mental Health Statistics Improvement Program (MHSIP) survey data for OHP members, as one means to assess changes in treatment patterns, service user and community outcomes, and health system expenditures. These two time periods are referred to in the subsequent discussion as "pre-implementation" and "post-implementation." In addition, the four-year post CCBHC study period was divided into two, two-year periods to acknowledge and capture potential pre- and post-pandemic differences.

While the majority of CCBHC service users are OHP members, CCBHCs serve a broad array of individuals. Data specific to non-OHP members were not available to make assessments specific to these other CCBHC service users, but the experience of OHP members likely reflects them. In order to effectively assess the CCBHCs uniformly across the four years of post-CCBHC implementation data, the quantitative analyses focused on the nine CCBHC sites that were active in the demonstration across all four years. As most CCBHCs are also CMHPs, OHP members served by CMHPs who were not CCBHCs were chosen as the best comparator group to allow assessment of changes that could be attributed to CCBHC program implementation. To assure that comparisons were made over time and between CCBHC and non-CCBHC service users, propensity score matching was used to assure that the characteristics of service users in each study period mirrored distribution of CCBHC service users in the first two post-implementation periods.

In addition to assessing overall CCBHC program effects, differential impact was assessed across race/ethnicity groups and OHP member place of residence. OHA provided REALD demographic data on race, ethnicity, and preferred language for OHP members from CY 2018 through CY 2021. These data matched with approximately 85% of OHP members included in the study from April 2015 through March 2021. While these data provided the potential to investigate CCBHC impact across these dimensions, the number of OHP members identifying across distinct race, ethnicity, and language categories was limited. The preferred language is predominately English (>95%), making assessments of CCBHC impact by language generally infeasible. Comparisons were sought wherever possible across groups approximating the nine major REALD race/ethnicity groups (RE9) but were limited in cases where group numbers were too small to credibly assess change. Place of residence was limited to rural, urban, and remote areas based on zip code of residence, as defined by the ORH (Oregon Office of Rural Health, n.d.). As remote residents constituted approximately 2% of the study sample, remote and rural residence were combined in several instances.

Findings and Recommendations

The following narrative is organized to respond to the four points stated in the 2021 legislative request regarding the impact of CCBHCs, plus two additional topics specified to the evaluation team by OHA in the April 2022 scope of work:

1. Increase access to behavioral health treatment for residents of this state;
2. Provide integrated physical and behavioral healthcare;
3. Offer services that result in improved health outcomes, lower overall healthcare costs and improved overall community health;
4. Reduce the cost of care for Coordinated Care Organization members;
5. Sustainability and potential expansion of the CCBHC model; and
6. Role of the CCBHC model in future Oregon health systems reform.

Increase Access to Behavioral Health Treatment for Oregon Residents

Increases in access to behavioral health treatment attributable to the CCBHC program were assessed through responses from CCBHC service users and providers, as well as OHP members specifically through the OHP claims data. The perspectives of the CCBHC service users regarding to access are presented first, followed by the information gained from the OHP claims data, and finally by broader issues related to access that were articulated by CCBHC clinic leaders.

Service User Perspectives on Access

Clinics engaged in multiple strategies to increase access, including expanding hours of operation, offering telehealth services, and providing same-day access. Same-day access, which refers to conducting an initial behavioral health assessment the day it is requested, was helpful for initiating engagement with clinics but did not address challenges in connecting service users with needed services following assessment. As noted by one service user: "*The intake was available within 48 hours but there was a wait of 3 weeks to be seen by the counselor the first time*" (Service User 31). Insufficient numbers of staff and inadequate optimization of workflows were two common barriers to ensuring quality follow-up care. Thus, while CCBHCs were able to increase initial access to care, it was often challenging to ensure continuity of care. In addition, expanding hours was not always a helpful strategy in communities with wide geographic spread and limited transportation options. Telehealth was not a good fit for all service users, with several clinic leaders noting that in-person services were sometimes preferred or even necessary for service users with complex needs. In addition, limited internet access was a challenge for some service users, particularly in rural communities.

These challenges with continuity of care were voiced by service users, and some reported setbacks in treatment or felt that the timeliness of services was affected by staff turnover and issues of capacity. One service user reported:

> *It can be a long wait to see therapists and get medication management. When I started services, I waited about a month to see someone, and then my counseling appointments were once a month because of how large the caseloads are. SUD treatment was quick; my SUD treatment counselor often gave me resources and support, but I did not feel very heard or supported by my mental health counselors or my med management doctor. The turnover for mental health*

> *counselors is high here, I went through 4 or 5 in just a couple of years. I ended up getting frustrated and transferring my services elsewhere the beginning of this year* (Service User 34).

However, the majority of service users indicated that their CCBHC was able to provide timely access to needed behavioral healthcare; one service user said: "*I sit in the lobby daily and I've done that for many years because of personal safety reasons. I do get a lot of service. Up until COVID I would see my therapist every day because they would come in and check in on me. I have a very extraordinary treatment team around me where I can contact them when I need to, and I have almost instantaneous contact with them*" (Service User 21).

One service user described observing a situation where language translation was not available when it was needed:

> *There was an incident not too long ago, where I think that there needs to be more translators for Hispanic people. There was a Hispanic man in crisis and there was nobody on the floor that could translate for him and they had to pull somebody in to translate for him, but there was nobody immediately available. And he was just getting more and more agitated. And the more agitated he got, the more he'd kick stuff, and he just got more and more angry because nobody could speak his language* (Service User 21).

In contrast, another service user offered this observation on language support services: *"My partner is deaf and so they arrange for an interpreter to come in during those appointments. That is very helpful and I appreciate it a lot. Not only do they care for me but they also think of my family as well"* (Service User 09).

Access to CCBHC Behavioral Health Treatment Among OHP Members

Table 3 presents the average annual number of OHP members attributed to CCBHC and non-CCBHC Community Mental Health Program (CMHP) sites in total, as well as CCBHC sites aggregated by type of county served, across the pre-implementation and two post-implementation periods. Percentage change from the pre- to the post-implementation periods is also included. County type is based on ORH designations where urban refers to counties that include at least one urban area, and rural or remote reflect overall population density. As noted in the methodology appendix (Appendix 3), attribution reflects OHP members in each study year who received a majority of their behavioral health services from CCBHC or non-CCBHC CMHPs.

Increases in the numbers of individuals served after CCBHC implementation were observed. The average number of OHP members served annually increased by 3.6% from baseline to the first post-implementation period, and then increased an additional 1.3% to a total of 4.9% increase from baseline. In comparison, among the non-CCBHC CMHPs used as a control sample, the average annual number of OHP members served declined from the pre-CCBHC to first post-implementation period by 5.8%, with a slightly smaller decline from the baseline of 4.2% in the second post-implementation period. CCBHCs serving urban designated counties had declines relatively similar to non-CCBHC CMHPs (3.2% and 8.3%, respectively), while CCBHCs serving rural (16.1% and 30.65, respectively) and remote (22.5% and 14.5%) designated counties had large increases in service users.

Table 3: Trends in OHP Members Attributed to CCBHCs and Non-CCBHC CMHPs

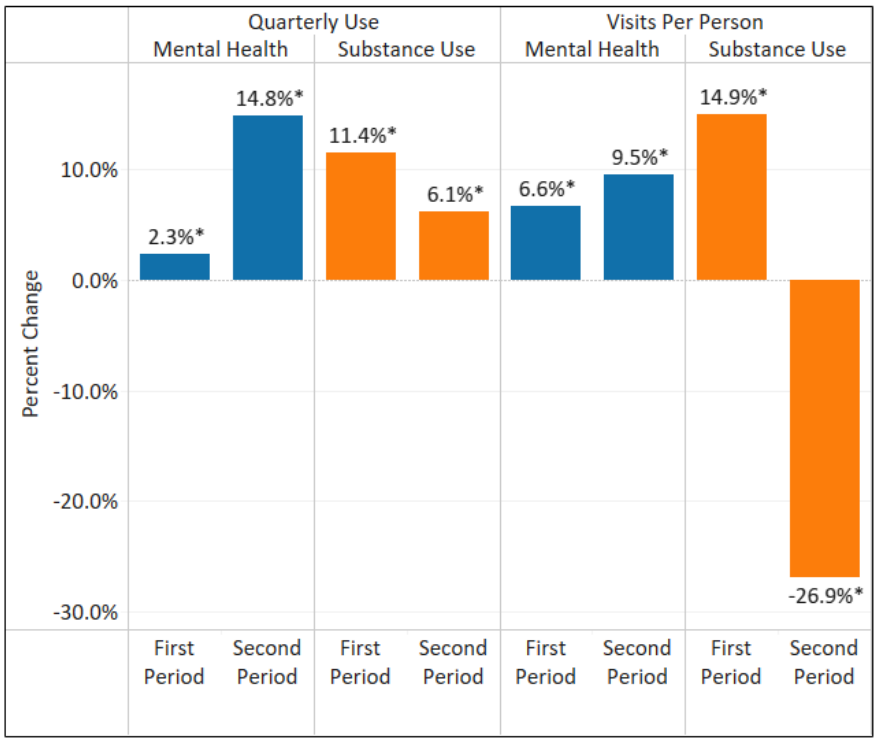
	Pre-CCBHC 2015Q2 - 2017Q1	First CCBHC Period 2017Q2 - 2019Q1		Second CCBHC Period 2019Q2 - 2021Q1	
CCBHC County Type	Average Annual Served	Average Annual Served	% Change	Average Annual Served	% Change
Urban	23,996	23,221	-3.2%	22,004	-8.3%
Rural	12,119	14,076	16.1%	15,830	30.6%
Remote	663	810	22.2%	759	14.5%
All CCBHC	36,777	38,106	3.6%	38,592	4.9%
Non-CCBHC CMHPs	28,680	27,018	-5.8%	27,483	-4.2%

Analysis of MHSIP survey data, discussed in more detail below, did not identify change in OHP members' perception of access overall but did find improved (yes/no) satisfaction scores for adults from rural and remote areas in the first post-implementation period. For children and youth, satisfaction scores for access increased for urban respondents in the first post-implementation period.

Figure 5 provides estimates of the change in quarterly use and visits per person for mental health and substance use services from the baseline pre-CCBHC period to each of the two post-CCBHC periods, after taking into account any contemporaneous changes among the non-CCBHC CMHP comparison group. Tables A7.1a and A7.1b in Appendix 7 provide estimates of changes in these measures across race/ethnicity and urban/rural/remote residence. Quarterly use represents the change in the percentage of individuals attributed to CCBHCs who use any service in a calendar quarter. Visits per person reflects the percentage change in the average quarterly number of visits across the CCBHC-attributed individuals studied. Quarterly use represents the likelihood of any use, while visits per person can be interpreted, in part, as the intensity of services provided.

For mental health services overall, CCBHCs increased both quarterly use (2.3% and 14.8%, respectively) and visits per person (6.6% and 9.5%, respectively) across both periods, with increasing levels from the first to second periods. These increases were distributed differently across race/ethnicity groups particularly for American Indian/Alaskan Native and Black/African American groups. American Indian/ Alaskan Native service users had a decrease in any service use (9.3%) but a 21.2% increase in visits per person in the first period, with flat or non-significant changes in the second period. Black/African American service users had either flat or smaller than average increases in both periods. Across both periods, increases in any outpatient mental health service use (9.1% and 24.2%, respectively) and visits (12.6% and 15.5%, respectively) were entirely concentrated among rural or remote residents. Urban residents had decreased use (6.7%) in the first period, and virtually unchanged use in the second post-implementation period with similar findings for visits in either period.

Figure 5: Change in Mental Health and Substance Service Quarterly Use and Visits Per Person for CCBHC OHP Members



* = statistical significance at p<.05

For substance use services overall, quarterly use increased but was attenuated in the second period (11.4% and 6.1%, respectively). Visits per person increased in the first period (14.9%) then decreased significantly in the second period (26.9%). American Indian/Alaskan Native, Black/African American, and Hispanic/Latino/a/x service users did not experience increases in quarterly use. American Indian/Alaskan Native service users experienced much larger decreases in visits per person in the second period (45.2%). Increases in quarterly use were heavily concentrated among urban residents (24.7% and 76.4%, respectively); quarterly use increased (7.6%), then decreased (14.4%), for rural or remote residents. Increased visits were more concentrated among rural residents in both periods (20.0% and 34.4%, respectively).

Characteristics of CCBHC OHP Members

Table 4 presents the characteristics of CCBHC OHP members across the pre-implementation and two post-implementation periods, changes from the baseline to the post-implementation periods, and the characteristics of the propensity score matched study sample. The CCBHC OHP population in the pre-CCBHC period was predominately 26-64 years old (mean age 32 years), majority female, urban residence, White race/ethnicity, English primary language, and OHP enrolled for a full study year. Prospective risk scores were calculated based on the Chronic Illness and Disability Payment System (CDPS), a risk adjustment model based on diagnostic data that is used to adjust capitated payments for Medicaid plans. The total CDPS prospective risk score (sum of the physical, mental health, and substance use components) was 1.6, indicating expected future expenditures at 1.6 times the average for all OHP members.

Table 4: CCBHC OHP Member Demographics by Period

			CCBHC Period			
		Pre - 2015Q2 - 2017Q1	First 2017Q2 - 2019Q2		Second 2019Q2 - 2021Q2	
Measure	Category	%/Mean	%/Mean	Change	%/Mean	Change
Age Group	<18 years	25.6%	27.1%	1.5%	25.4%	-0.2%
	18-25 yrs	12.6%	13.0%	0.4%	13.5%	0.9%
	26-64 yrs	58.8%	56.3%	-2.6%	56.7%	-2.1%
	65+ yrs	2.9%	3.6%	0.7%	4.3%	1.4%
Age		32.4	31.9	-0.5	32.5	0.1
Gender	Female	39.8%	40.8%	1.0%	40.8%	1.0%
	Male	60.2%	59.2%	-1.0%	59.2%	-1.0%
Residence	Urban	57.5%	55.8%	-1.7%	56.6%	-0.9%
	Rural	40.9%	41.6%	0.7%	41.5%	0.6%
	Remote	1.6%	2.6%	1.0%	1.9%	0.3%
Race/Ethnicity						
	American Indian/Alaskan Native	4.9%	5.4%	0.5%	5.4%	0.5%
	Asian	1.5%	1.6%	0.1%	1.7%	0.2%
	Black/African American	6.2%	6.5%	0.3%	6.5%	0.3%
	Hispanic/Latino/a/x	9.1%	10.9%	1.8%	11.2%	2.0%
	Middle Eastern/North African	0.1%	0.2%	0.0%	0.2%	0.1%
	Native Hawaiian/Pacific Islander	0.6%	0.6%	0.1%	0.7%	0.1%
	White	73.4%	73.7%	0.3%	72.1%	-1.3%
	Other/Multi-Ethnic/Unknown	4.2%	1.1%	-3.1%	2.2%	-2.0%
Primary Language	English	84.1%	89.7%	5.7%	91.8%	7.7%
	Spanish	2.5%	2.8%	0.3%	2.8%	0.3%
	Other Non-English	0.3%	0.3%	0.0%	0.3%	0.0%
	Unknown	13.1%	7.2%	-6.0%	5.1%	-8.1%
CDPS Risk Score	Physical Health	0.91	0.94	0.03	0.95	0.04
	Mental Health	0.61	0.64	0.03	0.63	0.02
	Substance Use	0.08	0.08	0.00	0.08	0.00

In terms of changes in the OHP member demographics from the pre-CCBHC period to the first post-implementation period, there were increases in the proportion of OHP CCBHC service users under 26 years; the over 65 years group increased by 3.6% (mean age decreased by 1.1 years). The proportion of service users identifying as female gender increased by 1%, while rural and remote resident proportions increased by 0.7% and 1.0%, respectively. The 1.0% percent increase in remote residents is notably large relative to its much smaller proportion overall and is consistent with rural site increases noted above.

While increasing OHP service users overall, there is evidence of increases in the relative diversity of the CCBHC service user population in terms of race/ethnicity. Service users identifying in race/ethnicity categories other than White or Other/Multi-ethnic/Unknown increased by 2.8% overall, with the largest change for the Hispanic/Latino/a/x group at 1.8%. From the perspective of relative growth (i.e., taking into account the initial size of the populations), the American Indian/Alaskan Native and the Native Hawaiian/Pacific Islander groups also had large growth. Changes in reporting over time led to reductions in the "unknown" categories for both race/ethnicity and primary language that incur increases in "known" groups. With adjustments in amount and rate of change of "unknown", the increases for race/ethnicity still appear to hold in general.

Similar to the changes in race/ethnicity, there appear to be some evidence of an increase in the number of OHP service users with a primary language other than English. English and Spanish primary language both increased; however, from a proportional change perspective, and considering the reduction in "unknown", it appears that only Spanish primary language is likely to have actually increased. Quarterly enrollment was steady and average CDPS prospective risk scores for physical and mental health conditions increased slightly. These patterns of change, while attenuated, generally held for the second post-implementation period. An exception was a large increase in full year enrollment (6.1%) that likely reflected pandemic related changes in OHP enrollment processes.

Changes in Location of Service for CCBHC OHP Members

CCBHC clinic leaders indicated that the program provided an ability to move services "outside the four walls" and thus increase access by meeting service users where they are. Table A7.2a and A7.2b in Appendix 7 provide detail on the distribution of service location over time as recorded on claims through Place of Service (POS) codes. The distributions over time are broken down by recorded race/ethnicity and urban/rural/remote residence. These codes tend to be oriented towards assessing location in terms of medical facility type, as opposed to community location, but provide some insights into service location changes that occurred through the CCBHC program. Overall, this evidence is consistent with CCBHCs reporting shifts in service location "outside the four walls", although office or clinic-based care, as recorded in claims data, was still the predominant location of service. While the focus here is on change over time, attention should be paid to the distribution of service location across service user subpopulations to assure that differences do not reflect inequities.

From baseline to the first post-implementation period, there were increases in service locations indicated as Temporary Housing/Unhoused and Correctional Facilities; however, the volume of these services was very low overall. School, Home, and Assisted Living/Group Home also increased and were of larger volume. Of these, all had persisting increases from baseline in the second post-implementation period except for Home and Correctional Facility. Increases in Temporary Housing/Unhoused-located services largely occurred among urban residents. All race/ethnicity categories, other than Middle Eastern, had increases by the second post-implementation period. Increases in Correctional Facility-

located services were predominately in rural or remote areas and centered in service users identifying as American Indian/Alaskan Native, Hispanic/Latino/a/x, White, and Other/Multi-ethnic/Unknown.

School-based services followed a similar pattern across most racial/ethnic groups with increases centered more in rural areas, while declining in remote areas. Home-based services also followed the same pattern for most groups but increases were more focused in rural and remote areas and among Asian and Native Hawaiian/Pacific Islander service users. Increases in Assisted Living/Group Home-based services occurred for most groups, particularly by the second, pandemic-related period, and were more focused in rural and remote areas and among White and Hispanic/Latino/a/x service users.

Telehealth services increased in the first post-implementation period and then jumped significantly in the second post-implementation period overall and for all groups, but the Native Hawaiian/Pacific Islander service users had significantly less than average use of these services in general, and remote area residents also had slightly less than average use. Finally, several groups had large proportions of their services coded as "Other Place of Service" (e.g., Native Hawaiian/Pacific Islander at 60-70%). Although this category did not increase in general, it may reflect some of the "outside the four walls" services and outreach that CCBHCs are providing. Notably, Black/African American service users were one group that had an increase in this area and also had distinctly higher MHSIP scores related to access.

Changes in Types of Service for CCBHC OHP Members

CCBHC providers spoke to the ability to provide additional or differently distributed services under the program, in part given the PPS payments they receive. Tables A7.3a and A7.3b in Appendix 7 provide assessment of the change in the proportions of OHP claims over time for the nine core service types required of CCBHCs: Crisis Services; Outpatient Behavioral Health Services; Primary Care Screening and Monitoring; Patient Centered Treatment Planning; Peer Services; Psychiatric Rehabilitation Services; Screening, Assessment and Diagnosis; and Targeted Case Management. These proportional changes are assessed overall, by race/ethnicity, and by urban/rural/remote residence.

Overall, there is evidence that the CCBHCs shifted emphasis in several service areas, including increases (at least by the second post-implementation period) in the volume of Peer Services provided. The shifts in service patterns varied by race/ethnicity and residence of service users. The proportion of Crisis Services increased overall, for all residence types and all race/ethnicity groups other than Middle Eastern. Outpatient Behavioral Health Services were largely unchanged with some increase for urban residents and Hispanic/Latino/a/x, Black/African American, and Native Hawaiian/Pacific Islander service users. Primary Care Screening and Monitoring decreased overall but increased for remote residents and followed the overall pattern for all race/ethnicity groups. It should be noted that this category may be under-counted as the claims used in this analysis are only for those services provided directly by CCBHCs (primary care is contracted out by some CCBHCs).

Patient Centered Treatment Planning increased in both post-implementation periods and increased mostly for urban residents and across all race/ethnic groups. Peer Services decreased slightly and then increased. This pattern was largely the same across race/ethnicity groups but did not increase consistently for rural residents. Psychiatric Rehabilitation Services increased with these increases more concentrated among urban residents and Asian and Black/African American service users. Screening, Assessment and Diagnosis services increased into the first post-implementation period then were largely unchanged relative to baseline by the second post-implementation period. Rural and remote

residents had increases in this service type across both periods. Native Hawaiians/Pacific Islanders experienced more consistent increases. Targeted Case Management decreased in both periods overall but was increased for remote residents in the second period and flat to increasing for Asian, Black/African American and Middle Eastern service users.

CCBHC Model's Impact on Access to Behavioral Health

CCBHC clinic leaders reported expanding their capacity to provide behavioral health services in their communities through implementation of the CCBHC model. They attributed this to the PPS payment model, which enabled them to hire more staff and provide "outside the four walls" care in their communities. "Outside the four walls" care enabled the CCBHCs to offer low-barrier access in diverse, non-clinic settings, such as schools, public spaces, jails, and community partner locations, or wherever service users were located. One clinic leader reflected that some people felt stigma coming into a behavioral health clinic and stated: "*We try not to make people come into our four walls if that's not where they're comfortable*" (Lead Clinical 08). Several clinic leaders appreciated the flexibility that the CCBHC program provided in allowing them to experiment with new ways to conduct outreach and provide services within the community. One explained: "*What I appreciate about CCBHC and that model [is] understanding that we can do things in a nontraditional standard … that will help break down those barriers to getting care*" (Lead Clinical 04).

This model of care was articulated by several clinic leaders as focusing on holistic, person-centered care. In this context, a holistic approach means to provide support that considers the whole person, attending to their physical, emotional, social and spiritual wellbeing. As reported by service users, some CCBHCs embrace this concept and operationalize it so that service users have access to a broad range of supports. One clinic leader commented: "*I think of CCBHC as an ACT team for everybody. You get a multidisciplinary team and that model of outreach, meeting people where they're at… You don't have to be SPMI to get a wraparound team of professionals with a peer and an MA and a physical health physician and your SUD or mental health clinician*" (Lead Administrator 13).

Many clinic leaders hired new staff members as part of their CCBHC implementation. The quantity and type of staff hired varied across the CCBHCs, depending on the size and needs of each clinic, and included qualified mental health professionals (QMHP), qualified mental health associates (QMHA), peer mentors, primary care physicians, nurses, medical assistants, community health workers, care coordinators, navigators, case managers, and data analysts. Position titles varied across clinics; the scope of this evaluation did not include a detailed analysis of how and to what extent the clinic workforce changed following CCBHC implementation. In general, clinic leaders reported that the PPS payment model enabled them to expand their staff, which in turn enabled them to provide the core CCBHC services. These new support positions improved the flexibility of clinics to rapidly engage new service users, relieve clinicians of some administrative and/or treatment burdens (in some clinics), and coordinate care both internally and externally.

Several clinic leaders reported efforts to optimize workflow in order to facilitate their intake processes, which also helped them to expand rapid access to new service users. However, some clinic leaders noted that barriers to ensuring quality follow-up care remain, including staffing shortages, high turnover rates, and inadequate data infrastructure systems. Clinic leaders requested more support from OHA for training in collecting and using disaggregated data.

Several clinic leaders were grateful that the PPS payment model enabled them to expand their peer workforce, which was beneficial to building trust in the community and facilitating outreach to various community groups. One clinic leader said: "*The biggest challenge and change for us was understanding and starting to really utilize peers. With CCBHC, that became a 'no brainer' that we were going to need to be really embracing the integrated use of peers throughout our programs. And now it's almost like a microwave oven, how did we ever live without this?*" (Lead Clinical 10). Another clinic leader noted:

> *The peer workforce is probably one of the most transformative developments in the field of behavioral health since psychotropic medications. It's their sense of mission, their ability to reach the people we really need to see. Culturally, there was a shift from, 'Treat the clients who are compliant and show up for appointments,' to 'Figure out how to reach the clients who don't, because they're actually the ones showing up in the ED, jail, and in the homeless camp that we should be trying to reach.'* (Lead Administrator 09)

While all clinic leaders reported providing services to underserved populations, several clinic leaders recognized that the provision of culturally and linguistically responsive services, whether internally or with community referrals, is an area for improvement going forward. One clinic leader said: "*I think [accessing culturally responsive services] is a place where we could do better, where we maybe have the box checked, but we were not fully meeting the spirit of CCBHC in really identifying resources for clients*" (Lead Administrator 06). Other clinic leaders indicated that they have goals to increase outreach to specific populations within their communities. One clinic leader said: "*Our penetration into our Hispanic community is lower than we would like it to be. We are exploring different ways that we can find culturally and linguistically appropriate and sensitive approaches to come to these communities and see what kinds of support would make sense in their communities*" (Lead Clinical 10). Additionally, several CCBHC clinic leaders identified low-income individuals as a group in their community for whom they were specifically aiming to increase outreach efforts and/or targeted services.

Many clinic leaders recognized the importance of hiring diverse staff. One said: "*We make an effort to make sure that our staff are diversified and represent our community well*" (Lead Administrator 01). Several clinic leaders prioritized hiring staff who were bilingual, in order to help serve their Spanish-speaking communities. However, the provision of equitable language services was still identified as a challenge by clinic leaders, despite efforts by OHA to ensure that OHP members get meaningful language access. Clinic leaders noted that it is particularly helpful to have relevant language services for behavioral health services. One clinic leader pointed out that while seeking to provide equitable access to bilingual service users, they wanted to avoid disproportionately burdening their bilingual staff:

> *Equity of access in language services is still a huge need. I don't think CCBHC particularly funds anything for that or requires anything around other than having access. We meet the bare minimum with interpretation, but [we'd like to see] some ways to incentivize that. We've struggled with that. Even just with hiring, how much incentive can we give for bilingual-bicultural staff, because they often end up with equal or higher workloads*? (Lead Clinical 02)

Oregon's Behavioral Health System

Findings highlight the challenges and limitations of Oregon's behavioral health system, which have a negative impact on access to behavioral health services. One interested party said: "*The CCBHC model is only as good as the rest of the system*" (Interested Party 05). A common and persistent theme from

interested parties, CBO representatives, clinic leaders, and service users was that Oregon's behavioral health workforce shortage has limited and continues to limit access to behavioral health services in Oregon. Factors contributing to the workforce shortage include inadequate compensation, administrative burden, and complex work. Additionally, clinic leaders, CBO representatives, and interested parties noted that stigma continues to play a role in limiting access to services. While stigma was often framed by clinic leaders as a barrier to help-seeking, at least one interested party noted the historical and current role that structural stigma plays in shaping behavioral health investments, regulations, and administrative rules. Some clinic leaders, interested parties, and CBO representatives acknowledged that certain populations, including BIPOC, Indigenous and Tribal, LGBTQ+, houseless, and justice-involved individuals, experience the burden of Oregon's workforce shortage disproportionally. These themes are aligned with recent reports that assess Oregon's behavioral health system (Coalition of Communities of Color, 2021; Governor's Behavioral Health Advisory Council, 2021; Secretary of State, 2020; Zhu et al., 2022).

These findings suggest potential strategies for both CCBHCs and OHA to center equity in Oregon's behavioral health system, and emerged from the synthesis of interviews, focus groups, and content analysis of community health reports. They include:

1. Diversifying the workforce, not only at staff levels but also leadership levels that have decision-making authority, and training the current workforce to work with diverse populations;
2. Investing in robust data infrastructure and resources to support the analysis of data to identify health inequities among historically and currently underserved populations, such as BIPOC and Tribal communities and LGBTQ+ and houseless individuals;
3. Collaborating with communities and community-based organizations to develop and implement culturally appropriate outreach and services, as well as to identify service gaps and barriers to access in the community; and
4. Redefining wellness to move away from a linear, medicalized definition of wellness to a more holistic, social definition that embraces multiple pathways and definitions of wellness.

Summary and Recommendations: Increase Access to Behavioral Health Treatment for Oregon Residents

CCBHCs have expanded access to behavioral health services in Oregon. CCBHCs increased the numbers of service users over time, even as decreases were seen in non-CCBHC CMHPs. The largest increases appeared to be associated with CCBHCs located in areas designated as rural or remote. These new service users tended to be under 25 years or over 65 years; female; from rural or remote areas; identified as American Indian/Alaskan Native, Asian, Black/African American, Hispanic/Latino/a/x, Middle Eastern, or Native Hawaiian/Pacific Islander; and spoke Spanish as the primary language. From a proportional change perspective, the largest changes appeared in remote residence and American Indian/Alaskan Native, Hispanic/Latino/a/x, and Native Hawaiian/Pacific Islander groups.

Rates of quarterly service use and visits per person for behavioral health outpatient services generally confirmed these findings. From the perspective of these outcome measures, the expansion in services was heavily tilted towards rural and remote areas. Findings suggested the presence of some potential inequities for American Indian/Alaskan Native and Black/African American OHP members.

The MHSIP data support findings of improvements in access to care from different perspectives. Rural adults and urban children and youth indicated increased satisfaction with access. The most prominent increases in perception of increased access were realized by Black/African American adult respondents who, as a racial group, have historically experienced and continue to experience the most significant barriers in access to healthcare due to systemic racism within both the healthcare system and society.

The PPS payment model provided CCBHCs with a means to pay for additional staff, including care coordinators and peer mentors, as well as to implement "outside the four walls" services. The latter enabled CCBHCs to conduct outreach to individuals who may not otherwise seek care. Significant changes in treatment service distribution were found for remote area residents as compared to urban, and for many ethnic/racial groups as compared to the overall average. Place of service data for CCBHC services indicate some growth in services "outside the four walls" with patterns that vary by area of residence and race/ethnicity.

While CCBHCs have expanded access to behavioral health in Oregon, they are limited in number and operate within a behavioral health system with well-documented challenges and limitations. Although all CCBHC clinic leaders acknowledged the importance of equity, many were uncertain about how to center equity in their work.

Clinics could benefit from additional guidance from OHA on how to 1) effectively identify and develop trusting relationships with community partners, particularly BIPOC, Tribal, and LGBTQ+ leaders, and culturally specific CBOs; 2) engage the community and their service users to identify community health needs; and 3) develop culturally appropriate outreach and services. Groups that are marginalized by historic and contemporary injustices should receive primary attention in efforts to destigmatize behavioral health services and increase access.

CCHBC program staff carried out on-site compliance visits at each CCBHC between July and November 2022. The collective findings from those site visits, as reported to the evaluation team by CCBHC program staff, revealed four core programmatic areas for technical assistance: integrated care model; care coordination/community outreach; equitable service delivery; and holistic, person-directed care. These are the initial topics for the All-Clinic CCBHC Learning Collaborative that was launched in October 2022 by CCBHC program staff who are holding monthly meetings with CCBHC leaders to provide technical support. In addition to the topics identified through the compliance visits, the Learning Collaborative could address additional topics identified through the evaluation interviews with CCBHC leaders.

Recommendation: Engage advocates and community leaders to recommend actions for the development and implementation of culturally and linguistically responsive outreach and services.

Potential strategies to address this recommendation could include: use of community assessment tools that specifically guide CCBHCs to collect information on health disparities by race, ethnicity, language, gender, sexual orientation, and disability; development of a list of recommended staff trainings on equity; engagement of communities that are marginalized by historic and contemporary injustices to identify service gaps and barriers; and alignment of outcomes data with state equity goals.

Provide Integrated Physical and Behavioral Healthcare

CCBHCs receive an enhanced Medicaid payment rate based on the anticipated costs of providing an expanded array of addiction and behavioral health services, along with basic primary care screening and coordination with primary care (U.S. DHHS, 2016). Oregon added an additional requirement that goes beyond screening and coordination and requires the CCBHCs to provide 20 hours of onsite primary care services per week. Integrating primary care services into behavioral healthcare settings is predicated on the need to connect individuals with serious behavioral health needs and SUD to preventive health services (Scharf et al., 2013). For individuals with serious behavioral health needs and SUD or with a dual diagnosis, community mental health clinics may be the only point of contact with the healthcare system, and they may feel most comfortable receiving care at their local community mental health clinic. In order to improve health outcomes among this specific population, facilitating access to primary care services preferably by bringing primary care providers onsite at the community mental health clinic, has been identified as a promising strategy (Scharf et al., 2013).

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) articulates a continuum of collaboration and integration that includes separate systems and settings with little to no communication or coordination, co-located behavioral health and physical health with some coordination, and fully integrated systems where behavioral health and primary care providers provide team-based, whole-person care (Heath et al., 2013).

Provision of Primary Care

Five clinic leaders explicitly indicated that they offered primary care services onsite prior to the CCBHC program. To meet the onsite primary care requirement, approximately half of the CCBHCs hired their own primary care provider to provide some level of integrated services; the other CCBHCs opted to contract with a primary care partner to co-locate physical health and behavioral health. Two clinic leaders reported explicitly that they had sought a waiver from OHA for the primary care requirement in order to reduce the number of hours required; two were less explicit but suggested that they had "worked it out with OHA" with respect to this requirement. As one clinic leader expressed: "*It's been a huge challenge… We are totally invested in having our clients get access to primary care and doing a better job of integrating with them, but the 20 hours has been difficult to impossible for us to actually do*" (Lead Clinical 09).

Several clinic leaders felt the primary care requirement was challenging for a variety of reasons, including difficulties with hiring or retaining primary care providers for part-time work amidst workforce shortages; insufficient patient panels to financially support 20 hours of onsite primary care; uncertainty about how best to manage an onsite partnership; and confusion about whether the 20-hour requirement applied to each clinic site or could be aggregated across sites when a CCBHC operated in multiple locations. Some clinic leaders believed that the primary care requirement should be revised to introduce greater flexibility and better account for local circumstances. One interested party also requested increased flexibility:

> *I'm not sure that it was the right thing to mandate 20 hours a week of primary care. The intent was to have more communication and coordination between primary care and behavioral health, but it didn't mandate that they were part of the same agency. If you have a primary care physician from another agency sitting there, but they don't use the same medical record, it's the same coordination challenges you would have if they were in their own office. A better*

> *investment might be the technology to support communication and coordination with primary care and behavioral health rather than always mandating it be co-located.* (Interested Party 01)

A few clinic leaders who reported challenges with establishing primary care services also expressed that the requirement pushed them to integrate, which led to more team-based care. One clinic leader shared that despite their struggles: "*We needed that impetus of being a CCBHC to become co-located and to partner with our medical providers more closely… Our team-based care increased exponentially after becoming a CCBHC, and that's a benefit to everybody*" (Lead Clinical 05). Unsurprisingly, clinics that had some level of existing primary care services prior to becoming a CCBHC reported that the 20-hour primary care requirement was neither burdensome nor difficult to achieve.

In addition, clinics with pre-existing integrated primary care services saw improvements with the CCBHC model. "*We were very siloed before. We had our primary care doing their thing, we had behavioral health doing their thing, and we didn't communicate very well. Now, we're really thinking about how we can do integrated care*" (Lead Administrator 06). Integration of behavioral and physical health also led to changes in organizational culture and approaches to care delivery. One service user commented: "*My team consistently helps me problem-solve and find solutions or resources when I am in need of other health services. My therapist has given me a few suggestions that have helped guide my primary care provider to helpful solutions for ongoing issues"* (Service User 32).

Staffing CCBHCs

For many clinics, the CCBHC model led to the adoption of a team-based, multidisciplinary approach to care. Staff such as QMHAs and peers were key contributors to these teams. These changes required a fundamental workplace cultural shift that was facilitated by leadership who were fully committed to the goal of integrated care during implementation. Clinic leaders reported that it was important to train staff on the "why" of integrated care and the benefits of these changes for their service users, in order to increase staff buy-in to these process changes.

At many clinics, additional staff were hired to fill new positions related to case management and care coordination. These positions do not necessarily fulfill the same roles across CCBHCs, and staff positions that were mentioned in these capacities included "care coordinators," "care navigators," "case managers," and others. It is unclear to what extent these positions have different roles across CCBHC sites. In general, these new staff positions were intended to facilitate communication and collaboration among providers, with the goal that service users receive holistic, person-centered care. As one clinic leader said: "*Care coordination, it's a partnership. So, if we're seeing a deterioration for somebody who is diabetic, we can be talking with their primary care provider about their care and management of that issue*" (Lead Administrator 06).

Integrating and Coordinating Primary Care and Behavioral Health Services

Some clinic leaders reported greater success with integration than others. A few recognized it as an area for continued improvement. In one clinic, care coordination services were only available to service users who established care with the onsite primary care provider, excluding those who accessed primary care elsewhere and received only behavioral health services from the CCBHC. Many clinic leaders discussed administrative difficulties associated with data infrastructure, such as inadequate (or absence of) data-sharing systems and electronic health records (EHR) that could not communicate well across primary care and behavioral health, whether internally within the CCBHC or externally with other healthcare

partners. Clinic leaders requested greater investment in infrastructure that supports data sharing and integration. One clinic leader stated:

> *Mental health records are not set up for some of this data stuff. We've been very creative. Our actual old EHR was very old … but we had it working as good as we could. We just switched to a new system [and] some of the systems we had didn't transfer over as well. It's really complicated because the medical records [do] some of this stuff, [but] mental health records don't. What we really need to get is a business intelligence program, to be able to analyze some of the data [and] really make good use of it. I have spreadsheets, on spreadsheets, on spreadsheets to track some of this stuff. … I have people that do nothing but spreadsheets, because it's really hard to do in our EHRs.* (Lead Clinical 08)

Other challenges included training behavioral health staff to collect data related to physical health and confusion about privacy laws (42 CFR Part 2, related to confidentiality of substance use disorder patient records, and HIPAA, related to protection of sensitive patient health information) governing the sharing of health data. 42 CFR Part 2, in particular, has been challenging for Oregon providers who report that different partners have varying interpretations of the regulation. One interested party noted: "*42 CFR Part 2 [is a barrier]. We have some organizations that even within their own organization won't talk to each other from the SUD side to the mental health side"* (Interested Party 02).

Findings from service users indicate that CCBHC integration with other health services (primary care, dentistry, etc.) may play a critical role in not only getting community members into behavioral healthcare but also in facilitating engagement with services across the broader health system. This may be due, in part, to the convenience of having multiple services integrated into the same facility and also because service users felt safe and respected as a result of the CCBHC's integrated approach to care. One service user noted: "*It's safe [at this clinic], because of their integration with the primary care facility. The approach to mental health here is very holistic. It's not just, "we're treating this," it's looking at the entire picture*" (Service User 25).

Many service users reported that their care was coordinated by their CCBHC in at least some way and were appreciative that their care team communicated with one another, particularly in regard to scheduling appointments across providers and monitoring medication plans. One service user said:

> *This is the first mental health facility that I've been able to access other than the VA, and there is no comparison between the capabilities of this clinic and the VA. The only reason that I even access care here is because they are integrated with [medical clinic] and they actually had a mental health person in with physical health. During a physical, they determined that it wasn't physical issues that I was having, it was my mental health. They were able to get me in with a mental health person right then, and now that [the medical and CCBHC] are in the same building, it's perfect.* (Service User 26)

Service users generally spoke highly of the care coordination that they received through their CCBHC and noted it helped them to progress in their treatment in a way that they did not otherwise feel would be possible. For some service users the perception that their care was not coordinated was due to a lack of familiarity with the term. However, a few service users reported very limited care coordination. One service user reported: "*There is some coordination between therapists and other workers, but I don't feel*

like coordinated is the right term. There is some mild collaboration, but it is far from a wraparound style treatment service" (Service User 30).

Several service users indicated that requirements for the use of integrated services may apply differently to those receiving services for SUD and those with a dual diagnosis. This suggests the need at both the clinic and CCBHC program level to investigate differences in the experience of integration of physical and behavioral health services for service users who are required to utilize CCBHC services as a component of their treatment and/or in order to receive medication for opioid use disorder (MOUD).

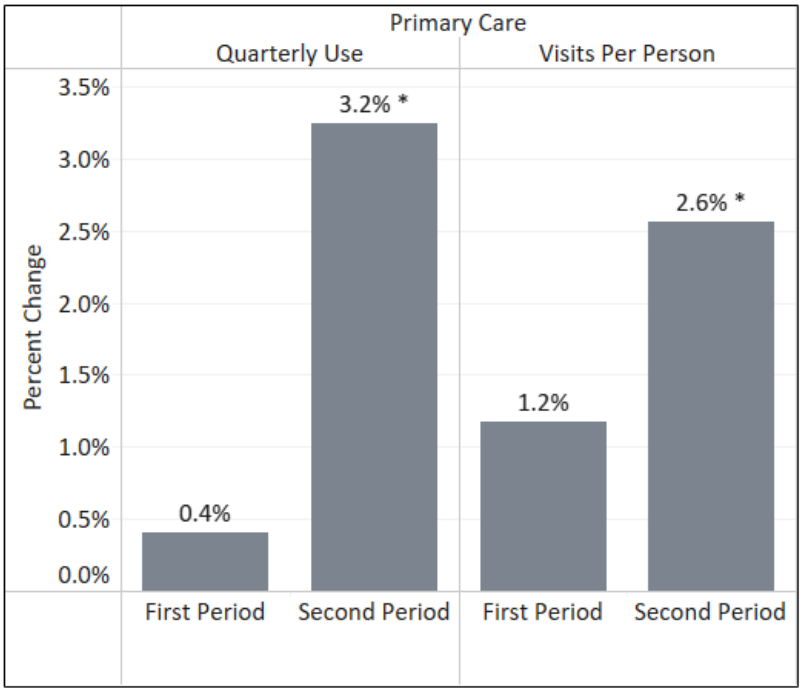
Even when integration with primary care was available, not all service users chose to take advantage of it. Some service users received specialist care that they were unable to receive through the CCBHC, while others had an existing relationship with their primary care provider prior to receiving services from the CCBHC that they wished to maintain. For service users relying on outside specialty services, care coordination activities were even more important to ensure all members of the care team had the same information. These findings indicate that it may be important for relevant Oregon decision-makers to reconsider the CCBHC primary care requirement specifications in order to account for service users who choose not to receive their physical healthcare through the clinic but could still benefit from care coordination activities that help to streamline their experience across multiple clinics and providers.

Integration and coordination of care are critical for improving healthcare outcomes. Interviews with clinic leaders and service users suggest that, even with the CCBHC model, challenges with data, communication, and information sharing remain. The CCBHC provides a promising model for integrating primary care into behavioral health settings. As one interested party noted: "*[The CCBHC] is definitely moving towards integrated care. It's not completely bringing in physical healthcare, but it's a start…the primary care is coming to behavioral health for those people who feel like their behavioral health clinic is their main doctor"* (Interested Party 05).

Primary Care Use

Figure 6 provides estimates of the change in primary care use and visits for CCBHCs overall and by race/ethnicity groups. Tables A7.4a and A7.4b in Appendix 7 provide estimates of changes in primary care by race/ethnicity and urban/rural/remote residence. Quarterly primary care use and visits per person were flat or increased minimally in the first post-implementation period but showed increases of 2-3% by the second post-implementation period. These changes most closely reflected the experience of White service users, while service users of other races/ethnicities did not clearly experience the same levels of increase (and may have seen decreases in some cases). The Hispanic/Latino/a/x group appeared to experience at least the same, and in some cases higher, rates of increases as the White group or overall average (e.g., an 8.6% increase in primary care visits per person in the second post-implementation period). Rural or remote residents experienced increases, and at higher rates than average, across both periods in primary care use (1.8% and 5.9%, respectively) and visits (3.8% and 6.7%, respectively). Urban residents did not appear to experience increases in use and had decreases in visits per person in both periods (2.0% and 3.1%, respectively).

Figure 6: Change in Primary Care Quarterly Use and Visits Per Person for CCBHC OHP Members



* = statistical significance at p<.05

Summary and Recommendations: Provide Integrated Physical and Behavioral Healthcare

The CCBHC program contributes to the integration of behavioral health and primary care services and the adoption of team-based care, particularly with increases in telehealth services during the COVID-19 pandemic. Increases in primary care use and visits were most prominent for White service users, although Hispanic/Latino/a/x service users had generally higher than average increases, and were found for rural and remote residents, but not for urban area residents. Benefits to service users in those CCBHCs that have integrated other services, such as dental care, include engagement with the broader health system. Several service users reported that they felt safe at the CCBHC clinic because of the holistic approach to healthcare.

While many service users indicated that their care was coordinated, some reported limited coordination. Some clinics faced substantial challenges in meeting the state requirement for 20 hours per week of onsite primary care, including difficulty recruiting and retaining a primary care provider, ensuring service availability, and identifying a sufficient patient panel, despite the fact that OHA currently offers flexibility in the onsite primary care requirement. Some service users reported receiving primary care at a clinic that was not the CCBHC because they already had a pre-existing relationship with another primary care provider. Inadequate data sharing infrastructures and inconsistent interpretation of 42 CFR Part 2 also posed barriers to effective care coordination. CCBHC program staff reported that in October 2022 they began facilitating a bi-weekly, service user-driven steering committee to discuss the Oregon-specific criteria of the CCBHC model. Topics to date have included standardizing the criteria of being person-centered, integrated, equitable, and community-

based. A change in the future to tiered criteria that establish both minimum and aspirational standards for care coordination and integration might be a strategy to better support the CCBHCs.

Recommendation: Establish clearer standards for primary and behavioral care coordination and integration that enable CCBHCs to better provide whole-person care and services that meet the complex and multiple needs of diverse service users.

Offer Services that Result in Improved Health Outcomes, Lower Overall Healthcare Costs, and Improve Overall Community Health

In order to assess the impact of CCBHCs on health outcomes, healthcare costs, and overall community health, this evaluation examined quantitative data on treatment service patterns and performance outcomes and qualitative data reflecting the perspectives of clinic leaders, interested parties, CBO representatives, and service users.

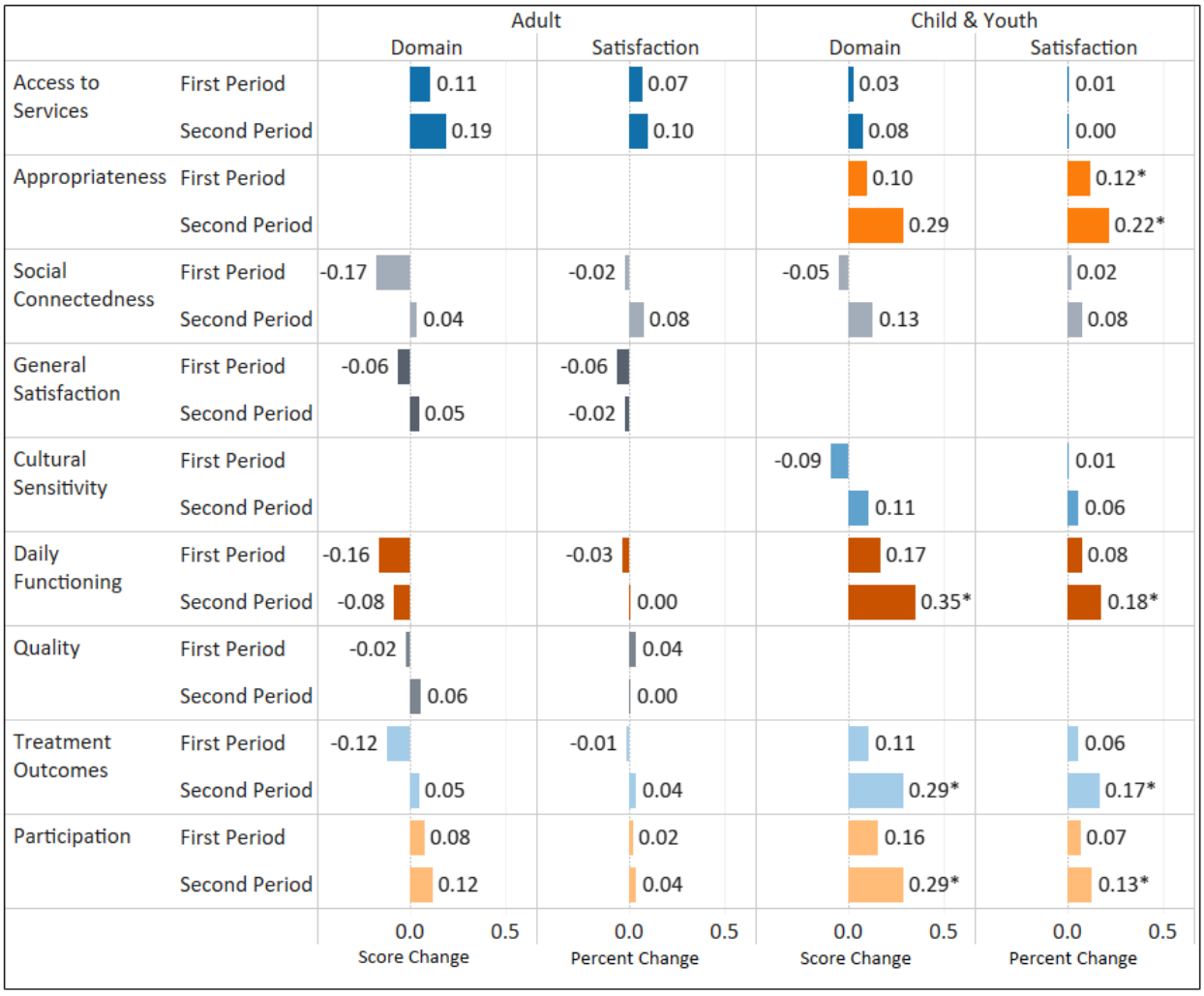
Improved Health Outcomes

The MHSIP survey provides information on OHP members' self-reported experiences using mental health and substance use services and was used to measure members' health outcomes. The survey covers domains that reflect treatment impact (Treatment Outcomes, Daily Functioning), as well as others tied to improvements in overall community health through addressing social determinants and inequities, including power imbalances in patient-provider relationships (Access, Social Connectedness, Quality, Participation, and Appropriateness). The MHSIP surveys are provided to Adults and Children/ Youth separately and in outpatient and residential settings separately. Each domain surveyed has a 1-5 domain score and a yes/no satisfaction score. As the domains differ slightly for adults and children, they are reported separately.

Figure 7 below provides the overall changes in MHSIP domain and satisfaction scores for CCBHC service users compared to those for non-CCBHC CMHP service users. Tables A7.5a-f in Appendix 7 provide changes by service user race/ethnicity and place of residence. These results indicate that the CCBHC program positively influenced OHP member experience in using mental health and substance use services. However, these positive changes were not uniform. They tended to accrue to specific groups of service users related to age, race/ethnicity or place of residence.

Among Adult Outpatient and Residential survey respondents, there were no significant changes in MHSIP domain or satisfaction scores overall. For rural or remote residents, the satisfaction score for Access to Services during the first post-implementation period increased and the domain score for Participation during both the first and second post-implementation periods. Service users identifying as Black/African American had increased domain and satisfaction scores on Access to Services in both post-implementation periods, increased scores for General Satisfaction in the second period, and an increase in the satisfaction score for Quality in the second post-implementation period. Overall, Black/African American service users had some of the largest score changes but also had some of the lowest initial (pre-CCBHC) scores. American Indian/Alaskan Native service users had increases in their satisfaction score for Participation in the first post-implementation period, and service users in the All Other Race/Ethnicity category had increased satisfaction scores for Treatment Outcome.

Figure 7: Change in MHSIP Survey Domains and Satisfaction for CCBHC OHP Members: Adult and Children and Youth Outpatient and Residential Services



* = statistical significance at p<.05

Among children and youth, there were identifiable increases in several domains. Among survey respondents for child and youth outpatient and residential services, overall domain scores increased for domain and satisfaction scores for Daily Functioning, Treatment Outcomes, and Participation for the second post-implementation period. Satisfaction scores for Appropriateness also increased for the first and second post-implementation periods. For children and youth, more domain and satisfaction score increases were realized for those patients living in urban areas. Urban residents had increases in domain scores in the second post-implementation period related to Appropriateness, Daily Functioning, Treatment Outcomes and Participation. Satisfaction scores for Access in the first post-implementation period, Social Connectedness in the second post-implementation period and Appropriateness in both post-implementation periods also increased. For rural or remote residents, only satisfaction scores for Daily Functioning and Treatment Outcomes during the post-implementation period increased.

Black/African American child and youth respondents had improvements in domain and satisfaction scores for Daily Functioning, Treatment Outcomes, and Participation during both the first and second post-implementation periods; domain scores for Appropriateness in both post-implementation periods and satisfaction in the second post-implementation period; and the Cultural Sensitivity domain score during the second post-implementation period. American Indian/Alaskan Native and All Other Race/Ethnicity respondents reported improved domain scores in Cultural Sensitivity during the first post-implementation period, while Hispanic/Latino/a/x and White respondents had increased satisfaction scores for Appropriateness in the second post-implementation period. White respondents also had increased satisfaction scores for Daily Functioning and Treatment Outcomes. Hispanic/ Latino/a/x and White respondents also reported increased satisfaction with the Appropriateness of services during the second post-implementation period, and White respondents also saw increased satisfaction with Daily Functioning and Treatment Outcomes domains. Cumulatively, all races and ethnicities reported improvements in these four domains during the second post-implementation period and, in the case of Appropriateness, during the first post-implementation period as well. Again, it is important to note that Black/African American respondents experienced stronger, positive effects than other racial and ethnic groups, likely due to the severity of existing disparities among that group.

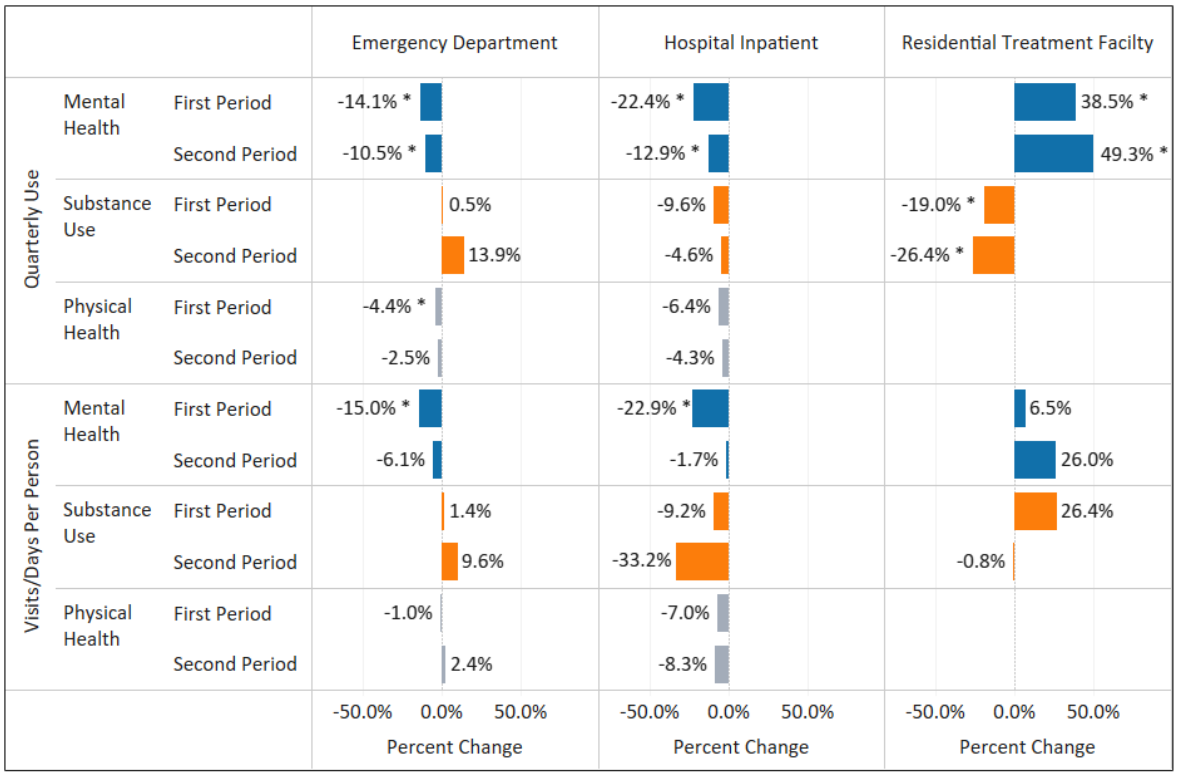
Changes in Inpatient, Emergency Department and Residential Treatment Facility Use

Reductions in emergency department (ED) and inpatient hospital services are generally both recognized as potential areas for cost savings that might result from improved outpatient access and treatment. They also are indirect measures of health status as reductions in these areas typically require better stabilization and management of health conditions. As the CCBHC program sought to increase behavioral health, substance use, and physical (primary care) outpatient service access, there is potential for reductions in ED and inpatient services across all three areas. Residential Treatment Facilities (RTF), focused on children and youth for behavioral health conditions and adults for substance use conditions, are intermediate providers between hospital-based inpatient and ED services. They can provide cost-effective localized residential treatment within facilities typically more integrated with community outpatient services; while they may be an effective substitute for hospital-based services, appropriate reductions in their use can also signal improved population health.

Figure 8 below provides estimates of the rate of change in quarterly use and the number of days in inpatient, ED and RTF treatment across mental health, substance use and physical health categories. Tables A7.6a-f in Appendix 7 provide these change estimates across race/ethnicity and urban/ rural/remote residence. There are notable changes, predominately reductions, in ED, inpatient and/or RTF services related to mental health, substance use and physical health.

For mental health conditions, ED (-14.1% and -10.5%) and inpatient (-22.4% and -12.9%) use declined across both periods. ED visits (-15.0%) and inpatient days (-22.9%) both declined in the first period but dissipate in the second. Mental health RTF use increased (38.5% and 49.3%) across both periods without discernable change in treatment days. The increase in mental health RTF use was almost entirely a phenomenon among urban residents (53.9% and 108.7%, respectively); use declined in rural or remote areas in the second period (28.5%). There were few discernable differences in the overall patterns by race/ethnicity; Black/African American service users had a large, estimated increase in second period use (243.8%).

Figure 8: Change in Inpatient, Emergency Department and Residential Treatment Quarterly Use and Visits/Days per Person for CCBHC OHP Members



* = statistical significance at p<.05

While substance use-related ED use and visits were consistently positive, and inpatient use consistently negative, none were statistically significant, making conclusions unclear. There were reductions in use of substance use-related RTF services (-19.0% and -26.4%) without clear change in days of treatment. The RTF use changes found were nearly all urban-based (33.7% and 41.5%, respectively), as with mental health RTFs. There are few discernable differences by race/ethnicity; Hispanic/Latino/a/x service users had a large increase in treatment days in the second period (97.8%).

Physical health-related ED use rates declined in the first period (4.4%). Changes in physical health ED visits were not identified. Use and days of physical health inpatient care were consistently negative but not discernable from a statistical perspective. There were no notable differences in these patterns by urban/rural/remote residence. There were much larger physical health ED use reductions (18.7% and 29.2%) for Black/African American service users. Hispanic/Latino/a/x service users had increased first period use (11.7%) followed by identical reductions in the second period visits (11.7%).

Healthcare Costs

Healthcare transformation initiatives often include efforts to not only improve quality and access but also to decrease costs, in line with the Triple Aim (Berwick et al., 2008). Evaluating whether CCBHCs decrease healthcare costs implies that the behavioral health system is adequately funded and that cost savings can be realized in a relatively short time period. Oregon has underinvested in behavioral health for decades prior to the large 2021 investments in behavioral health by the Oregon Legislature. Given

the large number of new service users that CCBHCs engaged in treatment during the demonstration, it is unsurprising that costs in some areas have increased. This appears to be the result of serving more Oregonians. Understanding the value for dollars spent requires the collection of meaningful outcomes data that are aligned with state equity goals. While cost savings may eventually be realized, it may take more time to see these cost savings as the system engages more people in treatment.

Interviews with interested parties suggest that in a system that has been chronically underfunded, concerns have primarily centered on increasing access to behavioral health services for historically and currently underserved populations. According to one interested party: "*Most people outside of the [behavioral health] sector don't understand how, because of our bad historic funding structures these agencies are way too lean on the operations side to deliver fidelity care or do innovation"* (Interested Party 23). Another interested party noted: "*We're trying to solve societal problems in the behavioral health system, which is the most underfunded system there is"* (Interested Party 24).

When considering costs in the context of behavioral health in Oregon, it is important to consider the value for investments, including increased access, quality, and equity. Clinic leaders were focused on increasing access to behavioral health services and providing quality care to service users, many of whom have complex physical and behavioral health needs related to multiple social determinants of health. They also recognized that there are limited resources elsewhere in the community for addressing the needs of these individuals comprehensively. One clinic leader noted:

> *We really are now seeing the most acute clients, with numerous concerns, mental health, substance use, health conditions, coupled with a lack of resources, so houselessness, lack of family support, challenges with staying or going to school, difficulty maintaining employment. So, it's high acuity, plus a lot of social determinants of health issues. … we've kind of honed in on that population because there are actually other providers in the community now that can see lower-level clients.* (Lead Clinical 05)

The PPS payment model was critical for providing CCBHCs with sufficient resources to begin responding to health inequities and addressing social determinants of health. This was due in part to the flexibility of the PPS mechanism, which enabled CCBHCs to engage in nontraditional outreach services without concern over a loss of funding. When reflecting on the role that CCBHCs can play in achieving health equity in Oregon, one clinic leader stated:

> *There's a strategy of what you have to do as a CCBHC, but then there's also the strategy of what you get to do as a CCBHC, that you have a wide-open door, and you're trying to meet the needs of the community in a unique way. And you're provided funding that allows you to do that rather than is this service going to pay? Is this reduced rate for this service going to pay the cost of the hour for this clinician here*? *That pressure is reduced to the point where you can think creatively about how to meet the needs of your community rather than how do you get your billing in order to pay your staff at the end of the day?* (Lead Clinical 10)

Another clinic leader indicated that the CCBHC model has contributed to a cultural change in their workplace, shifting from focusing on costs to focusing on care:

> *In all honesty, there's a broader culture of getting people what they need because they need it, as opposed to, how are we going to pay for this? Or, we don't have the money for that. So,*

> *serving more people and getting them the services that they need, and the care coordination, the transition planning, the follow up, the warm handoffs; all that stuff that CCBHC is big on, all of which a lot of times are not funded services.* (Lead Administrator 10)

Community Health

There are multiple definitions of community health; this evaluation relies on Goodman, Bunnell, and Posner's (2014) definition, which states:

> *Community health* is a multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities.

An equity-centered approach to community health is attentive to both power and trust (Yu and Haskins, 2022). It also requires a commitment of time and other resources to ensure that all community partners understand how racism and other forms of oppression manifest in organizations, systems, and policies in the community (Yu and Haskins, 2022). Assessing costs must also consider value for investment; the CCBHC model has facilitated cross-sector collaboration and greater engagement with CBOs, which supports overall community health. One key interested party noted the importance of "*community involvement and…being led by the wisdom and experience of our communities of color and people with lived experience"* (Interested Party 08).

While these evaluation data are limited in responding to the question of the influence of CCBHCs on community health outcomes, qualitative data highlight the perceptions of interested parties, CBO representatives, service users, and clinic leaders on the ability of CCBHCs to improve community health and CCBHC strategies that show promise for improving community health. A review of 44 community health reports, published from 2016 to 2022, from communities where a CCBHC was located also provides important contextual information about community health needs and priorities (refer to Appendix 1 for a summary of these community health reports).

Of the 44 reports reviewed, 33 listed behavioral health (defined as mental health and/or substance use-related health concerns) as a priority. Fifteen of the reports specified suicide and 12 reports referenced substance and alcohol use as priority concerns. In 21 reports, stigma related to behavioral health was reported as an ongoing challenge that served as a barrier to help-seeking. All communities listed behavioral health as a priority in at least one report; several noted it as a community priority in multiple years. Notably, only one report mentioned CCBHCs as a potential strategy to address community behavioral health needs. One 2018 community health assessment report acknowledged the local CCBHC but did not mention that the CCBHC served individuals regardless of insurance status, instead indicating that the clinic served OHP members. While many of the other reports referenced their local CCBHC, these reports did not indicate that these clinics are funded and operated under the CCBHC standards, nor what that might mean for community behavioral health needs. This raises questions about the degree to which local community partners and the community at large are aware that CCBHCs provide services to individuals regardless of insurance status. This is a concern since healthcare costs and lack of insurance were among the most commonly reported barriers in the community health reports. These findings have implications for equity; while approximately 1% fewer Oregonians had insurance in 2020

as compared to 2019, Latino/a/x, Black/African American, and Asian Oregonians experienced greater reductions in insurance coverage as compared to White Oregonians (OHA, 2021a).

Addressing community health requires collaboration across different sectors and active engagement of the community. While representatives from CBOs and service users reported positive perceptions of CCBHCs and the potential for CCBHCs to improve community health, they also identified persisting barriers to care in the community. Common themes that emerged among service users included a need for better access to behavioral health services, cost of care, and assistance with transportation.

> *There is a very high need for mental health services for those individuals who are homeless. Seeing those patients when they come in is critical as many do not have phones to be called back on when scheduling appointments, nor the transportation to get to the clinic. It would be great to have those individuals seen the same day and to provide wraparound services and peer support to assist them*. (Service User 31)

> *But the transportation, there is no taxi service in [location]. There's no place to go if you need to get to a doctor appointment today or something. Transportation is a real issue for people here.* (Service User 03)

> *People still cannot afford mental health therapy. Even people who have private insurance, others think, "Oh, you have private insurance, it's a hundred percent covered." But it's not. Because you still have to pay every month, then you have to pay a deductible and then a percentage. It's crazy because people can't afford the care that they need, that's a huge block for people getting the help that they need.* (Service User 22)

While these themes should be interpreted with caution due to challenges in recruiting service users to provide input to the CCBHC evaluation, they provide important insights into the potential for CCBHCs to improve community health by addressing critical barriers to care in the community. Some gaps identified by service users could be resolved by additional education to elevate community awareness of the presence of CCBHCs and available services and/or resources; other gaps could be addressed through additional or strengthened partnerships with community-based organizations and intentional engagement of the community and service users to improve community health.

Results from a focus group with CBO representatives, while limited due to a small number of participants, indicate that their local CCBHCs have been active participants in community meetings about community health needs. Some CBO representatives also indicated a greater willingness to collaborate: "*They have worked with peers really openly and honestly since around … 2017; [they recognize now] that peers can do things well in partnership and collaboration with them. Peers need [the CCBHC] walking that pathway with them, because they're not clinicians. They are mentors or support people*" (CBO Representative 03). One CBO representative noted: "*They [local CCBHC] do a decent job being involved and being a good partner, but they could be a little bit more involved with partnering with all the grassroots work that happens"* (CBO Representative 01).

Clinic leaders reported having a network of community partners in place prior to becoming a CCBHC; however, some reported that their CCBHC status pushed them to create new partnerships and/or to better leverage their existing partnerships in order to meet the needs of service users. Clinic leaders

reported a breadth of relationships within their communities, including with schools, child welfare, law enforcement, community corrections, jails, hospitals, other primary care or behavioral health clinics, local community centers, county or city government agencies, domestic violence shelters, houseless shelters, culturally specific CBOs, and other nonprofit organizations.

Clinic leaders sought to build trust by being visible within, and responsive to, their communities. One said: "*We listen, not enough, but we make efforts to listen, to really listen. We go into the community. I think the pairing that we did with our public health partners during COVID really increased trust and visibility of behavioral health. I mean, we have enormous relationships with community partners*" (Lead Administrator 09). Although most clinic leaders developed their own outreach program and relied on community partners, the balance between these two strategies varied across clinics. For example, one clinic leader explained that their clinic prioritized creating partnerships: "*I think that developing relationships with those organizations seems to be more useful than trying to [go] out into the community. Basically, we create partnerships and that's kind of how we've really tried to work in the community*" (Lead Administrator 06).

One CCBHC hosted listening sessions within their community as an effort to put organizational humility into practice and "…*to sit with the possibility that sometimes the way we've organized things, or the top-down working, is not the way it actually works in the community. Being open to that sort of critical and constructive feedback facilitates trust, like, 'Oh, they listen to me. They actually care'*" (Lead Clinical 02). Some clinic leaders in rural areas shared that they must rely on community partnerships by necessity and that building trusting relationships was a natural outgrowth of their geographic remoteness. One clinic leader said: "*I think because we're an isolated community, we feel that we have to have trusting working relationships with each other in order to get things accomplished for our community because other areas in the state are not always going to come to our aid*" (Lead Administrator 04).

Some clinic leaders commented that it can also be a challenge to navigate local culture. A few clinic leaders experienced opposition from staff or community members, such as resistance to harm reduction services, anti-government sentiments, and skepticism about equity-focused training or client surveys. After explaining how a cultural diversity training for their staff was met with political divisiveness in their community, one clinic leader reflected: "*Even things we might want to do as an organization are questioned or challenged. We're supposed to be apolitical, but we also have staff saying, 'We can't be silent about this.' Those are challenging things*" (Lead Clinical 02). Another clinic leader indicated: "*In a rural community, we still have challenges. We have people without a lot of exposure to individuals who present differently, and it will be an ongoing challenge for us to always make sure that we're establishing ourselves as a CCBHC that doesn't allow [bias], that the door is open and everyone's welcome. And if you don't welcome everybody, you don't belong there*" (Lead Clinical 10). These CCBHCs face the challenge of boldly centering equity in communities with residents who may not understand or support those efforts, while simultaneously trying not to alienate their service users.

Summary and Recommendations: Offer Services that Result in Improved Health Outcomes, Lower Overall Healthcare Costs, and Improve Overall Community Health

According to the MHSIP data, the greatest benefits in overall health outcomes and community health improvements were most clearly realized by two specific populations – children and youth, and those identifying as Black/African American. Increases in MHSIP scores across multiple domains, including Access, Daily Functioning, Treatment Outcomes, and Participation for child and youth

services, and Access, Quality, and Participation for adult services, helped illustrate the types of individual benefits realized by these populations as well has how CCBHC programming may address drivers of differential access and quality of behavioral health services.

It may be premature to expect to see substantial cost savings from the CCBHC model at this time. Increases in spending appear to be the result of CCBHCs engaging with more service users, providing more services, and ultimately expanding their service user populations. In a behavioral health system that has been historically underfunded, these increases may be appropriate, particularly in the short term. However, CCBHCs must engage potential community partners and their service users in providing feedback and advising the CCBHCs on how to ensure the appropriate allocation of resources to address service gaps and engage historically and currently underserved populations.

Assessing cost must account for value for investment; the CCBHC model has facilitated cross-sector collaboration and greater engagement with community-based organizations (CBO), both of which support overall community health. Communities where CCBHCs operate indicate that behavioral health is a community priority. However, the community health reports reviewed (see Appendix 1) rarely mentioned the role that CCBHCs already or could potentially play in meeting community health needs. While service users reported positive perceptions of CCBHCs, they also provided insights into barriers to care that affect community health.

OHA could support CCBHCs by building collective knowledge of strategies to increase awareness of their CCBHC status within their communities, including the services that they offer and their mandate to serve anyone regardless of insurance status or ability to pay. Increasing awareness of CCBHCs and how they are unique compared to other behavioral health clinics could enable communities to leverage CCBHCs more effectively in their pursuit of improving community health outcomes. While all CCBHC leaders reported collaborating with multiple CBOs, clinics could benefit from additional guidance from OHA on how to effectively identify and develop trusting relationships with community partners, particularly BIPOC, Tribal, and LGBTQ+ leaders and culturally specific CBOs; identify community health needs; and develop culturally appropriate outreach and services.

Recommendation: Elevate awareness of the CCBHC program in local communities and provide practical tools for communities to leverage the work of CCBHCs to address priority community health concerns.

CCBHCs need support from OHA to translate statewide CCBHC program aspirations and goals into the realities of their local communities, develop expertise in what centering equity means within their unique community and receive guidance on how to select appropriate community health outcomes to monitor CCBHC impact in their local communities.

Recommendation: Continue and expand current technical assistance efforts to support CCBHCs to achieve statewide CCBHC goals and meet local needs identified by CCBHC clinic leaders and service users.

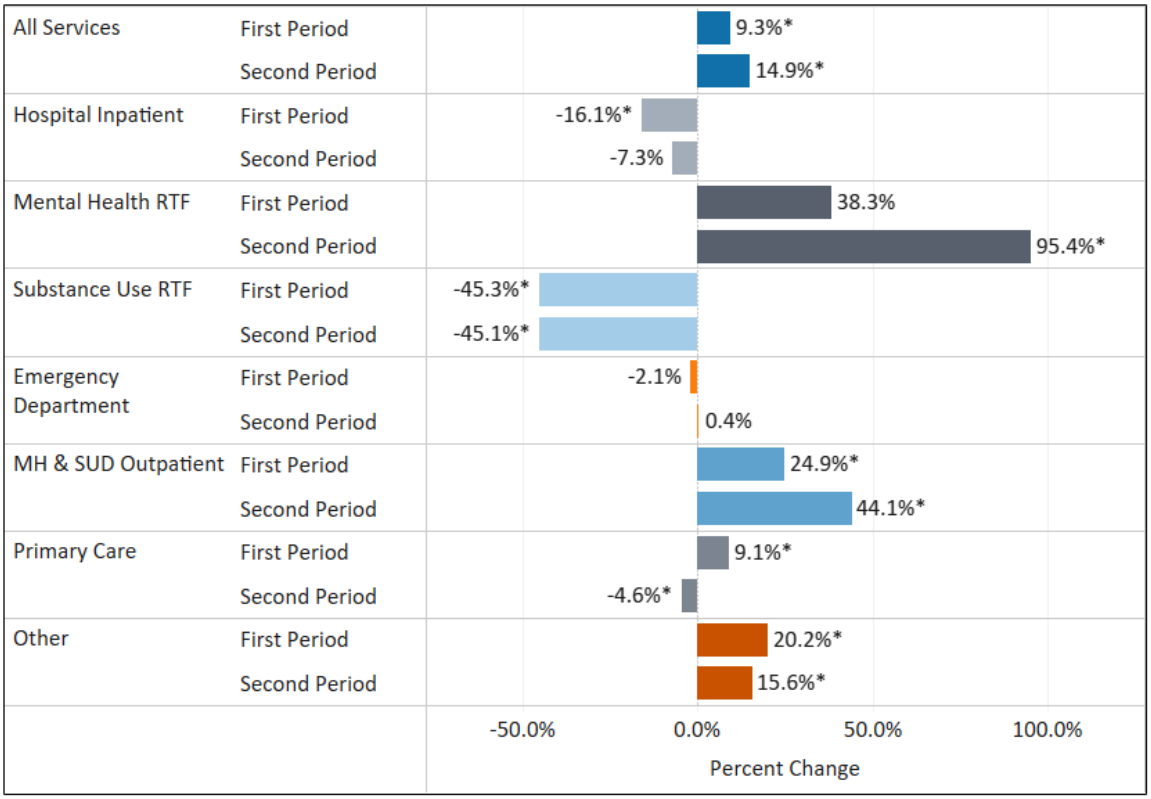
Monitoring and studying the impact of the CCBHC program merits ongoing attention so that OHA will regularly have evidence-based, comprehensive reports on the impact of the investments in behavioral health improve individual and community health outcomes.

Recommendation: Commission ongoing research to understand how investments in the CCBHCs and behavioral health more broadly can have an impact on improving health outcomes and community health.

Reduce the Cost of Care for Coordinated Care Organization Members

While the OHP claims data for this study help assess the relative level of resource change over time attributable to CCBHC activity, the data do not allow for any clear differentiation of CCO versus fee-for-service (FFS) (open card) OHP member costs or exact identification of CCO-related expenditures. The assessment of relative (percentage) resource level change that can be estimated is likely a reasonable estimate of the claims-based expenditure impact per person on all payors. The total impact combines the per person claims-based effect, the change in total persons served, and the additional wraparound PPS-based payments. Figure 9 provides an overview of relative per person expenditure level change for OHP members attributed to CCBHCs in total and by treatment service category. Tables A7.7a-h in Appendix 7 provide estimates of per person expenditure change in total and by race/ethnicity and residence for physical health, mental health and substance use-related services separately.

Figure 9: Change in Expenditure Levels per Person for CCBHC OHP Members Overall and by Service Type



* = statistical significance at p<.05

Total per person OHP expenditures levels increased by 9.3% in the first post-implementation period and 14.9% in the second post-implementation period. The CCBHCs also receive PPS payments net of any OHP related payments for PPS-related OHP service users. These payments are estimated to represent approximately an 8% increase in addition to the total OHP claims expenditure change. It should be noted, however, that these payments may be used to fund services to uninsured service users and so cannot be clearly attributed entirely to OHP members. At the outer bounds, total expenditures per person likely increased by approximately 17% in the first period to 23% in the second. Total expenditure change, accounting for the increase in OHP members served (3.6% and 4.9% per period, respectively), is estimated to be in the range of 21% to 28% across the two periods.

These expenditure level increases are primarily due to increases in behavioral health and substance use-related outpatient services attributed to the CCBHCs; they occur despite some of the areas of expenditure reduction (such as the inpatient services reduction of 16.1% in the first period) that can also be attributed to CCBHC activity as well as contributing to the improvements in individual and community health outcomes noted in the previous section. Savings from a program such as CCBHC presume that adequate resources exist within the system but are maldistributed. Within public mental health systems this typically manifests as over-reliance on hospital-based or other residential care that could be shifted to less costly outpatient care. Oregon, however, has a well-known history of under-resourced behavioral health and substance use services, both in inpatient/residential capacity and in outpatient services. This under-resourcing extends to private insurance systems. In some communities, CCBHCs reported that service users with private insurance were accessing CCBHCs due to service users' inability to adequately access behavioral health services through their private insurance provider network.

The impact of the CCBHC service on hospital-based services (inpatient and emergency department) was measurable and considerable; in states where these services are "over-resourced", these costs may significantly offset the increases in outpatient services that CCBHCs provided. Within Oregon's context, cost-effectiveness (i.e., what was received in additional outcomes as a result of the increased expenditures) is likely a better point of assessment than cost efficiency. This also aligns with the direction and understanding of CCBHC providers as discussed in detail below.

There were also some notable differences in expenditures by race/ethnicity groups and geographic location. American Indian/Alaskan Native and Black/African American service users did not have discernible increases in expenditures, while experiencing some of the larger reductions in inpatient and emergency department services (Black/African American: 48.0% overall inpatient first post-implementation period, 30.1% overall emergency department second post-implementation period; American Indian/Alaskan Native: 48.3% and 50.1% physical inpatient across the first and second post-implementation periods). These differences may reflect historic and current patterns of higher hospital service rates for these groups, allowing for more offsetting savings under the CCBHC program.

While urban and rural or remote areas had fairly similar increases in total expenditures, the underlying patterns of change were quite different. In particular, there were large increases in overall substance use related expenditures (77.7% and 136.8%, respectively) among rural or remote service users, with increases across all service types other than substance use RTFs. This difference may reflect historic under-resourcing or under-provision of these services relative to need in rural and remote areas.

The relevant qualitative data applicable to this point are limited in addressing whether the CCBHCs resulted in cost reductions for CCO members. Most interested parties and clinic leaders did not speak

specifically about CCO members. This is likely because CCBHCs serve anyone regardless of insurance status, not only CCO members. As one interested party noted: "*The CCOs are OHP, and OHP doesn't represent the majority of Oregonians, whereas your CCBHCs do serve that broader population*" (Interested Party 14). No service users explicitly spoke to cost savings as a result of obtaining services at a CCBHC. One service user described how their CCBHC had worked with them to establish low-cost appointment copayments through their private insurance; however, these were still considered unaffordable when all monthly CCBHC services were accounted for.

> *My husband has a union job and we pay for our insurance, but our insurance doesn't cover mental health all that well. It was getting expensive to the point where I almost stopped going altogether, but I can't stop my mental health treatment. Thankfully we were able to get to where I can pay $10 per appointment, but even with that I have to cut back on the full amount of services that I want to get; that's still expensive. I have weekly group therapy, and I had to cut back on my one-on-one sessions with my therapist to only once a month. And then my anxiety therapist, my skills therapist, my grief counselor, I have to do those once a month. That's still $80 a month and I still have other medical bills to pay [including] my medications and the medication nurse here that I still have to see."* (Service User 22)

Interviews with interested parties and clinic leaders suggest that their primary focus has been on expanding access to behavioral health services, rather than reducing costs. According to one interested party: "*The biggest barrier to behavioral health is we don't fund the system proportionate to the deliverables that we want. We've erred in talking about the system being broken when it is actually functioning at the level that it's funded*" (Interested Party 16).

Several clinic leaders described how the CCBHC model enabled them to prioritize outreach efforts over reimbursement concerns for the first time. According to one clinic leader: "*We now really encourage staff to go out there and not worry about billing. You do a non-billable note and you're doing intensive outreach and engagement; you're making a connection. We've had people where it's taken a year of us working with them, not getting paid. The CCBHC made it possible to get them to agree to an assessment, so that they could actually get psychiatric services*" (Lead Administrator 09). Some clinic leaders expressed that they need to have a place to document the activities in which they engage (without adding to the administrative burden of staff) and be reimbursed for that work.

Interviews with clinic leaders suggest there are variations in the relationship between CCBHCs and CCOs. Several reported strong relationships with their local CCO, where there is a willingness to collaborate and share information. One clinical leader recalled: "*One of their goals is to reduce the amount of emergency room visits. So, they look to us and say, 'What can you do to help us with that?' and we said 'We have very limited information on that, but if you share the information with us, we'll do what we can.' Participating in helping them solve their problems is usually how we engage with our partners*" (Lead Administrator 04).

Other clinic leaders reported greater challenges in getting access to data and information from their local CCO in order to properly coordinate care for service users or evaluate outcomes. One clinic leader reported: "*We could be a lot more effective at what we do if we had greater collaboration amongst all the payors, the contractors, and OHA. Right now, our CCO does not give us access to information that is incredibly important for us to coordinate care*" (Lead Administrator 03). Another clinical leader noted:

> *It has been a little challenging because we don't always have access to the data that the CCO has. So as a CCBHC, we are really, really interested in looking at the data and understanding our outcomes better. We have anecdotal data, but we want claims data. We don't have access to that. The CCO does. And so, there hasn't necessarily been buy-in on their end to work collaboratively around that kind of thing, really examining outcomes, not just money-wise, but outcome-wise. So that's an area where there could be a lot more work done at the state level to help us.* (Lead Clinical 07)

These challenges in coordination, access to data, and communication with CCOs and other payors likely limit the ability of CCBHCs to reduce the cost of care for CCO members.

Summary and Recommendations: Reduce the Cost of Care for Coordinated Care Organization Members

CCBHCs' activities result in cost savings in some service areas but do not reduce the cost of care for CCO members or other service users. The CCBHCs were able to accomplish transformations in the services provided and utilized, but these did not translate into overall savings for the CCOs (results apply across all services users; there were no different outcomes by payor). Given the historic underinvestment in behavioral health in Oregon, costs may increase as CCBHCs engage more service users in treatment.

Recommendation: Develop strategies to ensure sustainable CCBHC funding while redirecting the focus of behavioral health from an emphasis on cost savings to provision of equitable, quality care to all Oregonians.

Interested parties and clinic leaders note that greater coordination and collaboration among CCBHCs and CCOs would facilitate care coordination and quality improvement, which may lead to cost savings in the longer term. Some CCBHCs reported having a relatively collaborative relationship with their CCO, while others reported that their local CCO does not share data with them that would be helpful for care coordination or quality improvement. Qualitative data to assess whether CCBHCs reduced costs for CCO members is limited. Interested parties and clinic leaders highlighted that CCBHCs provide services to a broader population than CCO members, also serving privately insured and uninsured individuals. In addition, most interested parties and clinic leaders focused on the importance of expanding access, rather than cutting costs.

CCBHCs serve populations with complex health needs; it is possible that not enough time has lapsed for cost savings to be realized. CCBHCs were directed to expand access to services to a broader population but were not necessarily directed to be more cost efficient. The PPS payment model has enabled CCBHCs to be more flexible and financially stable in their operations, but there are concerns about whether the PPS rate will be adjusted in the future to reflect increasing operating costs for workforce and other operations. Clinic leaders seek to maximize the use of the PPS payment model. CCBHC program staff indicated in January 2023 that a process for OHA rebasing the clinic PPS rates has been initiated and is intended to be completed by June 2023; the intention is this will bring clinics' rates closer to the actual costs and also enhance OHA's understanding of actual costs.

Recommendation: Streamline CCBHC reporting requirements to reduce administrative burden wherever possible and enhance the utility and relevance to clinics of metrics and data collected.

Sustainability and Potential Expansion of the CCBHC Model

An important theme throughout this evaluation was the future sustainability and potential expansion of the CCBHC model. Key findings and observations relate to funding, workforce, community partnerships, administrative burden, data infrastructure, and needs for technical assistance and training.

Ensure Sustainable Funding

Clinic leaders at every CCBHC site spoke of the importance of adequate, continuous funding. The PPS payment model was the critical element that enabled clinics to expand access to integrated behavioral health services to new service users. As one clinic leader explained: "*The [PPS] payment model is the bottom line. It allows a CCBHC to serve people holistically*" (Lead Clinical 12). Another clinic leader stated: "*The PPS [payment model] is just unbelievably instrumental to the survival of community mental health centers and long overdue because FQHCs have been in this model for a very long time*" (Lead Administrator 13). Without reliable funding that enables clinics to maintain their staff, several clinic leaders suggested it would be nearly impossible to continue to meet the nine criteria for core CCBHC services. Service users echoed concerns over the importance of sustainable funding in order to support CCBHCs in meeting their needs in a timely, accessible manner. Some service users indicated awareness of CCBHC funding limitations and their implications for workforce recruitment and retention and their ability to provide reliable services. One service user said: "*There's just not a lot of funding to go around. If they had more funding to hire more therapists, ten people could see their therapists more because there'd be more therapists for other people to see…more staff to do more things"* (Service User 21).

Clinic leaders also noted the importance of sustainable funding with broad bipartisan political support. Several clinic leaders expressed concerns about the stability of the program and what uncertainties would mean for their clinic, given the magnitude of the commitment involved in becoming a CCBHC. One clinic leader said: "*It takes so much time and energy to start a program, whether you're hiring, training…if there were some kind of a guarantee that there was going to be some funding throughout, maybe beyond 5 or 10 years, that would create sustainability*" (Lead Clinical 01). Another clinic leader described experiencing the disruption of their program implementation:

> *We had the initial grant, always knowing that it could go away in three years. And then it did go away after three years. Everything that went in to building it up and then having to dismantle it, that was pretty traumatic for everybody…You end up feeling like you're taking a lot of risks, if there's not that certainty or stability* (Lead Administrator 08).

Other clinic leaders emphasized the importance of updating the rates in the PPS payment model regularly. As one clinic leader stated: "*Rate setting [is] hugely important. You can't increase Medicaid rates and not increase the CCBHC rates, because the CCBHCs will never see it*." (Lead Administrator 01).

Support Workforce Recruitment and Retention

Most clinic leaders reported that one of the most substantial barriers they faced in terms of expanding and maintaining capacity was the workforce shortage. Clinics leaders described struggling to recruit and retain staff, especially master's level clinicians, and particularly in rural communities. Clinic leaders largely attributed this challenge to lower pay compared to private practice, a high level of burnout, and fewer opportunities for telehealth work. There was also a general sentiment that this workforce crisis was exacerbated by the COVID-19 pandemic.

Another clinic leader reflected on barriers to implementing plans for a new care coordination team within their primary care department, saying: "*It's dependent on staffing. We're just struggling. We have some programs that are at 30, 40% staffed*" (Lead Clinical 03). Overall, clinic leaders recognized that their staffing shortages will eventually impede their ability to fulfill the goals of the CCBHC program. One clinic leader described how they continue to see monthly increases in the number of new service users since becoming a CCBHC, attributing this growth to the "*core CCBHC rule that you can't turn anyone away*." They also reflected: "*At some point, we're going to have to figure out a way to deal with the capacity problems because there's not enough workforce*" (Lead Administrator 04).

Clinic leaders, particularly in rural communities, expressed difficulty retaining clinicians. One clinic leader described their area as a "clinician desert"; they elaborated saying: "*There's not a lot of professionals… It's one of those areas where it's really hard to recruit, especially to get a master's level. And then, once you get somebody there, if they come from [elsewhere], they don't stay long*" (Lead Clinical 01). Other clinic leaders indicated that young providers view their clinic as a stepping stone on their way to private practice, where they will generally experience higher compensation and less complex work. Additionally, clinic leaders shared that some clinicians discovered the appeal of telehealth during the pandemic, which does not always lend itself well to the complex needs of service users with serious behavioral health needs. Reflecting on the workforce shortage, one clinic leader explained: "*Our work isn't telehealth. This is work largely that needs to be done in person, but our telehealth physicians fill up like that*" (Lead Administrator 11).

These concerns about Oregon's workforce shortage were widely echoed by service users, many of whom were aware of ongoing CCBHC challenges in staffing and retention. Some service users reported that while their CCBHCs were understaffed, the clinic was able to work around workforce challenges, while others reported being highly affected by the statewide shortage of behavioral health providers and stress created by COVID-19. One service user stated:

> *My counselor ended up leaving and it was just really frustrating; I feel like the care I was getting was better than nothing, but it wasn't great. Now I have another person who I'm meeting with until a new counselor is hired. With the pandemic happening we lost a lot of people, and people move on to different jobs, and well, that's good for them, but what about the clients that are here?* (Service User 04)

Both urban and rural service users expressed similar challenges in receiving care due to workforce shortages. Service users in urban areas spoke more to their care team balancing high caseloads that diminished the service users' ability to receive timely care and contributed to provider burnout and departure. Rural service users were limited by the workforce shortage in a similar way, except they had fewer options for counselors if their counselor left the CCBHC or they did not get along with the staff available to them. Staff departures were particularly difficult for service users with serious behavioral health needs who struggled to develop relationships and build trust, causing feelings of abandonment and frustration at needing to "start over" with multiple staff. One service user said:

> *That was one of my concerns about moving counselors, I knew that if I started with a new counselor, it's back to square one. When you make progress, you don't want to go back. One of the things the state really needs to look at is how to entice new people into the field, because there is a scary shortage in this field of counselors and support people for these centers. And I*

> *know counselors probably have between 150 and 160 [patients], because I know my social service person has that. I have yet to see the [social service person].* (Service User 05)

While many clinic leaders reported that the PPS payment model enabled them to expand staffing significantly, it did not provide sufficient funding to eliminate recruitment and retention challenges. They noted that competitive wages were potentially an important strategy to address these challenges. For example, one clinic leader stated:

> *There are a lot of opportunities for additional funding coming out from OHA, which is exceptional. It's also terrible timing because most of what we want to do with funding is hire staff to expand capacity. We are faced with opportunities for increased funding, and it just adds more vacancies. We're not often able to fill those positions. The sustainability of [the CCBHC] is in part tied to the workforce and whether or not there is a rate or amount that allows us to be more competitive in the recruitment of people.* (Lead Clinical 02)

Other clinic leaders sympathize with workers who avoid or leave the field, recognizing that there must be financial incentives for them to remain in a challenging work environment. One clinic leader concluded: "*We're in dire need of greater stratification in the pay ranges across our workforce. [There is a need] to think differently about incentivizing additional certifications and qualifications. That would help in terms of the draw of staying in what is…really a high acuity, really stressful, intensive work*" (Lead Administrator 12).

In addition, some clinic leaders suggested exploring creative interventions within the education system that could be designed to encourage or incentivize students to pursue a career in public behavioral health at all levels of the workforce. One clinic leader reflected:

> *The peer workforce and the multidisciplinary care team allow for some entry-level positions for people from communities that have really struggled to access higher education, but if we're going to make a real difference there, we have to get into community colleges and public universities and talk to people about the value of doing community mental health work*. (Lead Administrator 09)

Strengthen and Diversify Community Partnerships

CCBHC leaders and service users provided some evidence of creative cross-organization work where the CCBHC also served as a hub for service users to access information and services such as housing, job training and placement, tax preparation, peer support, classes (cooking, for example), and field trips. As one service user noted: "*I've been set up with Vocational Rehab and Developmental Disability Services through [CCBHC]. This has helped me greatly towards my personal goal of becoming more independent, which in turn has helped break me out of my shell of self-isolation. I couldn't be more thankful!*" (Service User 35). Where such collaborations were present, service users were very satisfied with them and their ability to access these services. Where they were not present, service users expressed interest and wondered what would be necessary for the CCBHCs to expand opportunities and engage service users by providing life enrichment activities that would complement and support their behavioral health journey. As one service user noted: "*Not only do they do the social group, but then we would meet up with one of the case managers… We take out about an hour of time a week and we go fishing. It's something real"* (Service User 18).

Many clinic leaders reported developing effective relationships with key local partners, such as various county services, health systems, behavioral and physical health providers, law enforcement, schools, and others who might facilitate care coordination and service integration. These partners were essential for expanding access to behavioral health in the community. Yet, many clinic leaders noted that their community partners were often unaware of their CCBHC status. Elevating awareness of CCBHCs and their unique attributes, particularly the integration of primary care and the requirement to accept anyone regardless of insurance status, could help communities better leverage the CCBHCs. In addition, diversifying the number and nature of community partners may help clinics develop a better understanding of local service gaps and provide opportunities to invite essential feedback and guidance on culturally specific outreach and services. One interested party noted the unique challenges that youth encounter and suggested: "*I don't know how much space there is within the CCBHC model for this, but [having] some way for youth to inform the development or the ongoing oversight. Maybe a consumer advisory council specifically for young people, to provide oversight and ongoing feedback to reduce barriers and improve engagement*" (Interested Party 26). Centralized efforts from OHA, drawing upon other OHA initiatives to identify and partner with CBOs and engage communities, could help CCBHCs adapt promising practices from other community-based initiatives and implement strategies to identify potential partners that would build effective relationships for mutual benefit.

Address Administrative Burden

Many clinic leaders described a high administrative burden from the metrics and reporting requirements; they observed a need for better alignment of required metrics with CCBHC goals. Clinic leaders generally believed that relieving some of the administrative burden would be a practical step toward reducing burnout among staff. One clinic leader stated: "*My request is fewer hoops to jump through so that clinical staff can focus more on client care. That would be really valuable. I know there have to be checks and balances. However, sometimes I think it's not necessary to do as many as are required*" (Lead Clinical 04). This sentiment was echoed by many interested parties, who noted that rules governing behavioral health are perceived to sometimes be too rigid and burdensome as compared to the rules governing primary care.

Some clinic leaders suggested that consolidating the requirements for various contracts within the state, where possible, could help reduce the administrative burden experienced by clinics. Referring to state contracts for being a CMHP and CCBHC, and their CCO contract, one clinic leader said:

> *There are three major systems that are separate, all with different requirements… Aligning those funding sources better and aligning the requirements and the metrics and the auditing and the certifications and all of that would be huge to better sustain us. Just pick the highest bar that we're going for here and go with that one. Don't have three different bars that are all at different levels.* (Lead Clinical 07)

Other clinic leaders raised questions about the suitability of some current metrics and wondered if they could be better aligned with the intentions of the CCBHC program. They recognized the difficulty in developing appropriate metrics, especially because of the perspective, shared by many clinic leaders, that "*so much of CCBHC isn't easily measurable*" (Lead Administrator 06). Clinic leaders held varied opinions on how the metrics could be improved. A few observed that the current metrics for CCBHCs are generally process-oriented, whereas they would prefer to see clear outcome-oriented metrics. Others noted that outcomes that are appropriate for urban areas are not necessarily the most relevant for rural

counties, and vice versa. Overall, clinic leaders supported rigorous data collection for evaluation but wanted to ensure metrics are meaningful and actionable and not unnecessarily burdensome.

Invest in Data Infrastructure

Many clinic leaders reported their data systems were not capable of the data collection for state reporting requirements for CCBHCs. Several behavioral health EHRs did not integrate well with primary care or were not capable of incorporating data from physical health screenings. The experience of clinic leaders suggests that the administrative burden for staff could be mitigated by higher quality data systems that are interoperable. As one clinic leader stated: "*You can have the best clinicians in the world, but you've got to have the infrastructure to do the things like data collection and have it integrated into your EHR, so people aren't doing double charting and double work with documentation*" (Lead Clinical 07).

Interested parties also highlighted the importance of adequate data infrastructure. One noted that Oregon's antiquated data systems were a barrier to increasing access to behavioral health:

> *Other states have implemented…data warehouses that push and pull data to create dashboards… We have none of that in the state of Oregon. The systems we have, they're old and they don't work… We can't even identify what we need to invest in [because] we have such poor data because we have not invested [in it].* (Interested Party 23)

Another interested party indicated that inadequate data capabilities impeded the ability of CCBHCs to identify underserved populations: "*They don't know who their underserved populations are because they don't have the data infrastructure*" (Interested Party 03). This was also a theme that arose in multiple community health reports. Some clinic leaders were able to hire a data analyst as a part of their staff expansion, which allowed the CCBHC to understand and utilize the data they collect much more effectively. Other clinic leaders expressed hope for an increased focus on data analysis in the future.

Several clinic leaders mentioned the potential value of being asked to report on metrics that reflect quality of life or well-being, rather than being asked to report on specific measurements or more generally on cost-saving outcomes. They suggested such modifications in metrics would reinforce the CCBHC program's goal of person-centered care. They would like to collect meaningful data that are aligned with state equity goals and help the clinics to better understand outcomes for service users and community health improvement.

Data and analytics are critical success factors for the CCBHC program. Better data systems, training in collecting and using disaggregated data, and staff who can make sense of those data could improve efforts to center equity and coordinate care. One clinic leader stressed: "*Sharing data is still one of our biggest challenges. We still have lots of data gaps and have different systems that don't communicate well with each other… I think there are opportunities to have better systems that share data and also have people who can really look at the data*" (Lead Clinical 09).

Provide State-Level Training, Technical Assistance, and Other Resources

Several clinic leaders remarked on limited OHA involvement at the beginning of the demonstration program, while expressing gratitude for recent increases in OHA communication and support. During the CCBHC implementation, some clinic leaders shared that they would have preferred more training and

technical assistance, especially with some of the administrative functions, including billing, data collection and reporting, and setting up data infrastructure to best facilitate these processes. One clinic leader shared: "*The more training we do, the more guidance is given [from OHA] … it's really valuable to make sure we're heading in the right direction*" (Lead Clinical 04). Another expressed: "*I think having the technical assistance and support from the state is really important. And because there's a learning curve, I think it's important to feel like it's a supportive process, rather than a punitive process*" (Lead Administrator 08).

Some clinic leaders expressed hope that OHA will continue to provide more regular opportunities for Oregon's CCBHCs to convene and learn from each other. One clinic leader explained: "*I get the most value from talking to my colleagues, the other community mental health programs, and CCBHCs*" (Lead Administrator 07). While clinic leaders spoke generally about the importance of OHA guidance and support, there is an opportunity for OHA to specifically provide more guidance to CCBHCs on all facets of the program, including using data for quality improvement, identifying service gaps in the community, and engaging community members and service users to develop and implement culturally specific outreach and services. This could be achieved through creation of an explicit learning community among the CCBHC leaders, such as has been successfully used in multiple previous OHA collaborative projects. It should be noted that clinic leaders were interviewed in July 2022; CCBHC program staff launched the All-Clinic CCBHC Learning Collaborative, mentioned earlier in this report, in October 2022.

The all-clinic data subgroup, which was launched by the CCBHC program staff in December 2022 and reportedly is meeting every three weeks, may help to advance discussions on how to standardize how metrics are collected, develop technical assistance on data collection, and assess the needs for data infrastructure for the CCBHC program. OHA's Office of Health Policy and Analytics is developing dashboards for the clinics to understand their status on metric collection. The CCBHC program team is drafting a technical assistance manual to help standardize operations of CCBHC program, with a goal to publish the manual in the summer of 2023.

Summary and Recommendations:
Sustainability and Potential Expansion of the CCBHC Model

Future CCBHC sustainability and expansion efforts need to build the capacity of CCBHCs to provide greater access, enhance the scope of services offered, and reduce administrative burden. CCBHC service users and clinic leaders recognized the negative impact of underinvestment in behavioral health in Oregon and noted the importance of ensuring adequate, continuous funding. While clinic leaders noted that the PPS model enabled CCBHCs to expand their staff, it did not eliminate challenges in recruitment and retention, and leaders suggested that creative solutions were needed to incentivize people to enter the behavioral health field. In addition to continued investment in Oregon's behavioral health system, future CCBHC sustainability and expansion efforts need to emphasize building the capacity of the CCBHCs to provide greater access and enhance the scope of services offered, by ensuring provision of consistent and reliable funding, delivering clinic-relevant technical assistance, and supporting the creation or continuation of effective community collaborations. An earlier recommendation addresses sustainable funding of CCBHCs.

Better alignment of required metrics with CCBHC goals could reduce administrative burden. While Oregon continues to participate in the federal demonstration program, there is a requirement to

report to CMS on the federal metrics. However, Oregon has demonstrated it can add metrics (the primary care requirement), thus there is evidence from this evaluation that metrics could be more focused on equity and the service user experience, in addition to the process measures prescribed federally. A concern identified by many contributors to this evaluation was the balance of the value of reporting on metrics as compared to the administrative burden to collect the required data, demonstrating limited return on investment for the effort of reporting. An earlier recommendation addresses potential changes in metrics to reduce administrative burden and enhance the utility and relevance of metrics and data collected.

A robust data infrastructure system, managed by staff who can make sense of those data, could improve efforts to center equity and coordinate care. This infrastructure could build upon current initiatives such as the HIT Commons, which is a public-private collaborative that governs statewide HIE initiatives and is co-sponsored by OHA and the Oregon Health Leadership Council (Oregon Health Leadership Council, n.d.). Finally, there is an opportunity for OHA to provide more guidance to CCBHCs on all facets of the program, including using data for continuous improvement, identifying service gaps in the community, and engaging community and service users to develop and implement culturally specific outreach and services.

Recommendation: Invest in the development and implementation of a health information exchange (HIE) to support coordination of care and identification of health inequities, building upon current initiatives such as the HIT Commons.

CCBHCs have been able to accomplish many positive things with limited guidance and oversight. CCBHCs need consistent and regular support and structure from OHA to achieve the CCBHC program goals, center equity in their work, and adapt these practices to local contexts through various forms of technical assistance, including supporting learning collaboratives for the CCBHCs and other forms of knowledge transfer. Several CCBHCs reported challenges in obtaining information from their local CCO to facilitate care coordination.

Recommendation: Identify opportunities to intentionally build upon or partner with other community-based initiatives, such as OHA's Regional Health Equity Coalitions and the Behavioral Health Resource Networks, to support CCBHCs in identifying potential partners and building effective, mutually beneficial local relationships, including with CCOs.

The Role of the CCBHC Model in Future Oregon Health Systems Reform and Transformation

CCBHC service users, clinic leaders, interested parties, and CBO representatives collectively indicated that the CCBHC model shows promise in supporting Oregon's ongoing health systems transformation, with the potential to contribute to improvements in behavioral healthcare in a way that supports Oregon's pursuit of the Triple Aim, securing better outcomes and higher quality of care for service users across the state (Berwick et al., 2008; OHA, n.d.(d)).

From the perspective of service users, the CCBHC approach to care integration, which centers behavioral health and coordination with physical and other health and social services, is critical to increasing their

engagement with the health system. Service users appreciated the CCBHC approach to care that views their behavioral health and well-being as paramount and emphasizes a holistic, person-centered approach. Many service users across multiple clinics expressed that the care they received through their CCBHC was clearly superior to care they had received in other locations, both in and outside of Oregon. One service user noted: "*I've been in counseling for most of my life, and I know [CCBHC] is the best one yet to be able to help me*" (Service User 20). Another indicated: "*I'm from [another state] and there is nothing at all like what [CCBHC] is offering*" (Service User 16). Service users indicated that CCBHCs support improving care quality and outcomes for service users by helping to bridge the gap between behavioral health services and primary care, particularly for those with serious behavioral health needs; this view was echoed by clinic leaders.

Among CCBHC clinic leaders, there was a general sentiment that the CCBHC model has the potential to be nationally accepted as the best model of care; they shared a sense that the CCBHC model could be the preeminent model for the future of behavioral health services delivery in Oregon and beyond. Some of the clinic leaders viewed CCBHCs as a potential replacement for Oregon's CMHPs. From the perspective of clinic leaders, the CCBHC model represents a meaningful investment in Oregon's historically underfunded behavioral health system in a way that allowed them to focus the resources and provision of services to historically and currently underrepresented and underserved populations. In particular, CCBHCs are unique in their ability to serve clients with serious behavioral health needs, given that other outpatient behavioral health settings may be less prepared to engage with this population. While CMHPs and CCBHCs offer similar services, CCBHCs have a much greater ability to coordinate and integrate care beyond behavioral services because of the PPS payment model. Interested parties and clinic leaders noted that while PCPCHs integrate primary care and behavioral health, the focus for PCPCHs is the integration of behavioral health into primary care settings. CCBHCs provide an opportunity to provide primary care services to Oregonians who have greater behavioral health needs.

CCBHCs were able to significantly expand access to behavioral health services, in part through their emphasis on providing services "beyond the four walls" of the clinics and engaging service users within the community. These low-barrier services helped CCBHCs engage with new service users and were perceived by clinic leaders as critical in reducing barriers to care in pursuit of health equity. Clinic leaders raised concerns regarding how CCBHCs, CCOs, OHA, and Oregon counties can best approach future growth through intentional collaboration to achieve their shared purposes. One clinic leader explained: "[*it has been] challenging and kind of awkward that the whole CCO model is sort of outside of [the CCBHC]. They don't really know what we're doing. And yet, they're working on many of the same goals and have many of the same expectations. I feel like at the state level, there isn't a solid integration of those plans… So how do we align those better and get everybody on the same page? That would be really great*" (Lead Clinical 07). While clinic leaders knew that CCBHCs and CCOs shared similar goals, they noted that the entities were not well aligned at the systems level and indicated that some CCOs may lack awareness of CCBHC goals and the services that they provide. Another clinic leader noted the importance of communication and role clarity, saying: "*Really having better dialogue between CCBHCs in the state, the CCOs, OHA… I think that's half of it. There's just a lot of confusion and misconceptions on both ends. To be successful, we need to have regular meetings. I know that's starting now, but it's been a missing element*" (Lead Administrator 06).

One area for further exploration is the interpretation of 42 CFR Part 2. Clinic leaders reported varying experiences with CCOs in their ability to obtain the data necessary for care coordination and quality improvement. On December 2, 2022, HHS published a notice of proposed rulemaking to modify specific

provisions of 42 CFR Part 2 in order to align the requirements for substance use disorder treatment records more closely with the HIPAA rules for protected health information (NAATP, 2022). The intent of this rulemaking is to enable agencies that are subject to 42 CFR Part 2 to use and disclose SUD treatment records and improve coordination of care (NAATP, 2022). Hopefully, OHA will closely monitor the proposed rulemaking and provide guidance to CCOs to develop a shared understanding and more consistent interpretation of 42 CFR Part 2 in order to facilitate integrated and coordinated care.

Clinic leaders recognized that eliminating health disparities is a goal of OHA and the state. While many clinic leaders feel that, by the nature of their work, CCBHCs are well-situated to contribute to this goal, some clinic leaders felt that they have not received sufficient training or guidance on where to start, what the expectations are, and how to account for the specifics of local culture, especially in rural communities. One clinic leader stated:

> *The fact that CCBHCs are open to everyone makes us best suited to eliminate health disparities. But we probably need help in identifying strategies for how to do that…We've got a spot in our org chart for a health equity manager, but even when we fill that position, it's really going to be a while before we're running with that and really making a difference. So, the state could bring resources to help us understand how to best do that.* (Lead Administrator 04)

Many clinic leaders echoed the sentiment that, although they have begun prioritizing work in this area, they recognized there is significant room for improvement. "*I still feel like we have a lot of work to do*" (Lead Clinical 05). Although the diversity of service users who provided feedback was limited, a few service users reinforced this sentiment. Two service users who identified themselves as LGBTQ+ expressed that their CCBHCs had made strides in creating "safe spaces" for them to receive services; however, they were unaware of community outreach from their CCBHCs to reach the LGBTQ+ communities in their respective locations. According to one service user: "*The counseling staff here has become a lot more open and diverse and accepting, so they help as much as they can. In the past, it was tolerated [to be a member of the LGBTQ+ community], now it's accepted. To me this feels like a safe space*" (Service User 24). Another service user expressed that if they wanted culturally specific services, they would not be able to get them from the CCBHC: "*I've never really been asked about [my Native American heritage]. I know there have been treatment services off and on at the reservation here, but I've never really seen [the CCBHC] coordinate with the Tribe… I do not think that the CCBHC would be receptive [if I wanted more culturally specific programs], it wouldn't be their program*" (Service User 13).

Although most clinic leaders agreed that CCBHCs have a role to play in eliminating health disparities and advancing OHA's equity goals, there was variation in how clinic leaders understood health equity. Most clinic leaders indicated little awareness of OHA's definition of equity before it was shared in interviews or focus groups. One clinic leader recognized that CCBHCs could play a role in "*pushing the notion of health equity, and what that actually means*," but also pointed out: "*I think CCBHC, all by itself, you could do it and not do anything about diversity or equity*" (Lead Clinical 03). This highlights an opportunity for OHA to collaborate more explicitly with CCBHCs and provide training and technical support for centering equity going forward and making progress towards the shared state and OHA goal with respect to eliminating health inequities.

The CCBHC model enables clinics to focus on the needs of historically and currently underserved populations in their communities, particularly communities of color and those who identify as LGBTQ+. In order to achieve this goal, CCBHCs will need sufficient and continued funding, adequate training and

resources, and guidance. Further evaluation will be needed with specific attention to thorough, community-informed recruitment in order to capture additional perspectives from service users and CBOs on how this may be achieved.

In order to realize their potential as a key component of Oregon's health systems reform, the CCBHC program will require thoughtful expansion of services and strategic statewide growth. An interested party also expressed the need for greater flexibility, noting: "*We're going to have to move away from a one size fits all [approach]. If we think about the PCPCHs, there are tiers; tier one, two, three, four. But CCBHC tends to be a little more rigid and probably for good intentions. But it's going to be important to have the ability to right size for the setting, especially as we look at sustainability in rural settings*" (Interested Party 16). The data collected in this evaluation highlight several areas to consider for future CCBHC expansion. CCBHCs will have an increased impact if operating requirements are streamlined and clarified, so clinics can focus on increasing access to a wide range of services, including prevention, outreach, primary care, social supports, and care coordination.

Service users and clinic leaders indicated that expansion of the CCBHC program will necessitate actions addressing Oregon's ongoing behavioral health workforce shortage in order to ensure that reliable and consistent care is available to all service users. This will require a dual focus on workforce recruitment and retention so that clinics are sufficiently staffed to respond to demand in real time. Some clinic leaders noted a desire for specific ways to improve their own clinics under the CCBHC model, hoping to reflect even more focus on holistic health; they hoped for opportunities to provide additional services, such as integrated nutritional counseling, dental services, and occupational health. While a few CCBHCs already offer some of these services, others may need additional support in how to scale their offerings to meet the needs of their communities.

Summary and Recommendations: The Role of the CCBHC Model in Future Oregon Health Systems Reform and Transformation

CCBHCs have been able to make contributions and play an important role in Oregon health systems reform and transformation. With thoughtful and appropriate expansion, the CCBHC demonstration program has the opportunity to continue to play a key role in Oregon's health systems transformation and ongoing reform efforts.

Workforce recruitment and retention were common themes raised, and these challenges may hamper the ability of CCBHCs to expand, let alone maintain, their current level of services. Furthermore, the CCBHC workforce may not reflect the diversity of the communities they serve. While some workforce incentive programs already exist, CCBHCs may not be utilizing these as well as they could. There are always challenges recruiting health workforce to rural communities, and there appear to be additional challenges to recruit and retain at behavioral health clinics.

Recommendation: Make investments in new or enhanced behavioral health workforce incentives (such as salaries, loan repayment, educational support, etc.) to augment the workforce in Oregon's CCBHCs.

If CCBHCs are to play a meaningful and central role in in Oregon health systems reform, a CCBHC should be located and supported in every Oregon county, to ensure all Oregonians have access to these behavioral health services. Since the role of CMHPs is to be the center of county-based safety

net behavioral health services, an effective strategy would be to ensure that all CMHPs have CCBHC capacity, such that there would be a CCBHC in every county. In addition, other organizations could take on CCBHC roles and services and receive CCBHC funding.

Greater communication and role clarity among CCOs, CCBHCs, and OHA is needed to ensure system-level coordination of effort and shared goals. CCBHCs present an opportunity to improve Oregon's behavioral health system while supporting state equity goals and working to address disparities in care and health outcomes for some of Oregon's most vulnerable populations, specifically those with serious behavioral health needs; however, evaluation findings suggest that further guidance and support from OHA is needed to center equity. CCBHCs could provide essential services in the behavioral health system in each Oregon county with OHA support and role clarification similar to that provided through OHA's PCPCH program. Future development of CCBHCs may benefit from addressing how CCBHCs might be enhanced using the principles and promising practices of other delivery system innovations such as PCPCHs, Federally Qualified Health Centers (FQHC), rural health centers, and CMHPs.

Recommendation: Expand the CCBHC program so that a CCBHC is located and supported in every Oregon county, to help ensure all Oregonians have access to essential behavioral health services.

Conclusions and Summary of Recommendations

Conclusions

The CCBHC model has the potential to support Oregon's efforts in health systems reform and transformation by contributing to substantial improvements in the delivery of behavioral health across the state, including behavioral health and SUD treatment services. The Oregon CCBHC program increased access to behavioral health services and enabled clinics to move toward providing whole-person care, which integrates behavioral and physical healthcare services. CCBHCs offer services that result in improved individual and community health outcomes but do not lower overall healthcare costs for service users on OHP or any other payor. While the CCBHC model may contribute to cost savings in the longer term, short term financial savings are limited as the provision of services is expanded to reach the substantial number of Oregonians who previously have not had access to comprehensive behavioral health services. These increases in costs may be appropriate given the historic underinvestment in Oregon's behavioral health system and the focus on expansion of access and services.

CCBHCs may hold promise in catalyzing a statewide cultural shift where behavioral health needs are viewed as central to individual well-being. CCBHCs could be the local community organizations where physical health and social services are integrated and coordinated, collectively working to ensure that all Oregonians have their behavioral health needs met and can thrive as engaged members of their communities. Given the role of CMHPs as the center of county-based safety net behavioral health services, ensuring that all CMHPs have CCBHC capabilities, such that there would be a CCBHC in every

county, may present a practical path going forward so that each county is prepared to serve all of its residents. This could greatly expand access to needed behavioral health services for Oregon residents.

CCBHCs have made important contributions in their communities, despite the limited awareness of their CCBHC status among local CBOs and community members. CCBHCs need practical technical assistance and training, ideally learning from and with other CCBHCs, on how to identify and collaborate with relevant CBOs, community leaders, and service users in order to better understand service gaps in their communities and develop culturally and linguistically responsive outreach and services. CCBHCs will benefit from further clarification and guidance on how to best work toward achieving Oregon's equity goals and translating state-level priorities into the realities of their local communities.

While Oregon's directive that CCBHCs offer primary care integration is important, this requirement must offer some level of flexibility to account for varying population sizes, service user preferences, and workforce availability at the local context. Future CCBHC sustainability/expansion efforts ideally will include extensive technical assistance from OHA to support CCBHCs to provide high-quality coordinated care, increasing access to services, enhancing their scope of services, and centering equity in their work.

In order to promote successful expansion of Oregon's CCBHC program, additional support from the state legislature and from OHA is needed to strengthen CCBHC effectiveness and sustainability and ensure a strong and diverse behavioral health workforce, particularly as CCBHCs continue to bridge existing gaps in the provision of services for non-OHP members.

CCBHCs have contributed to widespread increases in access to behavioral health services; continued financial investment is necessary to move Oregon's behavioral health system into the future. This is increasingly relevant given the 2020 approval of Measure 110, the Drug Addiction Treatment and Recovery Act, which over time may increase the number of Oregonians seeking community-based services for substance use disorder, and the recent approval of Oregon Measure 111, which amends the Oregon Constitution to require the state to ensure that every resident has access to affordable health care as a fundamental right.

This evaluation was conducted in a relatively short period of time, and provides a point-in-time assessment of the CCBHC program. Continued systematic program monitoring, perhaps with annual reporting as well as a robust evaluation every two years, would assist the Oregon Legislature and the Oregon Health Authority in understanding the evolution of the CCBHC program, its impact on community health outcomes, and its role in the transformation of behavioral health in Oregon. Ongoing evaluation should include both quantitative findings, recognizing limitations in the data systems available, and qualitative participatory insights that reflect the experiences of service users, advocates, community members, CCBHC leaders, and key interested parties. Regular data-driven, systematically assembled reports on CCBHC performance will be particularly important given the anticipated attention to behavioral health in the 2023 Legislative Session.

Recommendation: Continue to evaluate the CCBHC program operations and performance, potentially using community-centered participatory approaches to engage community members, service users, and advocates.

Summary of Recommendations

The following are the recommendations made in this report to the Oregon Legislature and the Oregon Health Authority to advance the CCBHC program as part of improving Oregon's behavioral health system:

1. Develop strategies to ensure sustainable CCBHC funding while redirecting the focus of behavioral health from an emphasis on cost savings to provision of equitable, quality care to all Oregonians.
2. Expand the CCBHC program so that a CCBHC is located and supported in every Oregon county, to help ensure all Oregonians have access to essential behavioral health services.
3. Establish clearer standards for primary and behavioral care coordination and integration that enable CCBHCs to better provide whole-person care and services that meet the complex and multiple needs of diverse service users.
4. Engage advocates and community leaders to recommend actions for the development and implementation of culturally and linguistically responsive outreach and services.
5. Make investments in new or enhanced behavioral health workforce incentives (such as salaries, loan repayment, educational support, etc.) to augment the workforce in Oregon's CCBHCs.
6. Invest in the development and implementation of a health information exchange (HIE) to support coordination of care and identification of health inequities, building upon current initiatives such as the HIT Commons.
7. Streamline CCBHC reporting requirements to reduce administrative burden wherever possible and enhance the utility and relevance to clinics of metrics and data collected.
8. Identify opportunities to intentionally build upon or partner with other community-based initiatives, such as OHA's Regional Health Equity Coalitions and the Behavioral Health Resource Networks, to support CCBHCs in identifying potential partners and building effective, mutually beneficial local relationships, including with CCOs.
9. Continue and expand current technical assistance efforts to support CCBHCs to achieve statewide CCBHC goals and meet local needs identified by CCBHC clinic leaders and service users.
10. Elevate awareness of the CCBHC program in local communities and provide practical tools for communities to leverage the work of CCBHCs to address priority community health concerns.
11. Continue to evaluate the CCBHC program operations and performance, using community-centered participatory approaches to engage community members, service users, and advocates.
12. Commission ongoing research to understand how investments in the CCBHCs and behavioral health more broadly can have an impact on improving health outcomes and community health.

In keeping with OHA's strategic goal to eliminate health inequities by 2030, it is appropriate to conclude with this quote from Yearby (2020):

> *To achieve racial health equity, government and public health officials must aggressively work to end structural racism and revamp all of our systems, especially the public health system, to ensure that racial and ethnic minorities are not only treated equally, but also receive the material support they need to overcome the harms they have already suffered. Only then can we truly begin to work towards improving the health and wellbeing of racial and ethnic minorities, so that we can achieve racial health equity.*

Portland, January 2023

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Appendices

Appendix 1: Summary of Themes from Review of Community Health Improvement Plans and Community Health Assessments

Appendix 2: Maps Illustrating Oregon's Population by Race/Ethnicity

Appendix 3: Detailed Methodology Overview

Appendix 4: Extended Report of Feedback from CCBHC Service Users

Appendix 5: Extended Report of Feedback from CCBHC Clinic Administrators and Clinical Leaders

Appendix 6: Extended Report of Feedback from Key Interested Parties and Community-Based Organizations

Appendix 7: Additional Quantitative Analyses Tables Referenced in the Main Report

Appendix 1: Summary of Themes from Review of Community Health Improvement Plans and Community Health Assessments

A review of 44 local health reports for geographic areas that included a community with a local CCBHC was conducted. These reports included community health assessments, community health improvement plans, behavioral health reports, and health equity reports, released between 2016 and 2022. In some cases, the reports were specific to one county; in other cases, the reports were specific to a regional area as defined by the author(s). Table A1.1 presents the number of community health reports reviewed related to each CCBHC.

Table A1.1: Community Health Reports Reviewed by CCBHC

CCBHC	Number of Reports
Cascadia	6
Columbia Community Mental Health	2
Community Counseling Solutions	7
Deschutes County Health Services	5
Klamath Basin Behavioral Health	3
LifeWorks NW	7
Mid-Columbia Center for Living	3
Options for Southern Oregon	4
PeaceHealth Medical Group	3
Symmetry Care, Inc.	7
Wallowa Valley Center for Wellness	8
Yamhill County Health and Human Services	2

*Total equals more than 44 since some reports are relevant to more than one CCBHC

Findings

Thirty-three reports list behavioral health, including mental health and/or substance use-related health concerns, as a community priority. In particular, fifteen of the reports specify suicide, twelve reports specify substance and/or alcohol use, and seven reports specify depression as particularly challenging or concerning in the community. Every community reported that behavioral health was a priority concern at least once between 2016 and 2022; many reported it in multiple years.

More than half of the reports include some consideration for barriers that prevent community members from accessing needed services. The most commonly reported barriers to needed services included a lack of culturally and linguistically appropriate services and a lack of health insurance and/or concerns about cost. In addition, 21 reports mentioned that stigma related to behavioral health was an ongoing challenge that prevented people from engaging in help-seeking and receiving needed services. Nineteen reports included some discussion about workforce challenges, including general workforce shortages and the lack of a diverse workforce that reflects the communities served.

While many of the reports discuss the importance of addressing health equity, only 19 explicitly discuss local challenges for achieving equity and potential strategies to address health inequities. In some

communities, equity was integrated into community health assessments and/or community health improvement plans; in other communities, a separate health equity report was created. How and if equity was defined varied across community health reports with more than half noting existing health disparities among specific populations within the community including BIPOC communities (specifically Black/African American, Latino/a/x, and American Indian/Alaskan Native populations); LGBTQ+ individuals; individuals experiencing houselessness; justice-involved individuals; youth and elders; immigrant and refugees; low-income children, adults, and families; veterans; and individuals with developmental disabilities. Few reports articulated the impact of historic injustices such as racism, sexism, classism, homophobia and transphobia, and other forms of oppression in creating and sustaining health inequities. Eight reports note that the lack of adequate data is a barrier to fully understanding health inequities in communities, while two note that an equity framework is needed to ensure everyone in the community has a shared understanding of health equity. Nine reports noted that collaborations with community-based organizations are critical for centering equity; six indicated training as a strategy for increasing awareness and cultural competency among providers and staff.

Notably, only one report (EOCCO 2021 Comprehensive Behavioral Health Plan) mentions CCBHCs as a potential strategy to address community behavioral health needs. One 2018 community health assessment report mentions that the local CCBHC is a CCBHC but does not mention that they serve individuals regardless of insurance status, instead indicating the clinic serves Oregon Health Plan members. While many of the other reports reference their local CCBHC, they do not indicate that these clinics are CCBHCs nor what that might mean for community behavioral health needs. This is true even when the CCBHC is listed as a partner in the development of the report. Given that behavioral health is identified as a priority community health concern for every community, and that cost and insurance are identified as common barriers to access to services, it is surprising that so few of the reports note the role that their local CCBHC could play in meeting community needs. Table A1.2 presents a list of all community health reports reviewed, in alphabetic order by author. A complete list of citations of these reports follows the table.

Table A1.2: Community Health Reports by CCBHC (alphabetized by author)

CCBHC(s)	Author(s)	Year	Title
Options for Southern Oregon	All in for Health and Jefferson Regional Health Alliance	2019	Equity Addendum
Options for Southern Oregon	All in for Health and Jefferson Regional Health Alliance	2019	Jackson & Josephine Counties: Community Health Improvement Plan 2019-2022
Options for Southern Oregon	Allcare Health	2019	Allcare CCO Jackson & Josephine County 2019 CHIP Addendum
Community Counseling Solutions	Blue Mountain Hospital District	2022	2022 Community Health Needs Assessment
Deschutes County Health Services	Central Oregon Health Council	2016	2016-2019 Central Oregon Regional Health Improvement Plan

Deschutes County Health Services	Central Oregon Health Council	2019	2019 Central Oregon: Regional Health Assessment
Deschutes County Health Services	Central Oregon Health Council	2020	2020-2024 Central Oregon: Regional Health Improvement Plan
Mid-Columbia Center for Living	Columbia Gorge Health Council	2019	Columbia Gorge Regional Community Health Assessment 2019
Mid-Columbia Center for Living	Columbia Gorge Health Council	2021	Columbia Gorge Regional Community Health Improvement Plan 2020-2023
Columbia Community Mental Health	Columbia Pacific Coordinated Care Organization	2019	Regional Health Assessment & Regional Health Improvement Plan 2019
Cascadia Health LifeWorks, NW	Comagine and Healthy Columbia Willamette Collaborative	2019	2019 Community Health Needs Assessment
Yamhill County Health and Human Services	Community Actions Team, Inc.	2018	Community Needs Assessment: Clatsop, Columbia, & Tillamook Counties
Deschutes County Health Services	Deschutes County Health Services, Public Health Division	2018	2018 Health Equity Report
Community Counseling Solutions	Eastern Oregon Coordinated Care Organization	2019	Grant County Community Health Assessment
Symmetry Care, Inc.	Eastern Oregon Coordinated Care Organization	2019	Harney County Community Health Assessment
Wallowa Valley Center for Living	Eastern Oregon Coordinated Care Organization	2019	Wallowa County Community Health Assessment
Wallowa Valley Center for Living	Eastern Oregon Coordinated Care Organization	2021	2021 EOCCO Community Health Plan for Wallowa County
Symmetry Care, Inc.	Eastern Oregon Coordinated Care Organization	2021	2021 EOCCO Community Health Plan for Harney County
Community Counseling Solutions	Eastern Oregon Coordinated Care Organization	2021	2021-2022 EOCCO Community Health Plan, Grant County Community Advisory Council
Community Counseling Solutions Symmetry Care, Inc. Wallowa Valley Center for Living	Eastern Oregon Coordinated Care Organization	2021	Community Health Plan (CHP) Progress Report

Community Counseling Solutions Symmetry Care, Inc. Wallowa Valley Center for Living	Eastern Oregon Coordinated Care Organization	2021	Equitable Health Care for All
Community Counseling Solutions Symmetry Care, Inc. Wallowa Valley Center for Living	Eastern Oregon Coordinated Care Organization	2021	Comprehensive Behavioral Health Plan: July 2021
Community Counseling Solutions	Grant County Public Health Department	2019	Grant County Public Health Department Community Health Assessment: 2019
Symmetry Care, Inc.	Harney District Hospital	2019	2019 Harney County Community Health Needs Assessment
Symmetry Care, Inc.	Harney District Hospital	2022	2022 Harney County Community Health Needs Assessment
Options for Southern Oregon	Health Resources in Action and Jefferson Regional Health Alliance	2019	2018 Community Health Assessment of Jackson and Josephine Counties
Cascadia Health LifeWorks, NW	Health Share of Oregon	2018	Together in Health: 2018-2020 Community Health Needs Assessment
Cascadia Health LifeWorks, NW	Health Share of Oregon	2019	Together in Health: 2019-2023 Community Health Improvement Plan
Klamath Basin Behavioral Health	Healthy Klamath Coalition	2019	Klamath County Community Health Assessment: 2018
Klamath Basin Behavioral Health	Healthy Klamath Coalition	2019	Klamath County Community Health Improvement Plan: 2019-2021
Klamath Basin Behavioral Health	Healthy Klamath Coalition	2021	Klamath County Community Health Assessment
PeaceHealth Medical Group, Oregon West Network	Live Healthy Lane	2016	2016-2019 Lane County Regional Community Health Improvement Plan
PeaceHealth Medical Group, Oregon West Network	Live Healthy Lane	2018	Lane County Community Health Assessment 2018-2019

PeaceHealth Medical Group, Oregon West Network	Live Healthy Lane	2021	Lane County Community Health Improvement Plan (CHP) 2021-2025
Wallowa Valley Center for Living	Northeast Oregon Network, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital, Winding Waters Medical Clinic, Building Healthy Families, and the Wallowa County Local Advisory Committee for the Eastern Oregon Coordinated Care Organization	2016	Wallowa County Comprehensive Needs Assessment
Wallowa Valley Center for Living	Northeast Oregon Network, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital, Winding Waters Medical Clinic, Building Healthy Families, and the Wallowa County Local Advisory Committee for the Eastern Oregon Coordinated Care Organization	2019	Wallowa County Comprehensive Needs Assessment
Cascadia Health LifeWorks, NW	Oregon Health Equity Alliance and Multnomah County	2016	Multnomah County Community Health Improvement Plan (CHIP)
Cascadia Health LifeWorks, NW	Oregon Health Equity Alliance and Multnomah County	2017	Community Health Improvement Plan (CHIP)
Cascadia Health LifeWorks, NW	Oregon Health Equity Alliance and Multnomah County	2019	Community Powered Change
Wallowa Valley Center for Living	PRC, Wallowa Memorial Hospital and Medical Clinics, Building Health Families, Wallowa Valley Center for Wellness, Winding Waters Medical Clinic, and Northeast Oregon Network	2022	2022 Community Health Needs Assessment: Wallowa County, Oregon
Deschutes County Health Services	Deschutes County, Public Health Advisory Board	2020	Central Oregon Public Health Equity Report 2020
LifeWorks, NW	Tuality Healthcare	2016	2016 Community Health Needs Assessment: Washington County, Oregon
Yamhill County Health and Human Services	Yamhill Community Care	2019	2019-2024 Community Health Improvement Plan
Yamhill County Health and Human Services	Yamhill County Public Health	2017	Community Health Assessment of Yamhill County

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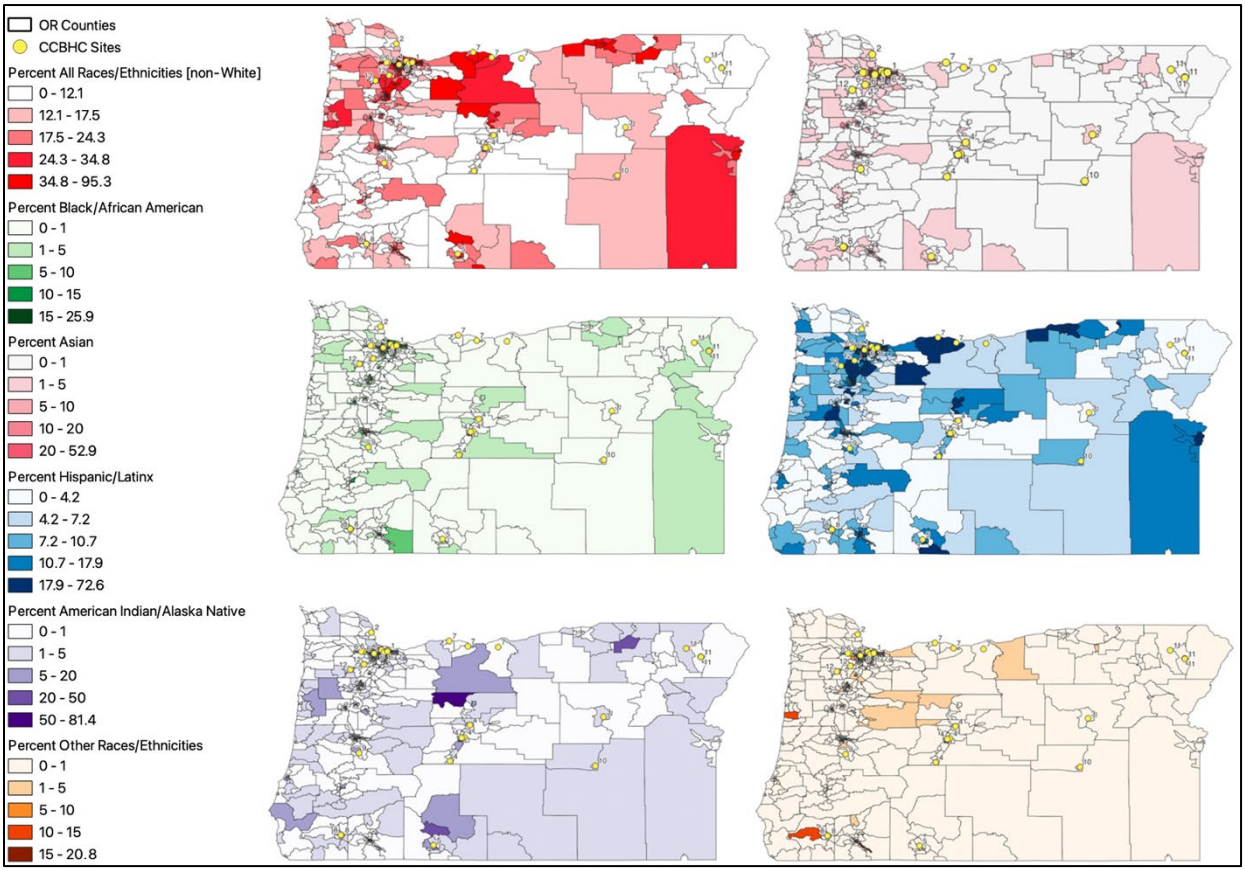
Appendix 2: Maps Illustrating Oregon's Population by Race/Ethnicity

Mapping disaggregated race and ethnicity data for the state of Oregon from the 2020 5-year American Community Survey (ACS) provides insight into the geographic location of CCBHCs relative to the historically and currently underserved racial and ethnic groups included in the analysis of CCBHC service utilization, user cost, domain performance, and self-reported outcomes (U.S. Census Bureau, 2022). The following figures illustrate clinic locations and percentages for Black/African American, Asian, Hispanic/Latino/a/x, American Indian/Alaskan Native, and other races/ethnicities. The map for all races/ethnicities (non-White) presented in the body of the report is replicated here for reference.



Appendix 3: Detailed Methodology Overview

The Oregon Health Authority (OHA) Office of Health Policy and Analytics contracted with a team from the OHSU-PSU School of Public Health, led by Professors Neal Wallace and Sherril Gelmon, in April of 2022 to conduct an evaluation of the Oregon Certified Community Behavioral Health Clinic (CCBHC) program. The evaluation was designed to address the four points in the 2021 Oregon legislative request retrospectively (for example, did the CCBHC demonstration sites meet outcome expectations) and prospectively (for example, is the CCBHC model sustainable in Oregon) using a mixed methods approach. The scope of work had four aims:

- **Aim 1:** Identify service user and community-based organization (CBO) perspectives on the CCBHC model's impact on equitable service delivery and community health outcomes.
- **Aim 2:** Identify the CCBHC model's impact on service utilization, expenditures and other treatment outcomes from available claims and other datasets.
- **Aim 3:** Identify the factors or conditions that facilitated or impeded the implementation of the CCBHCs.
- **Aim 4:** Identify the factors or conditions that help or hinder sustained and expanded CCBHC implementation.

In addition to Professors Wallace and Gelmon, the other members of the research team include:

- Robin Baker, Assistant Professor, OHSU-PSU School of Public Health
- Alexandra Kihn-Stang, Senior Research Assistant, OHSU-PSU School of Public Health
- Annette Crawford, Research Assistant, OHSU-PSU School of Public Health
- Erin Young, Research Assistant, OHSU-PSU School of Public Health

Throughout this work, the research team consulted and met regularly with the OHA liaison team (primarily Brigid Zani, CCBHC Evaluation Analyst/Consultant, and Kimberly Hoover, Behavioral Health Program Coordinator CCBHC) who provided information, identified resources, made introductions, and facilitated the conduct of this work.

The evaluation was organized using the RE-AIM framework (Reach, Evaluation, Adoption, Implementation, Maintenance) (Glasgow, Vogt and Boles, 1999). **Evaluation** was addressed in the first and second aims and was both qualitatively and quantitatively focused. **Reach**, **Adoption, Implementation** and **Maintenance** were addressed in the third and fourth aims and were primarily qualitatively focused.

CCBHC Evaluation Framework and Data Collection Strategy

In order to integrate the study aims with the RE-AIM framework, identify specific indicators related to the CCBHC program, and organize data collection and presentation of findings, an overarching evaluation framework was developed (adapted from Gelmon, Foucek and Waterbury, 2005):

I. Core Concepts: What do we want to know about CCBHCs?

The evaluation was designed around six core concepts with which to evaluate the impact of CCBHCs in Oregon: Equitable service delivery and health outcomes; Organizational impact; Cost/performance outcomes; Implementation; Sustainability/expansion; and Health systems reform role. Each of these is a high level, broad concept for which multiple indicators were operationalized that reflect the evaluation

aims. The concepts form the foundation of the evaluation and subsequent reporting of results. Multiple concepts may relate to more than one of the key questions.

II. Key Indicators: What can we observe or measure to generate evidence about the concepts?

The indicators all relate to a specific concept. These address the aims of the evaluation; the evidence was collected via qualitative and/or quantitative methods. There were multiple questions across multiple methods that provided evidence on individual indicators.

III. Methods: How will we collect the evidence?* and *Sources: From whom or where will we obtain this information?

Sources of information included focus groups with service users, supplemented by a survey of service users unable to attend a focus group; interviews with CCBHC clinic administrators and clinical leaders; focused group conversations or interviews with community-based organizations, supplemented by a survey for organizations not interviewed; interviews with key interested parties; community health assessment plans; community health improvement plans; CCBHC-specific evaluations or reports; and OHP claims and MHSIP survey data with REALD demographics.

Equity Framework

The evaluation team created an equity framework for this evaluation to frame the analysis of the impact of CCBHCs on addressing behavioral health treatment for Oregon residents (Equitable Evaluation Initiative, n.d.; Oregon Health Authority, 2021b; W.K. Kellogg Foundation, 2021; Yearby, 2020). This approach, derived from OHA's emphasis in the evaluation scope of work on centering equity in this evaluation, reflects OHA's commitment to health equity at a system level, as well as a central theme of the CCBHC program. The overarching question for this evaluation is: What is the effect of the CCBHC model on different populations and underlying systemic drivers of inequity?

The specific questions that informed the design of data collection and subsequent analysis are:

1. How do the CCBHCs define and identify communities that are experiencing health inequities in their service areas? How does this align with OHA's definition of equity?
2. How have community voices been invited into the development and operation of CCBHCs? How are they invited to provide feedback to the CCBHCs?
3. What are the outcomes for service users of accessing the CCBHCs? What were the community responses to the CCBHC program? Do the outcomes and responses vary by community?
4. What strategies could be modified or enhanced to ensure the needs of potential CCBHC service users are met?
5. What resources could be invested to enhance community collaborations and partnerships among CCBHCs and CBOs to ensure the needs of potential CCBHC service users are met?

CCBHCs are intended to transform the behavioral health system through the delivery of comprehensive and coordinated behavioral healthcare that is both person- and family-centered. Research demonstrates disparities in access to mental health and substance use treatment. BIPOC, particularly Black/African American, American Indian/Alaskan Native, and Hispanic/Latino/a/x individuals, have substantially lower access to mental health and substance use treatment services and are less likely to experience culturally appropriate treatment compared to non-Hispanic/Latino/a/x whites (SAMHSA, 2020). Thus, it was critical that the evaluation not only consider access but also the degree to which available services are culturally and linguistically appropriate.

The evaluation framework includes key equity indicators for each concept to ensure that data are collected that can answer questions about how resources were/are allocated across communities and the degree to which considerations for equity were/are included in planning, implementation, and sustainability. While equity should be embedded within an evaluation, the evaluation team also recognized the importance of specifically identifying equity to emphasize its importance. As a result, the framework centers an equity focus on understanding the impact on service delivery and community health outcomes from the perspectives of service users and interested parties from community-based organizations.

There are six evaluation concepts, each of which is linked to the aims and the RE-AIM model as illustrated in Table A3.1 below.

Table A3.1: Conceptual Framework and Evaluation Aims

Evaluation Concept	Aim(s)	RE-AIM Component
Impact on equitable service delivery and community health outcomes	1,2	Reach, Evaluation
Impact of CCBHC model on clinic operations	1	Evaluation
Costs/performance outcomes	2	Evaluation
CCBHC implementation	3	Reach, Adoption, Implementation
CCBHC sustainability/expansion	4	Maintenance
CCBHC role in Oregon health systems reform	4	Maintenance

The evaluation framework developed for this project, including concepts, key indicators (key equity indicators are in *italics*), and data collection methods and sources, is presented in Figure A3.1. This was updated from the framework submitted to OHA in June 2022, with refinement of the key indicators and adjustment of some of the methods and sources. All relevant data collection protocols are appended.

Figure A3.1: Revised CCBHC Evaluation Framework

Concepts	Key Indicators	Methods & Sources
Impact on equitable service delivery and community health outcomes (Aims 1, 2) RE-AIM: Reach, Evaluation	• *Impact on equitable service delivery* • Ease of access to CCBHC services • Provision of person- and family-centered care • *Methods by which CCBHCs engage Black, Indigenous, and People of Color (BIPOC), LGBTQ+ individuals, and Tribal communities and other communities subjected to historical and current injustices* • Community impacts of the CCBHC programs • Impact on community health outcomes • Outcomes for OHP members	• Focus groups/survey with CCBHC service users • Focus groups/survey with community-based organizations (CBOs) • Review of community health assessments • Review of community health improvement plans • Review of any CCBHC-specific reports or evaluations • Analysis of OHP claims and MHSIP survey data defined by REALD demographic data
Impact of CCBHC model on clinic operations (Aim 1) RE-AIM: Evaluation	• Impact on organizational scope and profile of services • Impact on staff work and profile of staff roles • Benefits to any specific groups of the CCBHC model • Extent to which CCBHCs expanded services to new service users • Organizational changes from CMHP to CCBHC and expansion of services • *Staff knowledge development on cultural competency and trauma-informed care* • Impact on service users • Impact on community and networks of relationships, partnerships, and referral patterns • Impact of Prospective Payment System (PPS)	• Pre-interview data form (simple survey with basic information) • Interviews with clinic administrators • Interviews with medical directors • Focus groups/survey with service users • Focus groups/survey with CBOs • Interviews with key interested parties • Review of any CCBHC-specific reports or evaluations (national or Oregon-specific)
Costs/ performance outcomes (Aim 2) RE-AIM: Evaluation	• Differences in physical and behavioral health outpatient treatment patterns and expenditures among CCBHC involved OHP members • Differences in physical and behavioral health treatment patterns and expenditures for services that may be related to outpatient treatment provision among CCBHC-involved OHP members • *Changes in number of service users in total and from historically and currently underserved communities served pre- and post-implementation* • *Outcomes for CCBHC service users, by race/ethnicity, gender, age group, and other identified demographics as available* • Outcomes by individual CCBHC site with consideration for differences in implementation and external environment • Differences in MHSIP survey domains for CCBHC-involved OHP members	• Analysis of OHP claims data • Analysis of MHSIP survey data • Analysis of REALD demographic subpopulations • Review of any CCBHC-specific reports or evaluations (national or Oregon-specific)

	• Differences in pre- and post-implementation outcomes for OHP CCBHC service users compared to outcome changes for non-CCBHC OHP service users over the same timeframe	
CCBHC implementation (Aim 3) RE-AIM: Reach, Adoption, Implementation	• Factors or conditions that facilitated or impeded the implementation of the CCBHC model • General and specific organizational attributes that led to the choice to implement practices or facilitated/hindered implementation • Extent to which clinic leaders understood, adopted, and/or adapted expected elements of the model • Benefits of participation in CCBHC demonstration project • *Facilitators of, and barriers to, delivering culturally and linguistically responsive services* • OHA provision of information, technical assistance • SAMHSA/CMS fiscal support • Involvement in Oregon behavioral health networks, national networks • Collaboration with CCO(s) in local area	• Interviews with clinic administrators • Interviews with medical directors • Interviews with key interested parties
CCBHC sustainability/ expansion (Aim 4) RE-AIM: Maintenance	• Factors or conditions that may help/hinder sustain and expand CCBHC implementation • Maintenance/enhancement of local partnerships • *Presence of equity plans for engaging historically and/or currently underserved populations* • *Future plans for providing culturally and linguistically appropriate services*	• Interviews with clinic administrators • Interviews with medical directors • Interviews with key interested parties • Focus groups/survey with CBOs
CCBHC role in Oregon health systems reform (Aim 4) RE-AIM: Maintenance	• Role for CCBHC model in Oregon health systems reform • Relationships of CCBHCs to CMHPs • Relationships of CCBHCs to CCOs • Support of behavioral health workforce • *Role of CCBHCs in achieving OHA's equity goals*	• Interviews with clinic administrators • Interviews with medical directors • Interviews with key interested parties • Focus groups/survey with CBOs

Data Collection Methods

Qualitative Methods

A variety of qualitative methods were used. All recruitment scripts (email or telephone), research information/consent sheets, and interview/focus group/survey protocols were approved by the PSU IRB (IRB #227800-18) in June 2022.

Interviews with Clinic Administrators and Clinical Directors

Individual interviews were conducted virtually using a standard protocol with the clinic administrators and clinical directors (or designates) at each of the 12 CCBHCs and were recorded using Zoom. All 24 interviews were completed between July 25 and August 16, 2022. Interviews were transcribed using Rev.com followed by review by an evaluation team member; all individual identifying information was removed to protect anonymity; and the de-identified transcripts were coded for common themes.

Focus Groups with Service Users (and Survey)

Clinic leaders were asked to identify a group of service users who would be invited by the evaluation team to an in-person focus group. Each clinic was asked to identify 15-20 individuals, with a goal of 8-12 participants in each focus group. Clinic leaders were also asked to identify a time that they thought would be most suitable for service users to attend (given that resources would only support one focus group per clinic), select a preferred site (if the clinic had multiple sites), and provide logistical support to identify a location for the focus group. The intent was that the evaluation team would reach out to the service users and minimize the added burden on clinic staff; in some cases, a list was provided readily, in others, the clinics first contacted the service users to obtain their permission, and in some others, the process of the clinic providing a list to the evaluation team was protracted. Where an email was provided, it was relatively simple for the evaluation team to contact the service users, explain the focus group, and invite them, and then provide the research information/consent sheet when they agreed to participate. When only a telephone number was provided for service users identified by the clinics, the evaluation team attempted to reach them by telephone and explain the focus group to them. In some cases, this resulted in agreement to participate (recognizing that some users did not use email); in many cases, it was not possible to reach the service users, or there was confusion about the purpose of the focus group.

Ultimately, despite all clinics receiving the same request, the numbers of service users identified by the clinics ranged from 3 to 21. The recruitment process was complicated by the fact that OHA was conducting its compliance visits to the clinic in parallel with the evaluation process, and many clinic leaders expressed frustration with being asked to identify service users for a second focus group. In most cases, these compliance visits occurred prior to the evaluation team's visit.

Focus groups were conducted with service users at the 11 CCBHCs that are currently active. No focus group was conducted at PeaceHealth Medical Group, Oregon West Network since that clinic had not been an active CCBHC in recent years and thus there were no current CCBHC service users. The number of service users who attended the focus groups, despite all clinics having confirmed numbers in advance, ranged from 0 to 5 as shown in Table A3.2 below. The evaluation team recognizes that the service users are all behavioral health clients with complex lives who may experience challenges in keeping a scheduled commitment. While the insights obtained from the limited number of participants were very

rich, future research involving in-person qualitative data collection with service users would benefit from careful recruitment strategies to maximize the number of participants.

Table A3.2: Focus Group Participation

Number of Focus Group Participants	Number of Clinics
0	1
1	3
2	2
3	1
4	3
5	1

Focus groups were conducted in person using a standard protocol at the 11 active CCBHCs between September 1 and October 4, 2022 and were recorded. All focus group attendees received a $25 Visa or Amazon gift card at the completion of the focus group; distribution was tracked by serial number and recipient initials to maintain anonymity. Focus group recordings were transcribed using Rev.com, followed by review by an evaluation team member; all individual identifying information was removed to protect anonymity; and the de-identified transcripts were coded for common themes.

Given the small number of service users who were able to attend the focus groups, a survey of service users was added to invite more input from this important group of respondents. The service users invited to the survey were those who had already been identified by the 11 clinics and for whom names and email contact information had already been provided. These individuals had previously been invited to a focus group but were unable to participate. Individuals who had already participated in a focus group were not invited to the survey. Seventy-four service users (previously identified by the clinics with emails) were invited to the survey and seven responded (9.5%). These responses were added to the focus group responses for analysis.

Focus Groups with Community-Based Organizations (and Survey)

Clinic leaders were asked to provide email contact information for community-based organizations that had some degree of familiarity with their clinic. The goal was to hold two virtual focus groups with approximately 5 to 8 representatives from community-based organizations at each conversation. The number of representatives identified by clinics ranged from 2 to 5. The evaluation team sent an email to 20 representatives from community-based organizations inviting them to participate in a virtual focus group. The email invitation explained the focus group, included the research information/consent sheet, and provided three dates in October as options. Ultimately, three representatives from community-based organizations attended a virtual focus group on October 18.

A standard protocol was used to conduct the focus group, and it was recorded via Zoom with consent. The focus group recording was transcribed using Rev.com, followed by review by an evaluation team member. All individual identifying information was removed to protect anonymity, and the de-identified transcript was coded for common themes.

A secondary survey was created to provide an additional opportunity for community-based organizations to give their input. The survey was intended to solicit information from community-based

organizations who were unable to attend the focus group, as well as community-based organizations that may have important insights into community needs but are not necessarily familiar with their local CCBHCs. The evaluation team used several strategies to identify community-based organizations in the latter group. They reached out to OHA contacts in the Office of Equity and Inclusion, the Transformation Center, and the Oregon Public Health Division to access lists of community-based organizations. In some cases, lists were provided that included email contact information; in other cases, the evaluation team needed to identify contact information. The team also conducted research about each community and identified organizations and contact information from organization websites. These methods produced 50 additional potential representatives from community-based organizations that might have relevant insights regarding CCBHCs. Organizations identified included school districts, law enforcement, health care organizations, social service organizations, shelters, substance use and recovery organizations, and advocacy groups.

Community-based organizations invited to fill out the survey included the 50 representatives identified by the evaluation team and by the 12 clinics and for whom names and email contact information had been provided. Individuals who had previously been invited to the focus group, but were unable to participate, were invited to participate in the Qualtrics survey. Individuals who participated in a focus group were not invited to the survey. Eighty-nine community-based organizations were invited to the survey; unfortunately, only 15 responses were received and only four were complete responses; this was a disappointing result given the level of effort required to develop this unique list of community-based organizations, but not completely surprising since the organizations had little or no connection with the CCBHCs or the evaluation team.

Interviews with Key Interested Parties

The evaluation team identified a number of interested parties and/or key organizations with whom to conduct individual interviews. This list was developed based upon insights from the interviews with clinic leaders, conversations with the OHA liaison team, and other observations throughout the initial data collection phase. The list was discussed with the OHA liaison team and then the evaluation team contacted the individuals or organizations. Interviews were conducted virtually using a standard protocol with consent, and were recorded using Zoom. Fifteen interviews were completed in October and November, 2022; see Table A3.3 for a summary (to maintain anonymity of interviewees). Most interviews were with a single person; in one case, the lead person suggested they be joined by additional individuals. A group conversation was conducted with the CCO Oregon Behavioral Health workgroup; 11 people attended that conversation. As a result, two of the interviews with behavioral health provider organization representatives consisted of groups (4 and 11 participants, respectively).

Table A3.3: Interviews with Key Interested Parties

Interviewees	Number Interviewed
OHA staff	4
Elected officials	2
Behavioral health provider organizations	15
Advocacy organizations	4
Public service organizations	3

The purpose of these interviews was to expand upon and further explore insights developed through the previous data collection methods. As a result, many of the interviews focused on the future orientation of the interested party with regard to sustainability, expanded scope, and potential expansion of CCBHCs from the perspectives of legislators, government employees, advocacy organizations, and insurers, among others.

Other Relevant Documentation

Additional documents were reviewed to supplement data collection. CCBHC-specific reports or evaluations (national or Oregon-specific) were reviewed to integrate previous lessons learned. Community health assessments and community health improvement plans were analyzed to identify community priorities and to consider what role the CCBHCs could or do fill in meeting those priorities. The evaluation team conducted an internet search to identify community health assessments and community health improvement plans for communities in which a CCBHC was located. The search parameters included any community health assessment or community health improvement plan published in or near 2016 and subsequently in order to allow the evaluation team to understand community priorities over time. Forty-four documents were identified and included for review, with a range of two to eight documents identified as relevant for each CCBHC (see Appendix 1).

The evaluation team analyzed the documents to identify whether behavioral health and/or substance use were identified as community priorities; common barriers to behavioral health and healthcare more broadly; any mention of the CCBHC program or a CCBHC clinic and how they or their services were described (if at all); identification of underserved populations; and strategies reported for improving access and equity.

Quantitative Methods

A variety of quantitative methods were applied to individual level, de-identified MHSIP survey, OHP claims, OHP eligibility, and REALD data. All quantitative protocols, including data security, were approved by the PSU IRB (IRB #227749-18) in June 2022.

Design Overview

The quantitative analyses developed for this report address aspects of each of the four questions posed by the Legislature, representing only OHP members. As described in more detail below, OHP claims, MHSIP surveys of OHP members, and REALD demographic data were the three available and feasible data sets primarily used for the analyses. Using these data, the analyses were able to provide information on whether CCBHCs:

1) increased access to behavioral health treatment for OHP members in their service area;
2) increased access to physical (primary care) treatment for OHP members;
3) improved health outcomes for OHP members as measured by the MHSIP survey; and,
4) lowered the cost of care for CCO organization members.

In addition, these four areas of inquiry were assessed from an equity perspective by comparing relative outcomes among OHP members identified as white or nonwhite based on nine REALD race/ethnicity categories, as well as from a geographic perspective based on service users' residence in urban, rural or remote areas based on zip code designations from the Oregon Office of Rural Health.

The overall design of the quantitative analyses employed a natural experimental design comparing change in outcomes for OHP members of CCBHCs before and after CCBHC implementation to those for OHP members served in comparable behavioral health organizations that did not become CCBHCs. As nine of the twelve CCBHCs were OHA-designated Community Mental Health Programs (CMHPs), OHP members served by non-CCBHC CMHPs served as the comparison group.

The technical term for this analytic design is a "difference-in-difference". The findings reflect the impact (change) in outcome measures associated with implementation of the CCBHC program (first difference) after accounting for any contemporaneous change occurring among the control group (second difference). Given that OHP members' characteristics may vary between CCBHCs and non-CCBHC providers, propensity score matching was used to equate characteristics of OHP members in the intervention (CCBHC) and control (non-CCBHC) groups, and across time within groups, to reduce bias in the difference-in-difference comparisons.

Data Sources and Study Population

The data sets used for the analysis were:

- All OHP claims and eligibility data from April 1, 2015 through March 31, 2021;
- MHSIP adult and child/adolescent surveys for outpatient and residential services for the years 2015 through 2021;
- REALD data for OHP members from CY 2018-2021; and
- Quarterly CCBHC prospective payment records.

Outcomes from the OHP claims and MHSIP survey data covered a pre-implementation period (April 1, 2015 through March 31, 2017) and two post-implementation periods (April 1, 2017 through March 31, 2019 and April 1, 2019 through March 2021). Two post-intervention periods were assessed primarily in order to isolate periods during the onset of COVID-19.

Inclusion Criteria

The OHP claims and eligibility data covered the entire study period. MHSIP survey data for 2016 were used for the pre-implementation period, 2017 and 2018 data for the first post-implementation period, and 2019 and 2020 data for the second post-implementation period. MHSIP surveys for 2015 could not be used as outcomes measures since the survey was changed after that year. MHSIP surveys for 2021 were considered largely beyond the study period. The CY2018-21 REALD data for OHP members were used to augment the race/ethnicity and language information available in the claims and eligibility data both concurrently and retrospectively (where members present during CY2018-21 were eligible in prior study periods).

OHP members with full enrollment within a calendar quarter who received services from the original twelve CCBHC providers and an additional 24 (non-CCBHC) CMHP providers based on National Provider Identification numbers (NPIs) with screening for behavioral health (billing) provider types, as indicated in the OHP claims, were included in the study. These OHP members were attributed to CCBHC or non-CCBHC groups in each study year based on the majority of CCBHC vs. non-CCBHC identified claims (or last service date for ties). Within each group (CCBHC vs. non-CCBHC), OHP members were assigned to a specific provider based on plurality of claims (or last service date for ties). All OHP and MHSIP survey responses for these individuals were then identified for potential use in the study. Ultimately, data for

individuals attributed to the three original CCBHC sites that suspended their participation in CCBHC after the first two years of the demonstration (Community Counseling Solutions - John Day, Mid-Columbia Center for Living, Peace Health Medical Group) were excluded to assure consistency across the study periods. Two of these sites have since resumed operation as a CCBHC but the relevant data were not available for the comparisons, thus their exclusion from this part of the analysis.

Study Measures

A variety of measures were developed from the OHP claims data capturing different layers and perspectives on OHP member cost and service utilization. First, outcomes were developed based on overall, mental health, substance use, and physical health services. This perspective was applied to specific service types: hospital-based inpatient, residential treatment facility, emergency department, primary care visits, mental health and substance use outpatient visits, and all other non-pharmacy services.

For each of the service categories noted above, a quarterly cost per person was calculated and a binary measure was created to determine whether any service in the category was used in a quarter. In addition, where feasible, counts of visits per quarter (i.e., outpatient and ED visits) or days (i.e. hospital, inpatient and residential treatment facility [RTF]) were also calculated. The cost per person per quarter is an overarching outcome measure of the cost and utilization on average for OHP members. The assessment of the probability of use based on the binary "any use" measure, and cost per user or the assessment of quarterly average costs only for those using a service in a quarter, were included as additional outcomes to identify how or why cost per person changed. Quarterly visit or day measures provide more specific identification of change in utilization patterns that further help understand the complete "picture" of CCBHC impacts on cost and utilization.

OHP claims data include both fee-for-service (FFS) and CCO encounter claims. For service users in some CCO areas, the CCO encounter data had large numbers of claims with zero payments. These typically reflect services provided under a global budget or other Alternative Payment Mechanism (APM) that does not provide payment on individual claim basis. Similarly, CCBHCs are instructed to bill for CCBHC services for non-CCO OHP (FFS) members at their PPS rate using HCPCS code T1014. Actual services justifying the PPS rate are required to be additionally submitted as claims but with zero payment value.

To more accurately identify the flow of service use and resource value incurred, several adjustments were made to the OHP claims data:

- Zero paid claims were counted as services provided in use and visit/day count measures
- Zero paid claims were valued at the allowed amount as indicated in the claim
- Claims with HCPCS code T1014 were not included in the data analyzed

These changes provided a consistent flow of resources used and their relative value over time allowing reasonable estimates of the rate of change in use and expenditure reported, but could not be used to estimate exact, actual use or expenditure levels at a point in time.

To adjust and account for variation in OHP member characteristics over time and across CCBHC and non-CCBHC CMHP sites, a variety of OHP member characteristics were used. These included age groups aligned with the Chronic Illness and Disability Payment System (CDPS) risk adjustor used, age in years, race/ethnicity, primary language, gender, urban/rural/remote residence, quarterly enrollment pattern,

and prospective CDPS risk scores for physical, mental health and substance use conditions. These measures were used to create propensity score matched samples at the study year level across the study period based on CCBHC service user characteristics in the second year of the first post-implementation period (April 1, 2018 to March 31, 2019). Matching was conducted separately for OHP members attributed to each of the nine CCBHCs in the study drawing matched individuals first from regional/contiguous counties, and then the remaining non-CCBHC CMHP cohort as needed. Exact matching was used for age group, race/ethnicity, primary language, gender, urban/rural/remote residence, and quarterly enrollment pattern. Continuous (caliper) matching was applied to age in years and the prospective CDPS risk scores for physical, mental health and substance use conditions.

The MHSIP data provided by OHA included data from adult and child/adolescent outpatient and residential surveys. For the purposes of this study, outpatient and residential survey results were combined for adults and child/adolescents separately, as the adult and child/adolescent surveys differ in content. The survey data included scores for survey domains that were computed as the mean of the Likert scores (1-5) across all questions associated with a domain. Satisfaction scores, aligned with the survey domains, were computed as the mean of the binary (0, 1) variable indicating whether a patient was or was not satisfied with the services under each domain. The domain and satisfaction scores constituted the outcomes used for this study.

For the Adult Outpatient and Residential population, domain satisfaction scores were available for each of the following seven domains: Access to Services, Social Connectedness, General Satisfaction, Daily Functioning, Quality, Treatment Outcomes, and Participation. For the Child and Youth Outpatient and Residential population, domain and satisfaction scores were available for each of the following seven domains: Access to Services, Acceptability, Social Connectedness, Cultural Sensitivity, Daily Functioning, Treatment Outcomes, and Participation.

Analytic Methods

Appropriate weighted regression analyses (ordinary least squares [OLS], exponential, logistic, Poisson) were conducted across the set of outcome measures on the matched samples. All regressions included binary measures indicating observations in the first or second post-implementation periods, the matching variables noted above, and fixed effects for specific CCBHC and non-CCBHC attributed site and time period (quarter). Standard errors were adjusted for repeated measures across individuals. The main reported results are the “difference-in-difference” coefficients for the first and second post-implementation periods noted above. These coefficients represent the extent of pre- to post-implementation change or impact attributable to CCBHC implementation (i.e., after accounting for contemporaneous change in the non-CCBHC sample). All cost and utilization implementation effects are reported as percentage change from baseline. MHSIP domain score changes represent change in the average (1-5) Likert score. MHSIP satisfaction score changes can be interpreted as the percentage point change in individuals indicating positive satisfaction.

To identify equity (race/ethnicity) and geographic (urban/rural/remote) effects across the cost/utilization and MHSIP outcome measures, regression models were run on samples of individuals meeting the specific race/ethnicity or geographic criteria. Some of these categories were too limited in sample size to credibly analyze. Remote area residents were combined with rural area residents throughout. Within race/ethnicity, American Indian/Alaskan Native, Black/African American, Hispanic/Latino/a/x and White were identified as large enough to separately analyze. Asian, Middle

Eastern/North African, Native Hawaiian/Pacific Islander, Other, Multi-ethnic, and Unknown groups were combined into a single category.

As illustrated in Appendix 7, where specific results for these groups are provided, some findings for specific race/ethnicity groups include unusually large increases or decreases in some of the service types which may reflect their limited sample sizes. These results are selectively not reported (NR) given concerns that they may not accurately reflect true effects. In addition, there is limited reference to findings for the combined "all other race/ethnicity" group as there is some instability in the "unknow" category over time and given difficulty in meaningfully interpreting the results across the multiple identities included.

Citations for Methodology Appendix

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Appendix 4: Extended Report of Feedback from CCBHC Service Users

This extended report of feedback from CCBHC service users provides a summary of the themes that emerged from the service user focus groups and survey. Data collection methods and analysis are described in detail in Appendix 3.

Service Users

While not all service users who participated in a focus group or completed the online survey volunteered the duration of their relationship with their clinic, most who offered this information had accessed services at their CCBHC clinic prior to implementation of the demonstration program. Of the 27 service users who participated in one of the focus groups, five reported accessing services at the clinic for less than five years, 12 reported accessing services between five and 10 years, and seven reported accessing services at the clinic for more than 10 years (i.e., before the start of the CCBHC program). Three service users either could not remember the number of years or declined to answer. Of the eight service users who completed an online survey answering the same questions covered in the focus groups, only one reported the number of years they had accessed the clinic where the CCBHC is now located (more than 10 years). See Table A4.1 for a summary of these data.

Table A4.1: Years of Accessing Clinic Services

Years of Service Utilization	Number of Service Users	Percent of Service Users
<5 years	5	14.3%
5-10 years	12	34.3%
>10 years	8	22.9%
Did not answer/remember	10	28.5%
Total	35	100%

Limitations of Data

Findings are limited by the number of service users who participated in each focus group, as well as the individual contexts of those service users. While each CCBHC was asked to identify a list of potential participants based on specific criteria, the evaluation team was not made aware of how closely each clinic adhered to those criteria. Additionally, there is the potential for sampling bias in the identification of service users for recruitment, as clinics could have potentially selected service users known to have positive experiences while excluding service users with negative experiences (or those who left services at the CCBHC). However, most of the service users provided honest and candid feedback that encompassed experiences that were both positive and suggested room for improvements.

Subpopulations represented by the service users in attendance included (self-identified) two members of the LGBTQ+ community, one service user of American Indian/Alaskan Native descent, and one veteran of the U.S. armed services; data on participant demographics is limited to only those service users who chose to self-identify. Only one of the service users who completed the online survey provided information on their identity. In addition, while several service users who cared for children who received services through the CCBHC were recruited across multiple clinics to participate in the focus groups and survey, none attended. Therefore, these results cannot speak to the experiences of those service users. Finally, the majority of service users who participated in a focus group resided in

rural service areas; therefore, there is limited evidence to establish whether service users located in urban areas had different experiences than those in rural areas.

Future evaluations may benefit from longer recruitment periods, multiple opportunities for data collection (as timing constraints meant that only a single focus group could be held per CCBHC), and coordinated recruitment efforts among CCBHC administrators, advocates, and community partners to ensure sufficient and appropriate outreach is conducted to include these important community perspectives. Future CCBHC evaluation using a community-based participatory research approach could engage service users in evaluating the impact of the CCBHC on individual and community health and identify strategies to guide the development of culturally and linguistically responsive outreach and services.

Findings

The following themes arose emerged from the focus groups with service users, and are discussed below:

- Timely and accessible care
- Person-centered care
- Family-centered care
- Community needs, gaps in CCBHC services, and service user recommendations
- Meaning of the CCBHC to service users
- Integration and coordination of care

Timely and Accessible Care

Most service users described the care they received from their CCBHC as both timely and accessible. Service users noted that they were generally able to contact their CCBHC without difficulty and that they were able to access services at times when they needed them. Nearly all service users expressed that their clinic was responsive to their individual needs; however, some noted that there could be delays in scheduling follow-up care or rescheduling missed appointments.

> *Care has been easy to access and they have made it easier to get that access in a variety of ways. I am always able to schedule my next appointment at the end of my current, and can call if an emergency arises. I have found the staff to be really helpful in both getting me to where I need to be and follow up.* (Service User 28)

> *[They are timely] both in crisis and in standard care. My crisis was immediate, I got help immediately and they helped me through that. Throughout my regular care I've had needs to come in and they've been very accessible.* (Service User 11)

> *They're an absolute team of all-stars in all areas, there is no doubt that they have got it fine-tuned. Every week I get plenty of contact and support and am able to go deep and find what it is that is partially causing my mental illness.* (Service User 16)

> *I try to sit in the lobby almost daily and I've done that for many years now because of personal safety reasons. I do get a lot of service. Up until COVID I would see my therapist every day because they would come in and check in on me. Even now, I have the ability to contact my counselor when I need to. I have a very extraordinary treatment team around me where I can*

> *contact them when I need to and I have almost instantaneous contact with them.* (Service User 21)

Overall, service users described few limitations or barriers related to their CCBHC that kept them from being able to access care. Many described their CCBHC as having connected them with resources that were critical in facilitating the accessibility of services, including clinic-provided assistance with enrolling in the Oregon Health Plan (OHP), transportation resources, translation services, as well as housing assistance or other social services needed to support service users in accessing care.

> *I've never had any trouble receiving timely and efficient care at this clinic. I feel my time here has been very well spent and has even helped connect me with a number of invaluable other services, such as Developmental Disability Services and Vocational Rehabilitation. My mood and general disposition have greatly improved since I've started receiving services here. I have no complaints.* (Service User 35)

> *They have a little program for low income folks and they have a person who does all the Oregon Health Plan stuff for free. That's how I got started here, they set me up [with OHP]. I had no income so I got to come here for free. They are also adamant about making sure that you find and click with the right person here.* (Service User 25)

> *My partner is deaf and so they arrange for an interpreter to come in during those appointments. That is very helpful and I appreciate it a lot. Not only do they care for me but they also think of my family as well.* (Service User 09)

> *I didn't know any resources and they were very good about making sure I knew where the clinic was, how to get there. I don't drive and I have never driven, so I began using the bus service. Being an older senior, they helped me figure out how to get hooked up with the bus service and things like that.* (Service User 03)

While most service users reported receiving the care that they needed at the time that they needed it, this experience was not universal and varied among CCBHCs and individual service users. Some service users reported that timeliness and accessibility of care had changed over time; these changes varied by CCBHC. Some service users noted that the ability to schedule appointments when needed had become more difficult in recent years due to COVID-19-related workforce challenges and staff turnover, while others said that scheduling had become more reliable since the CCBHC demonstration began.

> *When I first started coming to this clinic many years ago it was very trying to get an appointment, the resources were not plentiful and the counselors wouldn't stay long. It was very difficult to get appointments, let alone appointments with a counselor that was familiar with the LGBTQ+ community. I had one counselor, she was very good at her job but she left to go someplace else and it was a long time before I finally got back into the counseling cycle here. Now I go twice a month, at least, and I find it has gotten a little more accessible within the past year or so, as far as appointments are concerned.* (Service User 24)

Service users who needed support between regularly scheduled appointments described different experiences obtaining between-appointment support, depending on the clinic and the relationship

between the service user and their counselor. The majority of service users were pleased with their ability to contact their providers between regularly scheduled appointments, as needed, for support in working through issues as they arose. However, some service users expressed that they were not always able to contact their providers between appointments and, while they could turn to after-hours or crisis services, they would have preferred talking to someone already familiar with them and their case.

> *Care has been available when I need it. Sometimes the wait between appointments is longer than intended, but I can always reach out to my team in between scheduled visits if I need support. Most consistent and patient-friendly mental health services I've ever used.* (Service User 32)

> *When I've called and I've needed to talk to someone, they've gotten me someone, or they've provided the after-hours number. Those people are super compassionate when you need them, but there's only so much that people who don't know about your particular case can do. They're just trying to help you in that moment.* (Service User 05)

> *They're pretty good about having someone there for you. If you text them or if you call, they're not busy. If they are busy, it might take a minute for them to reply to a text, but somebody's always right on it.* (Service User 18)

> *My therapy appointment was the next day, but I really needed it that day. I texted my therapist and I said, "Hey, I'm going through it. I need to talk to you." She set up a time that same day and we talked. She helped me get through it, and it was great.* (Service User 09)

> *The accessibility has improved greatly over time at this facility. There were times when I would go with one appointment every two months and that wasn't cutting it. It wasn't crisis management team time, but it was "I need a counselor right now." And that's improved greatly.* (Service User 24)

The general sentiment among service users was that care from their CCBHC was both timely and accessible; however, some service users reported that their ability to be seen quickly was limited by workforce-related challenges, such as staff turnover and/or high provider caseloads, both of which contributed to challenges in scheduling. Some of these service users described challenges in scheduling appointments with the frequency needed to meet their individual needs and/or frustrations with establishing care with a new provider in response to a staff departure. Some of these service users noted that their CCBHC did well at working around scheduling challenges, either coordinating a quick phone or text check-in with their counselor between appointments or connecting them with a group meeting or similar service in the interim. Others expressed ongoing frustrations, particularly if they were told that the delay in care was the result of staffing issues without being provided an alternative solution. For service users who felt that their needs were not being met, the inability to obtain an appointment with a provider and/or lack of a consistent provider familiar with their case could exacerbate ongoing personal challenges. These challenges applied more often to urban service users.

> *Someone has always been able to contact me reasonably quickly, so I've never felt like I fell through the cracks. I have to admit that there have been a couple of times when I wasn't able to get in to see someone, but somebody has always reached out via phone, so I've been lucky that*

way. It's always been handled very quickly; I've never had to be referred out to another clinic or go to my primary care physician in lieu of being seen here. I've never experienced them failing to get me seen or have someone return my calls. (Service User 03)

Whenever I need something I'm able to call in and get help right away, whether it's a crisis or not. The only thing that I have found is that sometimes, and I know they're busy because they have a decent sized county to serve, sometimes when they say they're going to call me to check in on me, they forget to. (Service User 25)

I have found that there have been times that scheduling is such that I may be able to see my therapist perhaps once a month, and there have been times where, because of issues in my life, that felt too infrequent. I do have an arrangement with my therapist that if something were to come up, I could give her a call or send her an email, and we've had a couple of spontaneous sessions over the phone over the past few years. The accessibility has always been pretty good, I've never felt blocked out or neglected; but the scheduling, I would say the timeliness does not always fit my preferences. (Service User 23)

I do have a number to text to my therapist but I'm always told that they're understaffed and they're not always able to get back to me. Just a few incidences have happened like that, where I get told how understaffed they are. (Service User 08)

I'd meet with my counselor on the phone, and then there are times that she would call out and I wasn't aware of it. She ended up leaving and it was just really frustrating; I feel like the care I was getting was better than nothing, but it wasn't great. Now I have another person who I'm meeting with until a new counselor is hired. With the pandemic happening we lost a lot of people, and people move on different jobs, and well, that's good for them, but what about the clients that are here? (Service User 04)

Person-Centered Care

The majority of service users reported feeling that the care they received through their CCBHC was person-centered. Person-centered care was described to service users as the CCBHC putting them at the center of their behavioral health care and treating service users as a person who is involved in decisions about their care. Service users generally associated person-centered care with their ability to make decisions about their treatment. For most service users, person-centered care required involvement in deciding whether to take medication and in determining which medications or services were right for them at any particular time. Service users appreciated being able to drive their care decisions in a way that met their individual needs. Service users generally described feeling as though they were involved with and supported in making all decisions with regard to their care, and that they were respected as autonomous individuals who were allowed to decide what was right for their own treatment. They appreciated having an active role in their treatment plan.

I'm in control of my treatment, I decide, and this is the way it's been the entire time. I decide what I want to do, when I want to do it, with basically who I want to do it with, and start or stop something. I just started my medication just recently; I fought that for a long time and my prescriber was sitting on the sidelines, "Hey, when you're ready." That's the way it was the entire time. Even the substance abuse counseling, I probably could have graduated from the program

some time ago, but she didn't say that I needed to and I haven't asked to, and that's okay. I get what I need from these groups. (Service User 27)

My therapist does a really good job of making sure that I am happy with my health plan, while always reminding me that we can shift the focus and try new ideas if I am not happy with the current plan. I have also noticed that the handouts and documents they send do acknowledge the person-centered idea, in that they acknowledge the thoughts or emotions and give tips on how to handle them, echoing that idea. (Service User 28)

My therapist told me, "I think you could probably benefit from this." But she put it as my choice, she's not forcing it upon me. I started working on my anxiety and I got a lot of input, that's one thing I appreciate about the care here, it's not that they're like, "Here, you have to do this." They give you the choice to decide about your own therapy and what you need, I really appreciate that. The transition [between my primary care physician and the CCBHC] was really nice and very supportive; every few months you get that check in with your therapist and then they reevaluate where you are and they give you really good input. They give you the choice of what you want and how your case is going to continue. That's how it's been for me from the beginning since I started. (Service User 22)

They are great at letting you make your own decisions. There have been many times that my counselor has suggested something for me and I'm just like, "No, I don't want to. I'm not going to do that. I'm not going to want to go that route." And she says, "Okay, we will find alternatives." They've always worked with me on that. (Service User 12)

I believe my care is person-centered as both my therapist and care navigator make sure to include me in all decisions and make sure I have autonomy and authority over my care and treatment plan. (Service User 32)

As far as [CCBHC] goes, they've been very understanding and accepting [of my identity as an LGBTQ+ person], so I do appreciate that. I feel safe. That's important, when I have a counselor I can work with. (Service User 05)

Another frequent theme when discussing person-centered care among service users was the strong connection that they felt to their CCBHC and care team. This connection was an essential component of person-centered care and was important for service users who described feeling understood and cared for by CCBHC staff. Service users generally reported feeling respected as individuals, that their experiences were valued by CCBHC staff and that they were not being judged in their treatment. Additionally, many service users described the CCBHC as being flexible and willing to provide care in a way that best suited their individual needs.

They're just kind, first requesting whether or not they can use my first name and then using it constantly. Things like that set me at ease because the subculture I just came out of was racked with violence, racked with everything. People standing around me, things like that, coming into this place itself creates a lot of anxiety and I don't like being in here at all. But they're always kind, nice, helpful, anything that they can do. There's nothing about my care that I don't like. Yes, they're going through the boiler plate forms that they have to, but they recognize that I don't

> *want to be here. Nevertheless, they're still going through the processes that they need to go to make sure they can give the proper assessment back to whoever they need to give it to, and they do it pretty efficiently.* (Service User 02)

> *I have had to switch therapists multiple times but it has always been a really good fit, they're always very sweet and they get to know me. When they go there's another person and it's the same thing, they're very sweet and very understanding. They're there for me. I had a situation recently where I was just going through a really hard time and all of my care team was there for me; every single person I work with was very supportive. Any problem or issue I have, they are on it, they are ready to fix it.* (Service User 09)

> *With my primary therapist here, I receive absolutely 110% full respect. I think that the degree of rapport is just exceptional, almost to the point where even if she wasn't a therapist this would be a person I would go and confide in and find comfort in just the...almost companionship. It exceeds what I consider clinical therapy. It is very respectful.* (Service User 23)

While most service users felt the care they received was person-centered, this sentiment was complicated for those who noted being aware of workforce-related challenges at their CCBHC. Urban-located service users in particular expressed experiencing frustration when members of their care team left the organization, requiring them to connect and communicate with someone new to their case. These service users described the lack of continuity resulting in a feeling of reliving challenging moments from their past in order to catch these new team members up on historical events critical to their care with the clinic. Abrupt departures of CCBHC staff were especially difficult for these service users who felt unprepared and experienced a setback in trust as a result. This experience was mitigated for some if the departing counselor assured the service user that they would provide the incoming counselor with important details about their case, facilitating an internal warm handoff.

> *That was one of my concerns with moving counselors. I wasn't getting the service, but I knew if I started with new counselor, it's back to square one. And when you make progress, you don't want to go back.* (Service User 05)

> *My past counselor made sure that he typed up [notes] so that I won't have to relive these episodes with my new counselor. I was really grateful that my new counselor actually did read the details, it made me feel a lot better. I was kind of relieved that I didn't have to go back and restart over again, because that's my thing, is to restart from square one every time someone leaves, it's like, "Okay, I have to start all over again. Please, I don't know how to repeat these same things that we just got cleared up." When people are leaving and you have to start over again with new staff my anxiety just goes up, it's hard to connect.* (Service User 07)

Person-Centered Care and Substance Use Disorder Treatment Services

The experience of person-centered care was not always shared by service users who were in substance use disorder (SUD) recovery programs, particularly those who were actively involved with the legal system in connection with their treatment. Some of these service users felt they were without the same level of autonomy with regard to directing their care plans, lacking decision-making power over medication usage and what CCBHC activities they would participate in. These service users also acknowledged that their lack of autonomy was likely related to the terms of their SUD treatment.

Several service users from different CCBHCs described the perception of differences between SUD-specific services and those that were strictly behavioral health with regard to care quality, satisfaction, timeliness, and the array of available services. A few service users described stark differences in wait times for appointments depending on whether they were seeking care with a SUD counselor or a mental health counselor; others described feeling as though the programs and activities in which they participated received fewer resources and less attention than those specific to SUD recovery.

> *It can be a long wait to get in to see therapists and medication management. When I started services, I waited about a month to get in to see someone, and then my counseling appointments were once a month because of how large the caseloads are. SUD treatment was quick, I started with a CADC [certified alcohol drug counselor] within a week. My SUD treatment counselor often gave me resources and support, but I did not feel very heard or supported by my mental health counselors or my med management doctor. The turnover for mental health counselors is high here, I went through 4 or 5 in just a couple of years. I ended up getting frustrated and transferring my services elsewhere the beginning of this year. My SUD counselors were amazing. They listened, and supported me. They got to know me and met me where I was at. They even sent emails to my med manager when I felt I was not being heard. I spent months telling my med manager that the medicine I was on was making me worse and she kept upping the dose. In treatment not taking my mental health medicine was viewed as serious as a relapse. I really struggled with being on meds that were making my mental health worse.* (Service User 34)

> *They really try to meet people [in SUD treatment] where they're at but I think that they fail to meet that mark a lot. When I was here, I felt that I never got any say in my treatment plan, I never had any say in what I was doing or when I thought I was done. They basically put me in everything they wanted to put me in and they didn't care what I felt. But that has changed since I've been in [program]. I don't come to [CCBHC] anymore. All my counselors are there now and I absolutely love that program and I think that they're amazing; it's all under [CCBHC].* (Service User 13)

> *I don't feel as if I need [strictly behavioral health] counseling right now, but with my drug and alcohol counselor I think that I do. I don't think that I should need counseling to get my medications, but I guess the law or the rule that have here. I would rather that I have more decision making about that.* (Service User 15)

Some service users expressed concerns that funding for CCBHC programs and services was not always allocated evenly across behavioral health and SUD services. These service users described a perception that more clinic resources, particularly funding, were directed to SUD-specific services, while behavioral health services received comparatively less investment and/or attention. This opinion was understood by other service users who attended the same focus group and received SUD services. This concern was identified in a single focus group attended by service users who did and did not access SUD-specific services; this diversity of perspectives facilitated an organic discussion that did not occur at other CCBHC sites. These concerns cannot be generalized across all CCBHCs and warrant further exploration.

> *It just feels like the dual diagnosis side gets better treatment. That's what it feels like. They had better care, better services, more options available to them, better counselors.* (Service User 11)

Well, I know we have said multiple times over the years that we feel like most of the resources go into the dual-diagnosis. (Service User 12)

Family-Centered Care

The majority of service users reported that they had little to no family involvement in their care through the CCBHC. Most indicated they felt that their CCBHC would be respectful of their decision to include family in their care plan in the future but that doing so was not a priority at this time and was a matter of personal choice. For those service users who did report family involvement in their care, they felt that the CCBHC and their care team were respectful of their decision to involve family members and took steps to see that they were included in keeping with the wishes of the service user. No service users indicated that a lack of family involvement in their care was due to actions of their CCBHC, but rather that their lack of family involvement was a personal choice. A few service users described their CCBHC as suggesting that they involve family members in their care; this suggestion was approached in a way that was respectful of the wishes of the service user.

In discussing whether CCBHC services were family-centered, participants were asked whether the CCBHC respected the beliefs, cultures, and traditions of each service user's family. Very few service users elaborated on this aspect of family-centered care, aside from expressing that they did not have the need for family-centered care in that way.

My care is not super family centered, but that is by my choice as a lot of the reasoning behind why I sought therapy was to deal with familial issues. (Service User 28)

The SUD treatment I was in connected to [the CCBHC] has an amazing treatment that focused on my son and I coming together again, and the support I needed to be a full-time parent again. I am incredibly grateful for [the program]. (Service User 34)

There are only two days that I do not have my child with me, those are the only days that I can come in and see my team. They have been very open with working with me on that and are very understanding that I only have specific days [that I can come in for services]. (Service User 09)

There are times where, if I feel that I am in an agitated or trauma state, I've had my wife come into my counseling session. My counselor approves. At those times I feel like I might be in such a state that I may not even remember to inform my counselor of details or actions or reactions that I have had because I'm so agitated. Sometimes when I'm post trauma it's almost like that was another me before, I don't remember what was happening or how I was acting. My wife has been able to fill in the gaps. The ability to do family work with her involved has always been approved, always been accepted. It was not necessarily encouraged, but I would say it was not dis-encouraged. It was more like, "If it would be helpful." So not forced, but very natural and it was up to me. (Service User 23)

We [myself and my wife who also receives CCBHC services] have had family counseling together. Not as family counseling, but with her counselor and my counselor all meeting at the same time. We asked, "Can we meet up together?" And they said yes, so we tried that. They're open to it if you're open to it. I don't think they would deny us treatment if we wanted to have that kind of treatment moving forward. They've always respected our beliefs. (Service User 12)

One service user described a desire to have their partner involved in their care; however, this was complicated by their involvement in SUD recovery treatment and their partner's ongoing drug use. While this was a single perspective that did not arise as a theme among other service users, it was presented as an important issue that placed strain on the service user and presented a potential challenge to their sobriety after completing the treatment program.

> *I have a partner who is not my husband, but we've lived together for many, many years. He is also a heroin addict. He suffers still, and it's very, very, very hard because he has past dealings with [CCBHC], and they look at him a certain way. I try to get him help and they flat-out deny him, or they'll like take him once. There are different rules for me and him, even though we're very much the same. I wonder why they care so much about me, but they don't care about him. It's frustrating and it's hard and it's sad. It's sad because I really, really want him to be able to get the help that he needs, and he is stonewalled because of his past dealings [with the clinic] and who he is. I don't think that they take that into consideration at all, and I know that sometimes they'll help him more because of me, because I'm so adamant about it. I advocate for him a lot. He's my family, he's my person, and I love him very, very much. Even though I can't love him actively right now because I have to do my thing for me, he's right there at the door trying to do it, but no one will answer the door for him.* (Service User 14)

Community Needs, Gaps in CCBHC Services and Service User Recommendations

Service users were asked whether they considered their CCBHC to be responsive to community needs, including whether the clinic was inclusive of all community members, offered culturally responsive services, and generally made efforts to reduce barriers to care. Service users generally expressed satisfaction with how their CCBHC responded to community needs, with some noting that there had been changes in how the CCBHC had met community needs over time, and others noting areas for continued improvement.

> *This clinic is responsive to community needs. I came to the clinic because of community partners that trust [CCBHC] and helped me connect with services in the midst of a mental health crisis. The community partners and [CCBHC] staff were kind and helpful during my weakest moments.* (Service User 32)

> *They respect pronouns and they respect identity as far as I've inquired. I've had several of the [CCBHC] employees ask me, "How do you like to be addressed?" Well, I am he/him, but I have they/them and zee/zed, and I have those people who identify non-binary and others, so I see they're trying. It's all new, but they're trying. From my perspective that is a higher level that they at least are trying to understand.* (Service User 05)

> *The counseling staff here has become a lot more open and diverse and accepting, so they help as much as they can. In the past it was tolerated [to be a member of the LGBTQ+ community], now it's accepted. To me this feels like a safe space.* (Service User 24)

Most service users felt their CCBHC met their needs; they also identified some potential gaps where services could be added or expanded or where changes could be considered in order to improve access

to CCBHC services to reach more community members. Service users suggested that some gaps may be resolved by additional education regarding available services and/or resources, others may require additional or strengthened partnerships with community-based organizations, and others may require systemic changes within Oregon's broader behavioral health system.

> *There is a very high need for mental health service for those individuals who are homeless. Seeing those patients when they come in is critical as many do not have phones to be called back on when scheduling appointments, nor the transportation to get to the clinic. It would be great to have those individuals seen the same day and to provide wraparound services and peer support to assist them.* (Service User 31)

> *Culturally, I'm half Native American, so I've never really been asked about that… I know there have been treatment services off and on at the reservation here, but I've never really seen them coordinate with the Rez… I do not think that they would be receptive [if I wanted more culturally specific programs].* (Service User 13)

Service users in several focus groups discussed either the presence or absence of community-focused spaces where they could gather for peer support and/or other services. While some service users were aware of drop-in spaces for community members, others did not have knowledge of whether this type of offering was available or did not believe that their CCBHC offered such a space. Service user comments indicated that those who used drop-in community spaces found them to be invaluable resources, while those who did not would have liked to access such spaces.

> *If it wasn't for [the drop-in center], I'd be home-bound, I'd be stuck in the house. I don't get out. Even when I do have a chance to get out … If it wasn't for that, I wouldn't be able to get out. I was able to get out. I just won't go out…I'd stay in the house 24/7.* (Service User 01)

> *Or a drop in area [would be nice to have]. If you need a community not to be by yourself, you know, drop in at one of these locations, where you can just go and just be.* (Service User 05)

Transportation challenges were noted by many service users, although urban-located service users described a unique perspective given their proximity to multiple clinic locations. Some urban-located service users noted that there were varying transportation options available but their CCBHC did not always recommend the option most convenient to the service user. For these service users, it may be helpful to provide education and resources regarding all available transportation support services, and to work with each service user to determine what best meets their needs. For CCBHCs operating in more than one location, particularly those clinics located in urban areas, a few service users described that their ability to access services could be limited by service location. These service users explained that care could be made more accessible if they were able to select their service location based on personal preference and/or convenience to public transit, rather than proximity to their address of residence or placement by the CCBHC without consideration of these factors. Of the service users who received services from a CCBHC with more than one location, one described the clinic as already accommodating such requests, while another from a different CCBHC explained that, while their service location was closer to their residence, that particular location was more difficult to access via public transit and their reliance on a mobility aid made travel inconvenient on certain bus routes.

> *Technically, I probably should receive services from [another clinic location], but with how much I really need and depended on this location they have worked around that schedule. Overall, they've been awesome.* (Service User 08)

> *That location is really hard to get to. I take the bus there, if one bus doesn't show up, I have to [make another plan]. They used to have a bus stop right there but they took that bus stop out. It's really frustrating.* (Service User 07)

> *I was amazed [coming to this location], the bus dropped me off at the front door. This is perfect. I'd be coming to the clinic every time I had an appointment, because it's a reason to get out of the facility where I live. Maybe that's something that could be brought up, if it would be easier for someone has mobility issues or transportation issues to cross over between locations, even though it may be a little farther. I know a lot of people for whom accessibility is very important because it gives us our independence.* (Service User 05)

> *But the transportation, there is no taxi service in [location]. There's no place to go if you need to get to a doctor appointment today or something. Transportation is a real issue for people here.* (Service User 03)

Workforce issues were identified as a barrier during nearly all of the focus group conversations. As described in the discussion of timely and accessible care above, CCBHC employee turnover and high caseloads among service providers affected the timeliness of care for many service users. Staff departures resulted in changes to care teams that could be challenging for service users who struggled to build trust and develop rapport with their counselors. Some service users were frustrated by being told that their needs could not be met due to the clinic being too busy or having limited staff.

> *That was one of my concerns of moving counselors, I knew that if I started with new counselor, it's back to square one. When you make progress, you don't want to go back. One of the things the state really needs to look at is to entice new people into the field, because there is a scary shortage in this field of counselors and support people for these centers. And I know counselors probably have between 150 and 160, because I know my social service person has that. I have yet to see them.* (Service User 05)

> *I appreciate that the remaining staff are compassionate, that they're still there. Others who left have said, "This is too much for me. I have to get out of this. I just can't stay. It's not fair to me. It's not fair to you. It's not fair to the company, but I have to go." I'm just wondering, now what? Yeah, I'm making a lot of progress but now you're gone. Now I'm about to start all over again.* (Service User 07)

Despite the fact that the CCBHC model serves community members regardless of their ability to pay or their insurance status, when asked what might be potential barriers to community members in seeking care, service users at many of the focus groups noted financial constraints and inability to pay as a barrier to community members seeking care.

> *People still cannot afford mental health therapy. Even people who have private insurance, others think, "Oh, you have private insurance, it's a hundred percent covered." But it's not. Because you*

still have to pay every month, then you have to pay a deductible and then a percentage. It's crazy because people can't afford the care that they need, that's a huge block for people getting the help that they need. (Service User 22)

Meaning of the CCBHC to Service Users

A common sentiment expressed among service users was a feeling of gratitude for the services provided by the CCBHC and for the ongoing support that they received through CCBHC services and their care team. Even among service users who expressed frustration with regard to certain aspects of their care (such as scheduling appointments or staff turnover), the most frequent sentiment was that treatment through the CCBHC had made a positive impact on their lives. Many service users indicated that continuing their relationship with the CCBHC was important and the care that they received was high in quality, if not exemplary. Some service users described their CCBHC as a safe space for them to go where they felt accepted and cared for as a whole person.

I've been in behavioral health since I've been about 17 years old and I lived in [former state]. You think, oh, she probably had it made. Well, the mental health up here in Oregon is a lot better. The [CCBHC] and the [services] and all the clinics and all the things that help, I give them a four star rating or so. They're good, they care. That's why they're good, because they care about you. When I was there, they had some pretty good units, pretty good facilities, but the people there weren't caring, loving and caring like [CCBHC] is. (Service User 19)

I've been in counseling for most of my life, and I know [CCBHC] is the best one yet to be able to help me and not just focus on certain things. I mean, we focus on it, but there have been a lot of things that didn't get worked on throughout my life and finally got me on the right track with [CCBHC]. They're doing something right. (Service User 20)

It has been more than adequate for me, this is the first place that I will reach out to, even over my primary care physician. I feel like [clinic] has a pretty good thumb on what's going on in the community and what things are available to mentally ill people. It's just been a lifesaver for me. (Service User 03)

I like how it's been helping me. I'm better understanding myself now and how it's helped me significantly. My anxiety used to be so crippling and now, I'm able to go out in public. There are no words for it, because when you've had crippling anxiety, it's almost like freeing when you're able to go out and apply the tools that you learned. It's like, whoa. And I don't feel as embarrassed anymore when I go out in public. But these therapists give you the tools, and it's amazing how they worked here with me and enabled me to have that and helped me to see the connection between all the things. Now I'm able to peel back the layers and start conquering my issues now. I'm able to start doing the things to make my life better. I'm just thankful for the process that they're now implementing because the little patient input thing at the end where we're like, "What did we learn from this? What did we want to learn?" That little document collaboration or whatever they call it, that thing at the end really helps out because it makes me stop to think about when I'm going into my therapy now, what did I learn? How can I apply this now throughout my week, so that now I'm taking the feedback that I've gotten for my own self and then my therapist, how can I apply that better in my life? I'm so thankful for how [clinic] has

> *really changed within the two years that I've been here. They actually, in my opinion, have bettered themselves and better the way that they're doing things.* (Service User 22)

> *I want to say that I am in a really good place right now, and it is because of this facility that I am in a good place. I don't want to say that everything is bad, and we could always focus on, but it's dialectic. It's both; it's an awesome program and they could be better.* (Service User 14)

> *They helped me get into my apartment where I'm at now and helped me get on housing. If it wasn't for them, I would be homeless.* (Service User 21)

Integration and Coordination of Care

The experience of care coordination varied across CCBHCs and among service users. Many service users described care coordination as playing an important role in their mental and physical care, while for others it was a less prominent aspect of their case. Some service users appreciated care coordination and the communication that took place among members of their care team. For the service users who were aware of ongoing care coordination activities, most were appreciative of the ease with which the members of their care team communicated with one another, particularly with regard to scheduling appointments across providers and monitoring medication plans. Service users generally spoke highly of the level of care coordination that they received through their respective CCBHC and noted that it helped them to progress in their treatment in a way that they did not otherwise feel would be possible.

> *Everybody is in the loop. If any medication changes happen, the next place I go after my doctor's office is here.* (Service User 21)

> *My team consistently helps me problem solve and find solutions or resources when I am in need of other health services. My therapist has given me a few suggestions that have helped guide my PCP to helpful solutions to ongoing issues.* (Service User 32)

> *There is some coordination between therapists and other workers, but I don't feel like coordinated is the right term. There is some mild collaboration, but it is far from a wraparound style treatment service.* (Service User 30)

Some service users spoke of care coordination in the sense of connection between the CCBHC and their primary care provider and any specialists involved in their treatment, while for others care coordination included coordination with social services. Many service users described care coordination as going beyond simply connecting behavioral and physical health services, including coordination with social services, law enforcement, and other services as needed to support each case. Regardless of the degree of care coordination that occurred or the importance that service users placed upon their care coordination, almost all described some degree of coordination through the CCBHC. Few service users were unaware as to whether any care coordination occurred. A few service users described a complete lack of care coordination through their CCBHC which may have been more related to location resources. It could not be confirmed during the focus groups whether care coordination was truly absent for these select service users, as others from the same CCBHC described care coordination as occurring and noted regional challenges in securing primary care services more broadly.

> *At one point, I was in jail…and I contacted the drug and alcohol program here. They facilitated getting me back and putting me in their program, and I'm sure that was probably a paperwork nightmare and all kinds of things. Now that I think about it, there has been quite a bit of coordination and they've done pretty good at it.* (Service User 13)

> *It was my introduction to integrated care was [CCBHC]. That was the first time I've ever had anybody that would help me organize all of my care. It wasn't just the physical care at [clinic]. They helped me organize dental care, get dermatology appointments. They helped organize everything with the VA and get me into care and the community services.* (Service User 26)

> *I have a case manager that gets right on top of things. I call her, I ask a question, and boom, I get the answer. By coordinating my mental healthcare, they have their psychiatrists there, they have the people who do medications there. I know one of the nurses, if something happens, she'll come to the house and take care of it.* (Service User 19)

Integration of services varied by CCBHC. Some CCBHCs offered comprehensive integration of services, including in-house pharmacy, primary, and dental care, while others offered integration to a lesser degree. Some service users who reported receiving healthcare through the CCBHC described feeling comfortable receiving medical care through the CCBHC because their behavioral health needs were at the center of their care. Some service users reported having had integrated primary care at one point but losing that service due to internal issues within the CCBHC. Even when service integration was available, some service users preferred to receive non-behavioral healthcare services outside of the CCBHC for personal reasons, such as a history with a medical provider.

> *I have a doctor and a psychiatrist and a pharmacy there. That's where I get my prescriptions and that's where I see my counselor. All my support team is at the same facility.* (Service User 10)

> *This is the first mental health facility that I've been able to access other than the VA, and there is no comparison between the capabilities of this clinic and the VA. The only reason that I even access care here is because they are integrated with [medical clinic] and they actually had a mental health person in with physical health. During a physical they determined that it wasn't physical issues that I was having, it was my mental health. They were able to get me in with a mental health person right then, and now that [the medical and CCBHC] are in the same building, it's perfect.* (Service User 26)

> *It's safe [at this clinic], because of their integration with the primary care facility. The approach to mental health here is very holistic. It's not just, "we're treating this," it's looking at the entire picture. And there's so many different people with so many different ideas. And there's things where I've had those little epiphanies where somebody said something, "I've never thought about that." Whether it's my doctor or my therapist or my psychiatrist.* (Service User 25)

Appendix 5: Extended Report of Feedback from CCBHC Clinic Administrators and Clinical Leaders

The extended report of feedback from CCBHC clinic leaders provides a summary of the themes that emerged from interviews. Data collection methods and analysis are described in detail in Appendix 3.

Clinic Leaders

The evaluation team interviewed one clinical administrator and one clinical leader at each CCBHC for a total of 24 interviews. In some cases, these individuals brought an extra staff person with them to the interview to provide additional information.

Limitations of Data

These findings are limited only to the clinic leaders. The evaluation team did not interview other clinic staff. It is possible that other clinic staff may have different perceptions of the benefits and challenges of the CCBHC program and critical factors for sustainability. In addition, the clinic leader interviews were retrospective. Several years had passed since the implementation of the CCBHC program at each clinic. In some cases, due to turnover, clinic leaders interviewed were not the clinic leaders at the time the clinic became a CCBHC, resulting in gaps in knowledge; in other cases, it is possible that clinic leaders did not remember all relevant details. Finally, there is also the potential that the OHA compliance visits, scheduled during the same time period as the evaluation interviews were programmed, may have had an impact on how clinic leaders responded to the interview questions.

Future evaluations could consider including clinic staff such as peers, care coordinators, care navigators, primary care providers, qualified mental health associates, qualified mental health professionals, and other behavioral health providers, to gain a fuller understanding of CCBHC program and services. These individuals may have a unique contribution to make about the daily operations of the clinic, as well as the challenges and opportunities in expanding and sustaining the CCBHC program.

Findings

Three primary themes emerged from the interviews with clinic leaders: benefits of the CCBHC program; cultural competence; and implementation and sustainability. Subthemes are discussed for each.

Benefits of the CCBHC Program

Clinic leaders reported many positive changes that have occurred as a result of the CCBHC program, including the ability to increase “outside the four walls” service delivery, more robust care coordination, expansion of staff and diversity of staff roles, shifts in organizational culture, and stronger community partnerships. These changes were largely attributed to the prospective payment system (PPS) model, which has enabled CCBHCs to be more flexible and financially stable in their operations

“Outside the Four Walls” Service Delivery

Many clinic leaders reported that the CCBHC program provided an ability to move services “outside the four walls” and thus increase access by providing low-barrier services at diverse, non-clinic settings (such as schools, jail, DHS, or community centers). Clinic leaders highlighted that moving care outside the clinic

and into the community was helpful in engaging populations who were reluctant or unable to come to the clinic due to distrust of medical systems, transportation barriers, or stigma associated with accessing behavioral health services.

> *We do more outreach. We've always been a community-based provider and have always gone beyond the four walls [service delivery].* (Lead Administrator 13)

> *We've also tried to do as much as we can outside the four walls of our clinic. The PPS rate allows us to do that, be a little bit more liberal with respect to our community-based staff, and certainly ensure that we have more of those staff working out in the community where they can.* (Lead Administrator 12)

> *We try not to make people come into our four walls if that's not where they're comfortable. Pre-COVID, we actually paid [for] private offices in the community through the CCBHC, where people could still see our staff, but be in a private office. They didn't have to come into the mental health clinic. We could see them somewhere else because that's hard for people, especially working folks, they don't want to be seen…the stigma is still there.* (Lead Clinical 08)

Care Coordination

Clinic leaders reported that because care coordination is an integral component of the CCBHC model, it led to more robust care coordination. Some clinics built care coordination meetings into clinic processes in order to coordinate care with both internal and external primary care providers as well as with hospitals. Several clinics reported hiring care navigators and care coordinators to specifically assist with ensuring that service users received more coordinated care.

> *I think that that's one of the core pieces is the care coordination because that doesn't exist in community mental health programs. Or at least there's not really a funding source to cover that expense. The fact that the CCBHC is funded the way it is through the PPS model that allows us to have those additional ancillary things that make a difference for the client that help them progress in services. And it's all part of them getting well versus a contract that says well, no, this is what they get for that. It's different.* (Lead Administrator 04)

> *We really intentionally redid how we delivered service. We have multidisciplinary team-based huddles every day where we have all the different clinic programs in a huddle together, going through who was in the ED [emergency department] that night, who's inpatient that day, who's at risk, where do we need to do a warm handoff, who's fallen through the cracks.* (Lead Administrator 13)

> *I think that one of the biggest benefits CCBHC has really give us the opportunity to do more integration across our own CCBHC programs, as well as with primary care and physical health and create roles and opportunities and structures. We have what we call site-based huddles. Everybody sits down from more interservice referrals and coordination. I think that is one of the big benefits I think we derived from CCBHC.* (Lead Clinical 09)

Expansion of Staff and Diversity of Staff Roles

CCBHCs hired additional staff and diversified staff roles. Specifically, many clinic leaders reported that they substantially increased their peer workforce and added more qualified mental health professionals (QMHP) and qualified mental health associates (QMHA). The quantity and types of staff hired varied across CCBHC sites, and included peers, QMHAs (bachelor's level), QMHPs (licensed medical practitioners), care coordinators, care navigators, case managers, data analysts, registered nurses, nurse practitioners, community health workers, medical assistants, and primary care physicians.

> *[The CCHBC] changed our workforce. We added nurses, we added care coordinators, QMHAs, and peer support specialists significantly. So, really to round out treatment teams to make sure they were multidisciplinary, able to do team-based, complex community-based care.* (Lead Administrator 09)

> *The addition of MAs, we call them our integrated care team, so medical assistance, LPNs. So medical professionals, that'd be again one of those snapshot qualitative differences you would see. Then they're also engaged in the assessment process. So you would see your drug and alcohol counselor, but prior to, you'd see one of our MAs who would take your blood pressure and your height and weight and ask you about chronic health conditions. Peers. Yep. Peers and then our data. We had a data analyst that came on board to help us wrangle the information out of our EHR.* (Lead Administrator 07)

> *We added peer support QMHAs more, and I think it really helped people work at the top of their licensure. I think it can really help with being able to, as you know, right now in behavioral health, the workforce is few and far between, and being able to have people work at the top of their licensure is really important. Being able to have more appropriate services and a lot of times, peer support is going to be a much more effective intervention than seeing a psychologist… We've also been able to with our CCBHC…hire an application assister, and we actually have certified medical interpreters. So we're able to take care of a more diverse population.* (Lead Administrator 08)

Shifts in Organizational Culture

According to clinic leaders, the CCBHC model facilitated a shift in organizational culture. This cultural shift was necessary in order to design and deliver services in new ways to increase access and engage more service users. Clinic leaders noted the importance of managing change, highlighting the need for staff buy-in, the importance of explaining the "why and how" of the changes, and the need to focus on long-term goals and outcomes of the program.

> *In addition to just meeting requirements, this really required a full-scale culture change at our agency…working on not just the what we're going to do, but the why and the how, and then helping to try to connect that to long-term outcomes that you're not going to see in the first year or two or five or seven. I think that's one of the hardest things with CCBHC is we don't necessarily see the outcomes in a tangible way right now.* (Lead Clinical 07)

> *Culturally, there was a shift from, "Treat the clients who are compliant and show up for appointments" to "Figure out how to reach the clients who don't, because they're actually the*

ones showing up in the ED, jail, and in the homeless camp that we should be trying to reach." So, shifting our service models to more of an engagement model. And we're not there yet. I mean, we're farther along, but we work on that every year, every month. Like, "Don't tell me about an attendance contract. Tell me what creative things you're doing to engage this person." (Lead Administrator 09)

In all honesty, there's a broader culture of getting people what they need because they need it, as opposed to, how are we going to pay for this? Or we don't have the money for that. Serving more people and getting them the services that they need. And the care coordination and the transition planning and the follow-up and the warm handoffs, all the stuff that CCBHC is big on, all of which a lot of times are not funded services. (Lead Administrator 10)

Strengthened Community Partnerships

While clinic leaders reported having a network of community partners prior to CCBHC implementation, they also indicated that the CCBHC pushed them to prioritize and improve their community partnerships. CCBHCs established relationships with a variety of community partners, including primary care partners, coordinated care organizations (CCO), public health, emergency departments, other health care providers, K-12 schools, law enforcement, shelters, social service organizations, and other community-based organizations. Clinic leaders were aware of the importance of building trusting relationships with community partners.

We're even better now in figuring out how we can be a catalyst with our community partners to weave in mental health. We have a really good relationship with our police department. We have a staff member now that's assigned to the police department. We participate in crisis negotiation teams… CCBHC really is the catalyst to help us, makes us go out and say, "Hey, let's get these community relationships, and try to get clients in that maybe wouldn't come into our doors." (Lead Clinical 08)

We try to do as much as we can with respect to local partnerships. I think that's one of the ways in which we have access to those groups who may not necessarily be walking through our door… I think those organizations and those partnerships are key really to increasing our collaboration and ensuring that we're pulled in as needs arise. (Lead Administrator 12)

We also have a really good relationship with law enforcement, parole and probation, and they know where we are and who we are. Also, our office is located right next to the food bank and so very easy access there. Then also the juvenile department and the veteran's office is right across the parking lot. There's a lot of easy handoffs in that respect. Let's see…we do serve the jail as well and trying to help the jail out, especially with people who become suicidal or want some behavioral health supports… We also have weekly meetings with child welfare. We also have [CBO name], which is a domestic violence shelter that we have meetings with, I believe monthly… We also have a school-based health center in [XXX High]. And so we have mental health staff staffed in there as well…we kind of have our finger on the pulse in a lot of different areas of the community. (Lead Clinical 01)

We realize that we're more effective if we're in strong relationships with all of those community partners. (Lead Clinical 10)

> *When we do the listening sessions or when we invite advocates, we [try to] create a safe environment where we don't use too much jargon and acronyms or explain what they are if we're going to use them, where we don't quickly dismiss or explain how that's not the way it's supposed to be, or that shouldn't happen or that's not actually the way we do things, but to sit with the possibility that sometimes the way we've organized things or the top-down working is not the way it actually works in the community or in those private appointments or whatever. And so being open to that sort of when it's critical and constructive feedback, I think facilitates trust like, "Oh, they listen to me. They actually care."* (Lead Clinical 02)

Cultural Competence

Clinic leaders recognized the importance of cultural competence in behavioral health and reported their strategies and efforts to design and implement culturally and linguistically responsive outreach and services and ensure CCBHC staff were trained in cultural competence and trauma-informed care. Across the CCBHCs, several clinic leaders recognized room for growth and indicated that improving the cultural competence of the outreach and services was a priority area for improvement.

Culturally and Linguistically Responsive Outreach and Services

Clinic leaders reported a variety of strategies to implement culturally and linguistically responsive outreach and services, including evaluating clinic documents/websites for appropriateness for underserved populations, providing documents in Spanish as well as English, co-locating staff with community partners to facilitate access to services, diversifying board members, hosting community events or community listening sessions, and marketing/advertising to specific communities. Many clinic leaders reported more work was needed to provide culturally and linguistically responsive services.

> *I think that giving holistic care and culturally competent care will…hopefully, minimize that inequity. That is an area [with] room for improvement…most of our services are "come on in to us" and we don't go and expand and try to reach out to folks…we're working on different ways of outreach at this point, and building relationships…trying to have people located in different spots to capture underserved individuals or people who don't typically access these supports on their own"* (Lead Clinical 11)

> *"I think [providing culturally relevant services] is maybe a place where we could do better, where we have the box checked. But we're not fully meeting the spirit of CCBHC in the kind of really identifying resources for clients."* (Lead Administrator 06)

> *Equity of access in language services is still a huge need…we meet the bare minimum with interpretation. We've struggled with that even just on the hiring, how much incentive can we give for bilingual-bicultural staff? Because they often end up with equal or higher workloads too.* (Lead Clinical 02)

Cultural Competence and Trauma-Informed Training

Several clinic leaders reported that the CCBHC enabled them to invest in staff training. All recognized the importance of training on cultural competence and trauma-informed care, but how they ensured their staff got that training varied. CCBHC staff received trainings as part of onboarding at the CCBHC, through clinic workshops, via clinic learning management systems, or by participating in trainings sponsored or

hosted by community partners. Some clinic leaders expressed anxiety or uncertainty about how to select the right training. A few clinic leaders reported they faced resistance to some of their efforts to implement cultural competence training from both within and outside the clinic.

> *We have a really strong [Equity, Diversity, Inclusion] EDI department that is also very much connected within the community and cultural resources, and organizations that respond to culturally kind of specific needs of the community. I think that is probably maybe our greatest asset. We have so many trainings, many of them are optional. Some of them are not from our clinic, but come from within the community. Then we also have a staff training and development department that kind of works closely with both our equity, diversity and inclusion department, as well as the quality department.* (Lead Administrator 06)

> *Trauma informed [care] is a big deal. So again, you can do tons of trainings on that, right? But does it really guide your treatment? What we look at is we do an adverse childhood events trauma scale on every admission. We know from the beginning what their trauma scores are. Then when we do their assessment, we can look at that score, and it's also a part in your diagnosis as well, because you can see, for PTSD, obviously, but even in other behavioral health issues, trauma's a huge factor. We know that, and we train our clinicians on how to do the ACEs. What's the importance of those scores? When you look at treatment planning, how does that allow you to do treatment planning that's... I don't know, is it client appropriate, client-centered around their trauma experiences.* (Lead Administrator 01)

> *They receive [training in] cultural competency. It's not a good one. I mean, it's checking a box. We need a whole process here. But they at least get exposed to the concepts… We did a decent job with trauma-informed care. We had some good early cultural competency training. And then, all those staff are gone. We really need to do another one. The language has changed and the social backdrop has changed. I would like to launch another training and I'm having some angst about it because I think the conversation about cultural competency, and diversity, and equity has become more fraught, and more polarizing. Remember that I work in [rural Oregon] ... Our workforce is overwhelmingly liberal, and wants to think of themselves as DEI-informed, but they're overwhelmingly white*. (Lead Administrator 09)

> *We also had a very public debate a couple of years ago about requiring mandated training for all of our staff on cultural diversity training. Half of us have [continuing education units] CEU requirements to do it anyway. We did a mandatory training and it became a political issue debated by our board and concerns about what the content was going to be and wanting to have an outline of the presentation and all of that because it's a political hot-button issue. So there's been things like that as well, where even the things that we might want to do as an organization are questioned or challenged.* (Lead Clinical 02)

Implementation and Sustainability

Clinic leaders reported barriers and challenges during the implementation of the CCBHC model. Key findings relate to funding, equity, workforce, community partnerships, administrative burden, metrics, data infrastructure, the Oregon CCBHC primary care requirement, and resources and support, all of which are important to support expansion and sustainability of the CCBHC program.

Funding

Clinic leaders stressed that adequate funding is critical; they noted the importance of predictable and sustainable funding. In addition, several clinic leaders expressed concerns about the stability of the CCBHC program and what that would mean for their clinics, given the magnitude of the commitment involved in becoming a CCBHC.

> *It takes so much time and energy to start a program, whether you're hiring, training…if there were some kind of a guarantee that there was going to be some funding throughout, maybe beyond 5 or 10 years, that would create sustainability*. (Lead Clinical 01)

> *We had the initial expansion grant, always knowing that it could go away in three years. And then it did go away after three years. Everything that went into building it up and then having to dismantle it, that was pretty traumatic for everybody… You end up feeling like you're taking a lot of risks, if there's not that certainty or stability*. (Lead Administrator 08)

> *CCBHC was sort of a focus of stability. Yeah, that PPS rate was huge for us. Again, we didn't go on a huge spree of capital expenses and we did some and staffing. I think we had a conservative and I think which was prudent at the time to not just we're going to hire 25 new staff and look at all this. We're going to be you know. It's interesting. I mean, our needs assessment really showed that maybe we do need to grow.* (Lead Administrator 07)

The PPS was seen as the critical element that enabled clinics to expand access to integrated behavioral healthcare. Without reliable funding that enables clinics to maintain their staff, coordinate care, and provide services in non-clinic settings, several clinic leaders suggested it would be nearly impossible to meet CCBHC program objectives.

> *The payment model is the bottom line. It allows a CCBHC to serve people holistically.* (Lead Clinical 12)

> *In full disclosure, [CCBHC name] would be in huge financial trouble if we didn't have the CCBHC PPS payment… It's bringing parity to behavioral health in a way like FQHCs. So FQHCs are there to be the safety net clinic for medical services for the indigent and underinsured. Community mental health centers are as well, they've never been paid that way. While it allowed us to offer more services in a more targeted way around integration by bringing healthcare coordinators, primary care, and other services in, it stabilized the organization in a way that we've never had before … that PPS is just unbelievably instrumental to the survival of community mental health centers, and long overdue because FQHCs have been in this model for a very long time*. (Lead Administrator 13)

Equity

Clinic leaders reported that CCBHCs have a critical role in addressing health inequities, but they must be well funded, trained, and supported by the state in order to do this effectively. One respondent cautioned that the CCBHC model could be done without any focus on equity, highlighting the importance of communicating the importance of centering equity in CCBHCs. Clinic administrators and clinical leaders indicated guidance and technical assistance would help CCBHCs center equity in their

work, implement culturally and linguistically responsive outreach and services, and measure progress towards the goal of eliminating health inequities.

> *I think CCBHCs, by their very nature, the fact that we are open to everyone makes us best suited to eliminate health disparities. But we probably need help in identifying strategies for how to do that because not every CCBHC has that experience. We've got a spot in our org chart for a health equity manager, but even when we fill that position, it's really going to be a while before we're running with that and really making a difference. So the state could bring resources to bear to help us understand how to best do that.* (Lead Administrator 04)

> *Well, definitely having primary care on board [helps address health inequities]. And pushing the notion of health equity, and what that actually means. I think CCBHC all by itself, you could do it and not do anything about diversity or equity. I think, because of its structure…the expectations around, outside the four walls work and those kinds of things, to get at populations who are often underserved, I think helps with that.* (Lead Clinical 03)

> *By definition, we're serving low income people. We're disproportionately serving people of color, people of other groups who are underserved and basically have additional barriers to accessing services. I think we have flexibility and we have relationships, both with clients and other community stakeholders, to be responsive and to adapt and adjust our services to meet the needs.* (Lead Clinical 09)

> *I think they should be responsible…for having those equity programs, and making sure that they can accommodate all the different cultures and the needs that come into the building… If we can't provide something, we should at least have resources to be able to reach out, to help people. I do think CCBHCs are going to be paramount in that, because you can give us measures that says, "You will do this," and we'll have to do it.* (Lead Clinical 08)

Workforce

Most clinic leaders reported the broader behavioral health workforce shortage is one the most significant barriers they face in terms of expanding and maintaining capacity. Clinics leaders described struggling to recruit and retain staff, especially master's level clinicians, and particularly in, but not limited to, rural communities. While many clinic leaders reported that PPS payments enabled them to expand their staff, PPS did not eliminate recruitment and retention challenges. Clinic leaders largely attributed this challenge to lower pay compared to private practice and a high level of burnout.

> *It's dependent on staffing. We're just struggling. We have some programs that are at 30, 40% staffed.* (Lead Clinical 03)

> *There are a lot of opportunities for additional funding coming out from OHA, which is exceptional. It's also terrible timing because most of what we want to do with funding is hire staff to expand capacity. We are faced with opportunities for increased funding, and it just adds more vacancies. We're not often able to fill those positions. The sustainability of [the CCBHC] is in part tied to the workforce and whether or not there is a rate or amount that allows us to be more competitive in the recruitment of people.* (Lead Clinical 02)

> *At some point, we're going to have to figure out a way to deal with the capacity problems because there's not enough workforce.* (Lead Administrator 04)

> *There's not a lot of professionals…it's really hard to recruit, especially to get a master's level. And then, once you get somebody there, if they come from [elsewhere], they don't stay long.* (Lead Clinical 01)

> *We're in dire need of greater stratification in the pay ranges across our workforce. [There is a need] to think differently about incentivizing additional certifications and qualifications. That would help in terms of the draw of staying in what is…really a high acuity, really stressful, intensive work.* (Lead Administrator 12)

Many clinic leaders also recognized the need to diversify their staff to better reflect the communities they serve but noted the challenges of doing so, given Oregon's broader behavioral workforce shortage; this was particularly challenging in rural communities. One creative strategy reported by some clinics included covering the cost or a portion of the cost for current staff from underrepresented communities to receive additional training and credentials. Some clinic leaders noted that upstream solutions, such as targeting educational institutions, are needed to address this issue.

> *A big area of focus in our community is transgender youth and adults, and really trying to make sure that we have programs that specifically address their needs, and also really thinking about BIPOC community, and making sure that we have staff that are representative from the BIPOC community, and really focus on issues of racial trauma as part of their work. I think where we still have more work to do is a Spanish-speaking community, and we have bilingual staff, but I think we could do more work in terms of being culturally specific, and it's a large enough part of the community here, that's probably an area that we need to continue to focus on too.* (Lead Administrator 08)

> *I'm careful about saying this, because what I don't want to have is this underclass of staff who are in lower paid positions and represent our diversity. But it has been a way for us to bring people in who are not traditionally trained. And, at least get a foot in the door and we've developed ways we're trying to bring them further into the profession. We pay tuition reimbursement, we pay CADC stipends, and we pay a peer the same stipend we pay a master's level clinician if they have a CADC. We do things to try to really value that workforce and encourage them to get higher education.* (Lead Administrator 09)

> *Language is a barrier. We offer extra benefits for clinicians who can help us serve the Hispanic population. But again, when we're talking about disparities, it is not only in the access to services for these clients, but it's also the disparities in access to education so that they can get the credentials needed to be able to provide those services. When we talk about eliminating these disparities, we really also have to talk about what are we doing to eliminate the disparities in education so that we can attract a more culturally diverse population into the career field so that we can then provide the services that are going to reach that population. It's that piece. We've identified that there's a gap, we're hiring specifically to fill that need, but there's not a lot of diversity coming out of the schools of therapy and behavioral health.* (Lead Administrator 05)

Data Infrastructure

Several clinic leaders reported that their data systems are not capable of the data collection and reporting necessary for CCBHCs. Data and analytics are critical success factors of the CCBHC program. Better data systems and people who can make sense of that data were identified by clinic leaders as potential efforts to center equity, coordinate care, and engage in quality improvement.

> *Sharing data is still one of our biggest challenges. We still have lots of data gaps and have different systems that don't communicate well with each other. I think there are opportunities to have better systems that share data and also have people who can really look at the data*. (Lead Clinical 09)

> *You can have the best clinicians in the world, but you've got to have the infrastructure to do the things like data collection and have it integrated into your EHR, so people aren't doing double charting and double work with documentation*. (Lead Clinical 07)

> *Mental health records are not set up for some of this data stuff. And we've been very creative. Our actual old EHR was very old, and it was like a 20-year-old system, but we had it working as good as we could. And we just switched to a new system. Some of the built-in systems we had, didn't transfer over as well. And it's really complicated because the medical records are used to doing some of this stuff, mental health records aren't. What we really need to get is a business intelligence [BI] program to be able to analyze some of the data. Because we can get it in and we can kind of get it out, but we need to have a BI program to really make good use of it. I have spreadsheets, on spreadsheets, on spreadsheets to track some of this stuff. I have people that do nothing but spreadsheets, because it's really hard to do in our EHRs.* (Lead Clinical 08)

Community Partnerships

While many clinic leaders reported developing effective local partnerships to achieve mutually beneficial relationships with local partners (such as coordinated care organizations, county services, health systems, behavioral and physical health providers, law enforcement, K-12 education, and others), they felt strengthening collaboration with key community partners would facilitate better care coordination and improve access to behavioral health. In addition, clinic leaders indicated that diversifying their community partners may help the clinics develop a better understanding of service gaps in the community and provide an opportunity to get essential feedback and guidance on implementing culturally specific outreach and services.

> *I think the other piece is again a bit of a broken record, but is how do we build those alliances collaborations? How do we co-locate services with our veterans population? How do we co-locate with [CBO name] who actually has a pretty amazing outreach with the Native community, especially around COVID and food scarcity issues? Rather than having to trail blaze it, how do we join those entities already? I think that's probably it is how do we don't have to do it all and be it all here. We can join forces with those people that are already trying to reach out to those groups.* (Lead Administrator 07)

> *We have created and partnered with some community-based organizations. There's this [CBO name], for example, and working with them in the community and going on site to places where*

> *people work to try to engage them in different ways, and trying to find ways where we can be flexible with kind of our intake process, because again, we have these rules that dictate what we have to do to complete an assessment and to be able to then bill for services, but that, again, doesn't work... It doesn't work for a lot of people, but in particular, different cultures may really, really be guarded about coming in, and then just kind of going through a laborious interview process and not feeling like they're being heard. But I still feel like we have a lot of work to do and making sure we're continuing to do work in the community and find ways to be flexible where we can.* (Lead Clinical 05)

> *We could be a lot more effective at what we do if we had greater collaboration amongst all the payers, the contractors, and oversight sears. The CCBHC model could be really robust.* (Lead Administrator 03)

Several clinic leaders noted that their community partners were likely unaware of their CCBHC status. Elevating awareness of CCBHCs and their unique attributes, particularly the integration of primary care and the requirement to accept anyone regardless of insurance status, was a suggested strategy that could help communities better leverage the CCBHCs.

> *It's interesting because I don't know how many of our providers are really aware of how we've been doing what we do or why we do what we do. I think they just think we do all these things. I don't think that they realize. Everyone knows that we are a federally qualified health center, but I don't know that they realize that we are a certified community behavioral health center. Maybe the hospital would be aware. Those who we have an MOU with would be aware just because we have those MOUs. But if you were to call the schools, they would like, "They're what?"* (Lead Administrator 04)

> *I don't know if any of the community partners that we work with, they understand it. We're a CCBHC, but I don't know if they really understand the difference between a CCBHC and a CMHP.* (Lead Administrator 03)

Administrative Burden

Many clinic leaders noted that metrics and reporting requirements contributed to high administrative burden. Clinic leaders generally believed that relieving some of the administrative burden would be a practical step toward reducing burnout among staff. Some clinic leaders suggested that consolidating the requirements for various contracts within the state, where possible, could also help reduce the administrative burden placed on clinics.

> *My request is fewer hoops to jump through so that clinical staff can focus more on client care. That would be really valuable. I know there have to be checks and balances. However, sometimes I think it's not necessary to do as many as are required.* (Lead Clinical 04)

> *There are three major systems (CCHBC, CMHP, CCO) that are separate, all with different requirements… Aligning those funding sources better, and aligning the requirements and the metrics and the auditing and the certifications and all of that would be huge to better sustain us. Just pick the highest bar that we're going for here and go with that one. Don't have three different bars that are all at different levels*. (Lead Clinical 07)

Meaningful Metrics

Some clinic leaders questioned the suitability of the current metrics and expressed a desire for better alignment with the intended goals of the CCBHC program. Clinic leaders held varied opinions on how the metrics could be improved and acknowledged that it is difficult to develop appropriate metrics. One clinic leader expressed concern that it is hard to measure short-term outcomes of CCBHC's effects and that it is necessary to have a long-term plan to measure outcomes. Overall, clinic leaders supported rigorous data collection for evaluation but wanted to ensure metrics are meaningful and actionable and not unnecessarily burdensome.

> *So much of CCBHC isn't easily measurable.* (Lead Administrator 06)

> *I think that the CCBHC model has allowed us to collect information, reflect on that information, reflect on how we can improve care and care delivery. We're tracking that much more robustly and much more efficiently, but it's also at this point, I think helping us in the two years, since I've been here, really reflect on what we should be tracking or what would be more meaningful for us to track, to improve quality of care… I'm hoping that the primary gist of all this is to create improved quality of care. With quality, comes improved outcomes … there's some of what we're tracking. I'd really like to see [the metrics] changed. What is the purpose [of the metrics]? What is the meaning? Where is it driving our care? How am I supposed to use that information? I think that's what's never been shared with us is, "Here's this information you're collecting. This is how you should use it."* (Lead Administrator 03)

> *I know there was a big push on the data and the outcomes. We've pushed back pretty hard on what we think some of the benefits and limitations of those are. I'm not sure those are the best ways to ask those questions. I think the other challenge is that its sort of an investment in a long term, how do we ask these [questions] longitudinally over three, five, 10 years?* (Lead Administrator 07)

Primary Care Requirement

While many clinic leaders expressed appreciation for the primary care requirement, some clinic leaders reported difficulty in meeting the 20-hour-per-week primary care requirement. Several reported that integrating primary care was one of the more challenging aspects of meeting the CCBHC program criteria. Some noted that they could not ensure a patient panel to support 20 hours, while others indicated that service users preferred to establish primary care elsewhere. A few indicated that while primary care was available on-site, the infrastructure necessary to support integration of care was not in place. In addition, some clinic leaders wanted more flexibility in Oregon's primary care requirement.

> *It was 20 hours at each clinic site where you had to provide primary care. I mean, that is expensive. If you're just starting up, that's like, "Whew." I think we actually got a waiver to work with [primary care partner] on their site for primary care. They had a preexisting relationship. We actually used the opportunity. We spent most of our CCBHC money on getting our primary care up and going. It's been good for us because we are now an FQHC.* (Lead Administrator 06)

> *It took us about a year to stand that up where we're co-located with our local FQHC, but that did happen. That was a huge success. And downtown, we had already had [primary care partner]*

embedded, so that was just kind of a place we could learn from. That's continued to be a great partnership at our downtown clinic. [One location] there wasn't the demand for the 20 hours. They were really reluctant to continue to provide medical services for up to 20 hours when there wasn't enough financial incentive for them. (Lead Administrator 09)

OHA had a higher level of expectation than other CCBHCs around the country that said, you need to have at least 20 hours. We asked for a waiver, now we had already brought in one of our partners to one of our clinics…to offer primary care on site, but getting to 20 hours? We have never really achieved that. I think part of the issue is, as I said, that we have an FQHC literally down the street. Trying to tell people, make this your long-term primary care home in your episode of care with us, maybe six months, year, three months. Why? Why not just go down the street and establish primary care with someone there that really can be my long-term provider. (Lead Administrator 13)

It would be nice if that wasn't there. I mean, we did it. It would be nice if it lined up more federally, because the Feds don't require that 20 hours, that's a state thing. Then we could decide whether we still had it or not. We would probably continue, but I tell you, it costs more than it brings in. (Lead Clinical 09)

PPS and Medicaid Reimbursement Rates

Clinic leaders discussed the importance of the PPS rates for enabling them to increase access in their communities by providing services "outside the four walls," engaging more intentionally in care coordination, and expanding their staff. However, clinic leaders expressed concerns that the PPS rate had not been adjusted in recent years to keep pace with increases in the Medicaid reimbursement rates.

Rate setting [is] hugely important. You can't increase Medicaid rates and not increase the CCBHC rates, because the CCBHCs will never see it…that's a sustainability issue. (Lead Administrator 01)

There are some concerns recently about accessing PPS rates or payments, the prospective payment. Our business officer could speak on this for days, and very eloquently, and I can't, but I know there's real concern. If we can't access the PPS payment, because there's enhanced rates elsewhere, but those enhanced rates aren't covering the cost of us doing business, that's a problem. (Lead Clinical 05)

We need a recalculation of the rates. I mean, you know that the state just did this huge behavioral health fee increase. That's probably going to make it impossible for us to ever get any CCBHC revenue, maybe that's okay. Maybe all of this results in our being flush and being able to operate without an enhanced Medicaid payment. I don't think so, because even with the increases, it's a 10%, 17%, 30%, the CCBHC PPS is a three to one. It's just massive by comparison. All those increases get us up over a threshold, which means we can't draw down the enhanced rate. (Lead Administrator 10)

Resources and Support

Several clinic leaders remarked on limited OHA involvement at the beginning of the demonstration program, while expressing gratitude for recent increases in OHA communication and support. During the

CCBHC implementation, some clinic leaders shared that they would have preferred more training and technical assistance, especially with some of the administrative functions, including billing, data collection and reporting, and setting up data infrastructure to best facilitate these processes. Going forward, clinic leaders expressed hope that OHA would continue to provide more regular opportunities for Oregon's CCBHCs to convene and learn from each other. While clinic leaders spoke generally about the importance of OHA guidance and support, they identified an opportunity for OHA to specifically provide more guidance to CCBHCs on all facets of the program, including using data for quality improvement, identifying service gaps in the community, and engaging community and service users to develop and implement culturally specific outreach and services.

> *The more training we do, the more guidance is given [from OHA] … it's really valuable to make sure we're heading in the right direction.* (Lead Clinical 04)

> *I think having the technical assistance and support from the state is really important. And because there's a learning curve, I think it's important to feel like it's a supportive process, rather than a punitive process.* (Lead Administrator 08)

> *I get the most value from talking to my colleagues, the other community mental health programs, and CCBHCs.* (Lead Administrator 07)

Appendix 6: Extended Report of Feedback from Key Interested Parties and Community-Based Organizations

This extended report of feedback from key interested parties, including community-based organizations (CBO), provides a summary of the themes that emerged from interviews, focus groups, and surveys with key interested parties and CBO representatives. Data collection methods and analysis are described in detail in Appendix 3.

Key Interested Parties and CBO Representatives

Key interested parties and CBO representatives represent a range of perspectives, including school-based health centers, K-12 education, social service agencies, coordinated care organization (CCO) behavioral health directors, insurance, OHA leadership, law enforcement, advocates, Oregon legislators, hospitals, and peer recovery agencies.

Limitations of Data

The evaluation team engaged several key interested parties and CBO representatives with different perspectives and interests in Oregon's behavioral health system. However, there are perspectives that are missing, in particular representing the diversity of community-based organizations that potentially work with and/or have interests in the CCBHCs. Only three CBO representatives attended the focus group; despite inviting a wide range of CBO representatives to participate in the survey, only four completed the survey.

Future evaluations would benefit from longer recruitment periods, multiple opportunities for data collection, and coordinated recruitment efforts among CCBHCs and community partners to ensure sufficient and appropriate outreach is conducted to include these important perspectives. While CCBHC leaders often identified relevant CBOs in their interviews with the evaluation team, more participation likely could have been secured if the CCBHC leaders had contacted their partner CBOs directly; however, this would have placed an additional time and task burden on the CCBHC leaders. Particular attention needs to be given to engaging representatives from CBOs that serve communities that experience historic and contemporary injustices. Future evaluations ideally will use community-engaged participatory approaches to involve advocates, community leaders, community members, and CBO representatives in evaluating the impact of the CCBHC program on individual and community health.

Findings

The following themes emerged from the key interested parties and CBO representatives: behavioral health system capacity; care coordination; rightsizing the CCBHC model and establishing realistic standards; considerations for special populations; and sustainability. Subthemes are discussed below.

Behavioral Health System Capacity

Key interested parties and community-based organization (CBO) representatives interviewed had varying levels of familiarity with CCBHCs; however, all had knowledge of Oregon's behavioral health system. Interview findings with interested parties and CBO representatives highlighted the challenges and limitations of Oregon's behavioral health system and provided important context for the evaluation of the CCBHCs. As one key interested party noted: "*The CCBHC model is only as good as the rest of the*

system" (Interested Party 05). Priority capacity challenges reported by key interested parties and CBO representatives included inadequate funding, workforce challenges, and lack of residential treatment and housing.

Inadequate Funding

Inadequate funding was a commonly reported barrier to increasing access to behavioral healthcare in Oregon. Several key interested parties noted that the funding invested into behavioral health did not match the expectations, with one key interested party reporting that the behavioral health system is expected to address systemic social issues with limited resources.

> *I think that the biggest barrier to behavioral health is, frankly, we don't fund the system proportionate to the deliverables that we want. I think that we've then maybe erred in talking about the system being broken when it is actually functioning at the level that it's funded.* (Interested Party 14)

> *Most people outside of the [behavioral health] sector don't understand how because of our bad historic funding structures these agencies are way too lean on the operations side to deliver fidelity care or do innovation.* (Interested Party 23)

> *We're trying to solve societal problems in the behavioral health system, which is the most underfunded system there is.* (Interested Party 24)

Workforce Challenges

Key interested parties reported that one of the biggest barriers to access to quality behavioral healthcare in Oregon is the persistent behavioral health workforce shortage. Contributing factors include low wages, high administrative burden, heavy caseloads, and complex work.

> *[Workforce shortages] … especially in rural areas … Then not just that, but [within] the limited workforce that we have [there is] the poaching of providers. It's the kind of merry-go-round or musical chairs, if you will, of our actual existing workforce.* (Interested Party 16)

> *We have armies of care coordinators in a room talking about one person, and we can't find a care provider for that person. And everyone in the room is a master's level clinician. I'd be hesitant to just want to throw more care coordination responsibilities and resources out there when we need people to do the care.* (Interested Party 15)

> *We too often throw people with the least amount of experience into situations where they're working to provide care for people who are the most complicated and we pay them the least, we prepare them the least and then they cycle out. It's a very clear workforce issue.* (Interested Party 08)

> *Until we right size the wages... In other words, pay people more for working in the public system than the private system, I don't know that we'll ever solve that problem.* (Interested Party 23)

Inadequate Residential Treatment and Housing

CBO representatives and key interested parties reported that there is a lack of adequate residential treatment and housing in Oregon. One CBO representative pointed out that the lack of youth residential beds results in their community's children being sent outside the community. Another CBO representative reported that while the CCBHC is responsive to crisis calls, the lack of residential treatment leaves the community with few options for individuals needing more intensive levels of treatment and support.

> *We do have a youth residential home, operated by our CCBHC. They don't have a lot of beds, so there's not a lot of room. Often kids in foster care get placed there because there's nowhere else to put them. We need more comprehensive residential treatment. I know that Oregon as a state overall has a huge gap there. A lot of our kids get sent [outside the community], but we know keeping kids in their own community is important.* (CBO Representative 01)

> *When there is a mental health crisis that has escalated within the community, there is no place [for them] other than a jail cell. Which I'm grateful for a jail cell, because it gets the person a little bit of containment, but it's not the right place. Whether it's youth or adults, there just isn't any place. If we call behavioral health, they come and help, but they don't have a resolution or a solution. They come and help deescalate, but then they leave and our inexperienced employees still have the person there with them and there's no place to take them other than if they violate the law.* (CBO Representative 03)

> *[The behavioral health system] can't be evaluated on secure housing, they're doing their best here, but they're not in the housing business, and don't have near enough resources for adequate housing and residential treatment.* (Interested Party 05)

> *People who need more than just outpatient, who need somewhere to go and hang out for a while with a bed and staffing. We call it secure residential or residential treatment facilities…I mean, housing's a problem for the whole state, but it's really going to be hard to have people be adherent to a medical regime and a treatment plan if they're living outside or in jail.* (Interested Party 10)

Care Coordination

Interview participants also noted that while evidence suggests that integrated care is critical for whole-person care, Oregon's healthcare system is not set up to facilitate integrated care. Inadequate data infrastructure, EHRs that are not interoperable, and bifurcated funding streams make it challenging to eliminate gaps and duplication of services. One key interested party noted that 42 CFR Part 2, a federal regulation that prevents substance use treatment providers from sharing treatment information with other providers without written patient permission, is often a barrier to integration as clinics and partners hold different interpretations of what is allowable.

> *Providers have done workarounds to make care look integrated…but in the operations, in the back room, it's like running a candy store in a shoe store. It is completely not integrated. We have not made the payment structures, the operations structures, or the auditing structures to actually deliver integrated care. Everything is still siloed…so that means you have immense waste in cost and administrative burden in the back of your shop and it's not efficient.* (Interested Party 23)

We've had…a clunky infrastructure that's been fragmented and not well enough supported. (Interested Party 08)

We see this in our clinics, that primary care doesn't talk with mental health. There's all these barriers around information sharing, intake, EHRs not talking to each other. What do warm handoffs look like? (Interested Party 25)

42 CFR [Part 2] … We have some organizations that even within their own organization won't talk to each other from the SUD side to the mental health side. (Interested Party 01)

Rightsizing the CCBHC Model and Establishing Realistic Standards

Several key interested parties reported that flexibility may be necessary to accommodate the needs of different communities. While this recommendation for greater flexibility was often centered on the Oregon CCBHC primary care requirement, some spoke more generally about the CCBHC program. Two key interested parties spoke about the need to set more realistic standards in the Oregon Administrative Rules (OAR), rather than establishing aspirational standards that are not achievable.

I think we're going to have to move away from a sort of one size fits all. If we think about the PCPCHs, there's a tiering, tier one, two, three, four. But CCBHC tends to be a little more rigid, again, getting back probably to good intentions. I think it's going to be important, especially as we look at sustainability in rural settings, that ability to right size for the setting. (Interested Party 14)

When you set standards, of course you're setting the bare minimum, but…particularly [with] the workforce challenges across the state and the diversity of those challenges, it is reasonable to consider something less than the current standard of 20 hours per week. I think there's quite a variation of what one might say is the relationship to primary care and that interconnectedness and maybe markers of how to ensure that those are strong and clearly accessible and meeting the needs of the patients. I'm not sure what exactly those would be, but I don't think that one needs to hang their hat on a half time in-person primary care. (Interested Party 07)

The OARs are aspirational versus realistic. The way they've been constructed in particular over the past decade has just added a lot of things that aren't actually federally required, and that needs to be snuffed out. At the state level we haven't really crosswalked the contracts, the OARs and the statutes for those entities [CCO, CCBHC, CHMP] to make sure they're not duplicating services, or that we're consistently updating them as we develop new programs and to remove archaic or antiquated language. That's a huge lift and something that some of us are working on, but I think [a barrier] is that the OARs are aspirational and also that we just continue adding more on as opposed to making sure that it's jiving with the real world. (Interested Party 12)

Considerations for Specific Populations

Key interested parties noted that while capacity issues affect the entire behavioral health system, certain populations bear a disproportionate burden. Considerations for the additional supports or services needed are critical for health equity. Key interested parties spoke to the unique needs of those whose preferred language is not English; justice-involved individuals; and youth, particularly BIPOC and LGBTQ+ youth.

> *It's not enough to just translate materials or provide videos in the languages that people speak. Also we have to think about the quality of those translations and the quality of the interpreters that we have… It's not enough to just translate the material, but we also have to do a back translation to make sure that it makes sense, that it's at the appropriate reading level. Because a lot of times when you translate materials from English into another language, on average I think it increases the reading level by two or three grades.* (Interested Party 09)

> *There's not great coordination [after jail discharge] and the time delay is huge. So, we have some folks where [this is] the first 48 hours they haven't been using meth, and this is the time we need to do something with them. And then to give them a business card…"Hey, your intake will be in a week. Make sure to call this number on your not-phone and put it in your not-calendar." Doesn't make any sense.* (Interested Party 06*)*

> *OHP gets turned off when they come into jail custody. And then, often if they leave before anybody who's got a hand on that process knows it, they're back into the community and their resources have not been reactivated, which is hugely problematic.* (Interested Party 22)

> *I don't know how much space there is within the CCBHC model for this, but some way for youth to inform the development or the ongoing oversight. I think this is a growth area for our program as well, but is it a consumer advisory council specifically for young people, that can provide that oversight and ongoing feedback of, "this is how services are being delivered. Like, this would help reduce barriers or improve engagement"? Also, potentially required trainings for providers within the CCBHC around specific topics that matter to young people. Again, from the policy review we've done, training on trauma-informed clinical services, culturally and linguistically supportive services, could help because that has been identified by young people as a barrier and a potential solution.* (Interested Party 01)

> *There are concerns around parents "finding out", quote-unquote, about the services that they're receiving. They're concerned about providers not looking like them. A lot of providers... and we see this in our clinics... are white, cisgender, primarily female. So, there's a lot of young people who are like, "I would really love to have a queer provider. I would really love to have a Black, or Pacific Islander provider who looks like me and understands my culture."* (Interested Party 26)

Sustainability

Key interested parties and CBO representatives reported on a range of issues that are important for the potential expansion and future sustainability of the CCBHC program. The most notable themes included diversifying and training the workforce, strengthening community partnerships, investing in a robust data infrastructure, implementing meaningful metrics, and redefining wellness.

Diversifying and Training the Workforce

CBO representatives and key interested parties indicated that diversifying the behavioral health workforce was critical. One CBO representative noted that it was not sufficient to hire people from underrepresented and underserved communities; attention must be given to power dynamics. A key interested party noted that diversifying the workforce was a long process, and it is important to also ensure the current workforce is trained to engage with diverse populations, reflect on cultural biases and how they may show up in the clinic, and provide culturally and linguistically appropriate services.

> *If you hire people that come from those communities, you're going to have more success. That's just the way it is. We know that.* (CBO Representative 03)

> *Employing people that are a part of those populations and not just employing them but giving them power and decision making.* (CBO Representative 01)

> *We need to diversify the workforce. In the meantime, because that's going to take a very long time to actually do that, we need to train the current workforce to be able to work with all the populations in our state and in both culturally and linguistically appropriate ways. [We need to] make sure that current providers have what they need in terms of training, in terms of technical assistance, and that they're getting the learning opportunities that they need so that they can even just be aware of cultural biases that we all carry and hold. And also normalizing that for them too, right? Because we all have them. So awareness is such a huge piece of that ahead of even thinking about digging into how do you provide culturally and linguistically appropriate services, just even on a very personal level, thinking of your own biases and how those show up. How does white supremacy show up in the ways that folks are doing their work?* (Interested Party 09)

Strengthening Community Partnerships

CBO representatives and key interested parties reported that strengthening community partnerships and engaging the community were important strategies for meeting the needs of the community. One key interested party noted that acknowledging harms caused by the behavioral health system, power-sharing, and seeking community input on services were all important for serving historically and currently marginalized communities. Another key interested party highlighted how community members can enhance clinic conversations about diversity, equity, and inclusion.

> *Our community has a lot of grassroots work that happens, a lot of smaller nonprofits, things like that. I think maybe our CCBHC could, I mean I think they do a decent job being involved and being a good partner, but I guess could just be a little bit even more involved partnering with all the grassroots work that happens.* (CBO Representative 01)

> *We may not speak the language. We may not understand the culture. They may not have transportation to get to us. They may be fearful of engaging with an agency that's being led by white dominant culture. They just don't show up. We don't provide them care and we're not structured to provide them care. I think we have to upend all of that, and it begins with just a recognition of the harm that we've caused and understanding that we need to build trust. And to do that, we need to share power and to have community help inform our decision making so that*

> *we build an array and an approach of services that actually is designed in a way to serve communities other than white dominant culture. We need to do that with CCBHCs and everywhere else.* (Interested Party 08)

> *Even if you have a DEI committee, those conversations probably look different on a professional level versus if you go and talk to the patients or the grassroots community members. They might have some insights that aren't even in the realm of awareness.* (Interested Party 09)

Investing in Robust Data Infrastructure

Inadequate data infrastructure was a noted barrier to increasing access to behavioral health, coordinating care, and identifying health inequities. One key interested party noted that Oregon has not invested in good data systems, which has resulted in the inability to make strategic investments to support the larger behavioral health system. Another key interested party reported that CCBHCs will not be able to achieve the CCBHC program objectives without a health information exchange.

> *They don't know who their underserved populations are because they don't have the data infrastructure … this isn't just true for CCBHCs, but given what they're tasked to do without a solid health information exchange platform, they'll never achieve that.* (Interested Party 01)

> *Other states have implemented…data warehouses that push and pull data to create dashboards… We have none of that in the state of Oregon. The systems we have, they're old and they don't work… We can't even identify what we need to invest in [because] we have such poor data because we have not invested [in it.]* (Interested Party 23)

> *We need to get a better information exchange. I don't know if that necessarily means we line up the regions. I really wonder how we can use technology to help us get that better information exchange.* (Interested Party 11)

Meaningful Metrics

Key interested parties spoke about the importance of selecting the right metrics to monitor progress and inform quality improvement efforts. Concerns included careful selection of metrics that demonstrate successful outcomes, are informed by service users, and are not too burdensome.

> *We've been struggling with the right metrics for the behavioral health system to show that we're successful. I think the CCBHC Demo is a way to get there. Frankly, I think a lot of the quality metrics are just process, and I don't think it shows outcomes very well… We need to make sure that we're all on the same page with the metrics to show success; if we go to using outcome metrics, as a way to measure success, then we've got to get rid of, or pair down all those administrative requirements and rules as a way to measure whether we're doing what we're supposed to be doing.* (Interested Party 05)

> *That's where the metrics and incentives I think ought to be built in. Simple metrics that really highlight, especially with our most complex populations, what success looks like and informed by what those people say success looks like, not just what we think… I think that's in that iteration of designing CCBHCs, we ought to be thinking ahead to what success looks like and then to build*

> *that in, in terms of financial incentives and the clear reporting. Frankly, right now, we collect too much information and we collect too much noise, and we aren't guided by the information we collect because it's mostly useless.* (Interested Party 08)

Redefining Wellness

One key interested party noted that a shift in how the system defines wellness is required to improve Oregon's behavioral health system. They emphasized that centering equity will require new definitions of wellness that move away from a linear, medicalized model towards one that acknowledges multiple pathways to wellness.

> *There's [this perception that] recovery in the mental health world looks like your symptoms don't bother me anymore. [Recovery] doesn't look linear, but we're expecting it to look linear. You come in, you take your meds, you look normal, and you act normal. We don't embrace the 'foil helmet' as okay. You don't need to medicate the fact that you want to wear a foil helmet. Why can't we just accept that?* (Interested Party 24)

Appendix 7: Additional Quantitative Analyses Tables Referenced in the Main Report

The following tables present extended analyses of OHP claims and MHSIP data to investigate distributed effects of the CCBHC program by OHP member race/ethnicity and place of residence. These tables are referenced and key findings provided within the main report. These additional tables are listed below in the order they are referenced in the main report. In all tables, results in **bold** and *italics* are statistically significant at p<.05. As noted in Appendix 3, some unusually large increases or decreases within the results for the smaller race/ethnicity categories are not reported (NR) given concerns for their interpretability.

List of tables in Appendix 7:

- Table A7.1a: Changes in Mental Health and Substance Use Service Quarterly Use and Visits Per Person Overall and by Race/Ethnicity for CCBHC OHP Members
- Table A7.1b: Change in Mental Health and Substance Service Quarterly Use and Visits Per Person Overall and by Place of Residence for CCBHC OHP Members
- Table A7.2a: Location of Behavioral Health Services by Place of Service Code Overall and by Race/Ethnicity for CCBHC OHP Members
- Table A7.2b: Location of Behavioral Health Services by Place of Service Code Overall and by Place of Residence for CCBHC OHP Members
- Table A7.3a: Distribution of Behavioral Health Services by CCBHC Service Type Overall and by Race/Ethnicity for CCBHC OHP Members
- Table A7.3b: Distribution of Behavioral Health Services by CCBHC Service Type Overall and by Place of Residence for CCBHC OHP Members
- Table A7.4a: Changes in Primary Care Quarterly Use and Visits Per Person Overall and by Race/Ethnicity for CCBHC OHP Members
- Table A7.4b: Changes in Primary Care Quarterly Use and Visits Per Person Overall and by Place of Residence for CCBHC OHP Members
- Table A7.5a: Changes in MHSIP Survey Domain Scores - Adult Outpatient and Residential Services Overall and by Race/Ethnicity for CCBHC OHP Members
- Table A7.5b: Changes in MHSIP Survey Satisfaction Scores - Adult Outpatient and Residential Services Overall and by Race/Ethnicity for CCBHC OHP Members
- Table A7.5c: Changes in MHSIP Survey Domain Scores -- Children and Youth Outpatient and Residential Services Overall and by Race/Ethnicity Services for CCBHC OHP Members
- Table A7.5d: Changes in MHSIP Survey Satisfaction Scores - Children and Youth Outpatient and Residential Services Overall and by Race/Ethnicity Services for CCBHC OHP Members
- Table A7.5e: MHSIP Survey Domains and Satisfaction Scores – Adult Outpatient and Residential Services Overall and by Place of Residence
- Table A7.5f: Changes in MHSIP Survey Domains and Satisfaction Scores -- Children and Youth Outpatient and Residential Services Overall and by Place of Residence for CCBHC OHP Members
- Table A7.6a: Changes in Emergency Department Quarterly Use and Visits Overall and by Race/Ethnicity Services for CCBHC OHP Members
- Table A7.6b: Change in Emergency Department Quarterly Use and Visits Overall and by Place of Residence for CCBHC OHP Members

- Table A7.6c: Change in Inpatient Service Quarterly Use and Days Overall and by Race/Ethnicity Services for CCBHC OHP Members
- Table A7.6d: Change in Inpatient Service Quarterly Use and Days Overall and by Place of Residence for CCBHC OHP Members
- Table A7.6e: Change in Residential Treatment Facility Service Quarterly Use and Days Overall and by Race/Ethnicity Services for CCBHC OHP Members
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- Table A7.7a: Change in Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services
- Table A7.7b: Change in Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence
- Table A7.7c: Change in Mental Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services
- Table A7.7d: Change in Mental Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence
- Table A7.7e: Change in Substance Use Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services
- Table A7.7f: Change in Substance Use Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence
- Table A7.7g: Change in Physical Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services
- Table A7.7h: Change in Physical Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence

Table A7.1a: Changes in Mental Health and Substance Use Service Quarterly Use and Visits Per Person Overall and by Race/Ethnicity for CCBHC OHP Members

MH/SUD Outpatient	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Mental Health						
Quarterly Use						
First CCBHC Period	***2.3%***	***-9.3%***	0.8%	***5.3%***	***2.4%***	***9.2%***
Second CCBHC Period	***14.8%***	1.9%	9.0%	***16.8%***	***15.7%***	***24.1%***
Visits per Person						
First CCBHC Period	***6.6%***	***21.2%***	1.5%	-0.5%	***6.4%***	21.3%
Second CCBHC Period	***9.5%***	7.1%	7.0%	8.5%	***8.8%***	***38.1%***
Substance Use						
Quarterly Use						
First CCBHC Period	***11.4%***	-1.4%	7.4%	3.8%	***14.0%***	13.8%
Second CCBHC Period	***6.1%***	-3.6%	-6.0%	-13.3%	***11.4%***	7.0%
Visits per Person						
First CCBHC Period	***14.9%***	-8.3%	23.0%	26.0%	***16.0%***	6.6%
Second CCBHC Period	***-26.9%***	***-45.2%***	9.2%	-22.6%	***-25.7%***	***-45.6%***

Table A7.1b: Change in Mental Health and Substance Service Quarterly Use and Visits Per Person Overall and by Place of Residence for CCBHC OHP Members

MH/SUD Outpatient	All CCBHC	Urban	Rural or Remote
Mental Health			
Quarterly Use			
First CCBHC Period	**2.3%**	**-6.7%**	**9.1%**
Second CCBHC Period	**14.8%**	1.8%	**24.2%**
Visits per Person			
First CCBHC Period	**6.6%**	-1.4%	**12.6%**
Second CCBHC Period	**9.5%**	-0.2%	**15.5%**
Substance Use			
Quarterly Use			
First CCBHC Period	**11.4%**	**24.7%**	**7.6%**
Second CCBHC Period	**6.1%**	**76.4%**	**-14.4%**
Visits per Person			
First CCBHC Period	**14.9%**	7.2%	**20.0%**
Second CCBHC Period	**-26.9%**	-1.7%	**-34.4%**

Table A7.2a: Location of Behavioral Health Services by Place of Service Code Overall and by Race/Ethnicity for CCBHC OHP Members

Place of Service Groups	All CCBHC	Am Ind/ Al Native	Asian	Black/ Afr Am	Hispanic Latino/a/x	Mid East/ N African	Native Hawaiian & Pac Isl	White	Other/ Multi/ Unknown
Temporary or Un-Housed									
Pre	0.003%	0.000%	0.000%	0.003%	0.000%	0.000%	0.000%	0.003%	0.000%
First Post	0.005%	0.006%	0.000%	0.000%	0.001%	0.000%	0.000%	0.006%	0.000%
Second Post	0.018%	0.006%	0.006%	0.093%	0.010%	0.000%	0.002%	0.013%	0.006%
Correctional Facility									
Pre	0.007%	0.014%	0.000%	0.014%	0.002%	0.000%	0.000%	0.007%	0.000%
First Post	0.010%	0.019%	0.000%	0.014%	0.004%	0.000%	0.000%	0.009%	0.006%
Second Post	0.002%	0.006%	0.000%	0.001%	0.003%	0.000%	0.000%	0.002%	0.000%
Workplace									
Pre	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
First Post	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Second Post	0.000%	0.000%	0.000%	0.000%	0.004%	0.000%	0.000%	0.000%	0.000%
School									
Pre	0.747%	1.960%	0.171%	0.312%	1.295%	0.254%	0.014%	0.683%	0.155%
First Post	1.315%	2.980%	0.570%	0.492%	1.859%	0.000%	0.083%	1.216%	0.077%
Second Post	1.045%	2.236%	0.429%	0.613%	1.165%	0.049%	0.128%	0.989%	0.276%
Home									
Pre	0.155%	1.357%	9.664%	3.593%	0.024%	9.742%	23.392%	0.039%	0.000%
First Post	0.161%	1.807%	9.903%	4.726%	0.025%	12.260%	29.063%	0.007%	0.000%
Second Post	0.151%	0.945%	10.058%	3.181%	0.019%	9.086%	31.571%	0.007%	0.000%
Asstd. Living/Group Home									
Pre	0.010%	0.005%	0.051%	0.003%	0.002%	0.000%	0.001%	0.010%	0.000%
First Post	0.023%	0.001%	0.000%	0.024%	0.043%	0.000%	0.000%	0.023%	0.000%
Second Post	3.439%	0.001%	0.000%	0.003%	0.057%	0.000%	0.000%	4.524%	0.000%
Telehealth									
Pre	0.03%	0.03%	0.01%	0.01%	0.03%	0.00%	0.00%	0.04%	0.02%
First Post	0.56%	0.54%	0.14%	0.16%	0.37%	0.25%	0.03%	0.61%	0.46%
Second Post	15.76%	17.18%	9.38%	12.71%	20.44%	15.21%	1.01%	15.23%	16.37%
Tribal Health									
Pre	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
First Post	0.000%	0.001%	0.000%	0.000%	0.001%	0.000%	0.000%	0.000%	0.000%
Second Post	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Nursing/Custodial Facility									
Pre	0.039%	0.012%	0.000%	0.026%	0.015%	0.000%	0.000%	0.047%	0.005%
First Post	0.025%	0.006%	0.000%	0.003%	0.002%	0.000%	0.000%	0.031%	0.000%
Second Post	0.035%	0.001%	0.006%	0.019%	0.006%	0.000%	0.000%	0.044%	0.000%
Hospital/RTF									
Pre	7.67%	4.39%	7.27%	8.51%	3.68%	0.30%	1.03%	8.13%	1.18%
First Post	6.59%	3.78%	8.34%	5.97%	1.89%	0.20%	0.53%	7.24%	0.39%
Second Post	9.84%	10.90%	14.88%	9.00%	3.08%	0.39%	0.31%	10.48%	0.50%
Office/Clinic									
Pre	90.8%	87.5%	47.4%	79.0%	94.9%	44.3%	5.1%	90.9%	49.3%
First Post	90.9%	87.6%	49.8%	78.2%	95.7%	56.6%	6.4%	90.8%	49.5%
Second Post	69.3%	66.1%	42.8%	67.7%	75.1%	59.2%	5.6%	68.7%	41.4%
Other Place of Service									
Pre	0.5%	4.8%	35.4%	8.5%	0.1%	45.4%	70.5%	0.2%	49.3%
First Post	0.4%	3.3%	31.2%	10.4%	0.1%	30.6%	63.9%	0.1%	49.5%
Second Post	0.4%	2.6%	22.4%	6.6%	0.1%	16.1%	61.4%	0.0%	41.4%

Table A7.2b: Location of Behavioral Health Services by Place of Service Code Overall and by Place of Residence for CCBHC OHP Members

Place of Service Groups	All CCBHC	Urban	Rural	Remote
Temporary or Un-Housed				
Pre	0.002%	0.003%	0.001%	0.003%
First Post	0.004%	0.008%	0.000%	0.000%
Second Post	0.016%	0.030%	0.001%	0.000%
Correctional Facility				
Pre	0.006%	0.004%	0.010%	0.000%
First Post	0.009%	0.004%	0.016%	0.000%
Second Post	0.002%	0.001%	0.004%	0.002%
Workplace				
Pre	0.000%	0.000%	0.000%	0.000%
First Post	0.000%	0.000%	0.001%	0.000%
Second Post	0.000%	0.000%	0.000%	0.000%
School				
Pre	0.667%	0.115%	1.446%	1.093%
First Post	1.190%	0.152%	2.599%	0.281%
Second Post	0.964%	0.228%	1.900%	0.446%
Home				
Pre	2.799%	3.097%	2.222%	4.869%
First Post	3.045%	3.104%	2.832%	4.618%
Second Post	2.743%	2.723%	2.499%	6.960%
Asstd. Living/Group Home				
Pre	0.008%	0.011%	0.006%	0.000%
First Post	0.021%	0.001%	0.011%	0.430%
Second Post	3.171%	0.051%	7.132%	1.088%
Telehealth				
Pre	0.03%	0.01%	0.06%	0.00%
First Post	0.50%	0.18%	0.87%	1.02%
Second Post	14.53%	15.75%	13.34%	9.75%
Tribal Health				
Pre	0.000%	0.000%	0.000%	0.000%
First Post	0.000%	0.000%	0.001%	0.000%
Second Post	0.000%	0.000%	0.000%	0.000%
Nursing/Custodial Facility				
Pre	0.035%	0.031%	0.041%	0.039%
First Post	0.022%	0.030%	0.012%	0.027%
Second Post	0.032%	0.051%	0.009%	0.045%
Hospital/RTF				
Pre	6.84%	9.45%	3.06%	6.17%
First Post	5.96%	8.36%	2.98%	5.08%
Second Post	9.07%	12.42%	4.92%	9.79%
Office/Clinic				
Pre	81.0%	76.5%	88.0%	74.3%
First Post	82.3%	79.8%	86.0%	74.5%
Second Post	63.9%	62.8%	65.7%	57.4%
Other Place of Service				
Pre	8.6%	10.7%	5.2%	13.5%
First Post	7.0%	8.3%	4.6%	14.0%
Second Post	5.6%	6.0%	4.5%	14.5%

Table A7.3a: Distribution of Behavioral Health Services by CCBHC Service Type Overall and by Race/Ethnicity for CCBHC OHP Members

CCCBHC Service Types	All CCBHC	Am Ind/ Al Native	Asian	Black/ Afr Am	Latino/a/x	Mid East/ N African	Native Hawaian & Pacific Isl	White	Other/ Multi/ Unknown
Crisis Services									
Pre	0.8%	0.9%	0.7%	0.5%	0.8%	2.1%	0.9%	0.8%	1.0%
First Post	1.0%	1.0%	0.9%	0.9%	1.0%	1.8%	0.8%	0.9%	0.9%
Second Post	1.1%	1.3%	1.3%	1.0%	1.1%	1.5%	1.4%	1.1%	2.6%
Outpatient MH & SUD Services									
Pre	51.3%	52.9%	47.5%	50.5%	57.9%	63.9%	50.4%	50.3%	62.4%
First Post	51.8%	53.5%	45.1%	51.4%	60.8%	66.5%	55.0%	50.6%	67.6%
Second Post	49.0%	51.2%	46.5%	52.1%	59.9%	61.9%	58.8%	47.2%	55.5%
Primary Care Screening & Monitoring									
Pre	7.3%	6.2%	6.1%	4.9%	6.6%	6.5%	5.4%	7.6%	7.9%
First Post	6.7%	5.7%	6.7%	4.8%	5.4%	3.7%	5.6%	7.1%	5.8%
Second Post	6.4%	5.2%	6.2%	4.9%	5.4%	5.6%	5.2%	6.7%	6.8%
Patient Centered Treatment Planning									
Pre	7.3%	6.2%	6.1%	4.9%	6.6%	6.5%	5.4%	7.6%	7.9%
First Post	6.7%	5.7%	6.7%	4.8%	5.4%	3.7%	5.6%	7.1%	5.8%
Second Post	6.4%	5.2%	6.2%	4.9%	5.4%	5.6%	5.2%	6.7%	6.8%
Peer Services									
Pre	13.8%	11.7%	19.1%	17.6%	11.7%	3.4%	12.0%	14.0%	4.6%
First Post	11.8%	11.5%	12.8%	10.9%	10.3%	3.1%	11.5%	12.2%	4.2%
Second Post	17.0%	16.3%	16.6%	14.4%	11.4%	5.9%	12.9%	18.1%	7.9%
Psychiatric Rehabilitation Services									
Pre	7.4%	8.4%	7.2%	6.1%	4.3%	0.1%	13.1%	7.9%	2.4%
First Post	10.0%	9.9%	14.2%	11.8%	4.4%	0.1%	6.8%	10.5%	3.0%
Second Post	8.8%	8.7%	11.2%	8.1%	4.4%	0.2%	1.9%	9.5%	0.4%
Screening, Assessment & Diagnosis									
Pre	6.4%	7.5%	6.0%	6.6%	7.7%	11.4%	5.9%	6.1%	9.4%
First Post	6.7%	7.5%	5.8%	7.3%	8.1%	11.5%	7.3%	6.4%	8.7%
Second Post	6.3%	6.8%	5.9%	5.9%	7.9%	11.2%	8.4%	6.0%	16.9%
Targetted Case Management									
Pre	5.8%	6.2%	7.3%	8.9%	4.6%	6.0%	7.0%	5.7%	4.4%
First Post	5.4%	5.4%	7.7%	8.3%	4.7%	9.8%	7.4%	5.2%	4.1%
Second Post	5.1%	5.4%	6.1%	8.7%	4.5%	8.2%	6.3%	4.8%	3.0%

Table A7.3b: Distribution of Behavioral Health Services by CCBHC Service Type Overall and by Place of Residence for CCBHC OHP Members

CCCBHC Service Types	All CCBHC	Urban	Rural	Remote
Crisis Services				
Pre	0.8%	0.6%	1.2%	0.8%
First Post	1.0%	0.7%	1.4%	0.9%
Second Post	1.2%	0.9%	1.5%	1.3%
Outpatient MH & SUD Services				
Pre	54.5%	53.8%	56.0%	49.1%
First Post	54.6%	54.6%	55.6%	45.4%
Second Post	51.4%	53.9%	49.0%	41.3%
First Post				
Pre	7.7%	8.2%	7.3%	3.3%
First Post	7.0%	7.5%	6.5%	6.1%
Second Post	6.7%	7.3%	6.0%	5.8%
Patient Centered Treatment Planning				
Pre	1.4%	1.2%	1.7%	0.4%
First Post	1.6%	1.4%	1.8%	0.8%
Second Post	1.7%	1.9%	1.7%	0.4%
Peer Services				
Pre	14.6%	15.8%	13.1%	10.9%
First Post	12.5%	10.6%	15.1%	10.3%
Second Post	17.9%	14.0%	23.1%	9.3%
Psychiatric Rehabilitation Services				
Pre	7.9%	5.7%	9.7%	27.8%
First Post	10.5%	11.1%	8.3%	27.3%
Second Post	9.3%	9.4%	7.7%	30.7%
Screening, Assessment & Diagnosis				
Pre	6.8%	7.0%	6.8%	3.6%
First Post	7.0%	7.0%	7.2%	5.3%
Second Post	6.6%	6.1%	7.2%	5.8%
Targeted Case Management				
Pre	6.2%	7.7%	4.2%	4.1%
First Post	5.7%	7.1%	4.1%	3.8%
Second Post	5.3%	6.4%	3.9%	5.5%

Table A7.4a: Changes in Primary Care Quarterly Use and Visits Per Person Overall and by Race/Ethnicity for CCBHC OHP Members

Primary Care	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Quarterly Use						
First CCBHC Period	0.4%	1.3%	-1.3%	1.2%	0.7%	-8.6%
Second CCBHC Period	***3.2%***	1.4%	-2.9%	3.3%	***4.0%***	0.2%
Visits per Person						
First CCBHC Period	1.2%	3.5%	-1.7%	3.3%	0.8%	1.5%
Second CCBHC Period	***2.6%***	-4.3%	-11.8%	***8.6%***	***3.2%***	7.1%

Table A7.4b: Changes in Primary Care Quarterly Use and Visits Per Person Overall and by Place of Residence for CCBHC OHP Members

Primary Care	All CCBHC	Urban	Rural or Remote
Quarterly Use			
First CCBHC Period	0.4%	-1.3%	***1.8%***
Second CCBHC Period	***3.2%***	-0.2%	***5.9%***
Visits per Person			
First CCBHC Period	1.2%	***-2.0%***	***3.8%***
Second CCBHC Period	***2.6%***	***-3.1%***	***6.7%***

Table A7.5a: Changes in MHSIP Survey Domain Scores - Adult Outpatient and Residential Services Overall and by Race/Ethnicity for CCBHC OHP Members

MHSIP Domain	All Races/ Ethnicities	Am Ind/ Al Native	Black/ African American	Hispanic/ Latino/a/x	White	All Other
Access to Services						
1st Period	0.11	0.13	***1.10***	0.15	0.08	-0.17
2nd Period	0.19	-0.11	***1.92***	-0.03	0.16	0.10
Social Connectedness						
1st Period	-0.17	-0.35	-0.55	0.31	-0.15	-0.12
2nd Period	0.04	-0.84	-0.09	-0.20	0.05	-0.83
General Satisfaction						
1st Period	-0.06	0.26	0.99	0.30	-0.08	0.25
2nd Period	0.05	0.16	***1.55***	0.16	0.01	0.06
Daily Functioning						
1st Period	-0.16	0.29	-1.05	-0.36	-0.15	0.52
2nd Period	-0.08	0.25	-0.47	-0.16	-0.09	-0.51
Quality						
1st Period	-0.02	0.45	0.87	0.08	-0.06	-0.09
2nd Period	0.06	0.31	0.61	0.13	0.02	0.36
Treatment Outcomes						
1st Period	-0.12	0.14	-0.38	-0.44	-0.09	0.42
2nd Period	0.05	0.11	0.17	-0.32	0.06	-0.44
Participation						
1st Period	0.08	0.57	0.50	0.15	0.04	-0.13
2nd Period	0.12	0.41	0.20	0.52	0.10	0.13

Table A7.5b: Changes in MHSIP Survey Satisfaction Scores - Adult Outpatient and Residential Services Overall and by Race/Ethnicity for CCBHC OHP Members

MHSIP Domain	All Races/ Ethnicities	Am Ind/ Al Native	Black/ African American	Hispanic/ Latino/a/x	White	All Other
Access to Services						
1st Period	0.07	0.25	***0.79***	-0.06	0.07	-0.27
2nd Period	0.10	-0.05	***0.84***	-0.17	0.08	0.30
Social Connectedness						
1st Period	-0.02	-0.18	-0.20	0.27	-0.01	0.05
2nd Period	0.08	-0.23	0.09	0.17	0.07	-0.38
General Satisfaction						
1st Period	-0.06	0.42	0.24	0.04	-0.07	0.25
2nd Period	-0.02	0.30	***0.68***	-0.09	-0.05	-0.04
Daily Functioning						
1st Period	-0.03	-0.22	0.08	-0.05	-0.04	0.22
2nd Period	0.00	-0.11	-0.08	0.06	-0.03	0.29
Quality						
1st Period	0.04	0.22	0.41	0.10	0.03	-0.17
2nd Period	0.00	0.21	***0.50***	0.23	-0.03	0.54
Treatment Outcomes						
1st Period	-0.01	0.16	6.00	0.12	-0.02	***0.54***
2nd Period	0.04	0.01	0.28	0.17	0.02	0.44
Participation						
1st Period	0.02	***0.51***	0.62	-0.17	0.00	-0.02
2nd Period	0.04	0.42	0.23	0.20	0.02	0.56

Table A7.5c: Changes in MHSIP Survey Domain Scores -- Children and Youth Outpatient and Residential Services Overall and by Race/Ethnicity Services for CCBHC OHP Members

MHSIP Domain	All Races/ Ethnicities	Am Ind/ Al Native	Black/ African American	Hispanic/ Latino/a/x	White	All Other
Access to Services						
1st Period	0.03	0.37	-0.46	0.39	-0.04	0.40
2nd Period	0.08	0.22	0.35	0.22	0.00	-1.24
Appropriateness						
1st Period	0.10	0.21	***0.70***	0.31	0.02	0.86
2nd Period	0.29	0.04	***1.68***	0.54	0.15	0.19
Social Connectedness						
1st Period	-0.05	0.16	0.15	0.2	-0.10	0.01
2nd Period	0.13	-0.04	0.50	-0.05	0.15	-1.18
Cultural Sensitivity						
1st Period	-0.09	***0.49***	0.15	-0.34	-0.09	***0.72***
2nd Period	0.11	0.10	***0.93***	-0.07	0.10	0.86
Daily Functioning						
1st Period	0.17	0.49	***0.95***	0.43	0.09	1.21
2nd Period	***0.35***	0.25	***1.88***	0.49	0.27	-0.62
Treatment Outcomes						
1st Period	0.11	0.31	***0.69***	0.43	0.01	0.66
2nd Period	***0.29***	0.01	***1.86***	0.48	0.21	-0.86
Participation						
1st Period	0.16	0.47	***0.75***	0.21	0.11	1.18
2nd Period	***0.29***	0.55	***1.97***	0.40	0.16	0.23

Table A7.5d: Changes in MHSIP Survey Satisfaction Scores - Children and Youth Outpatient and Residential Services Overall and by Race/Ethnicity Services for CCBHC OHP Members

MHSIP Domain	All Races/ Ethnicities	Am Ind/ Al Native	Black/ African American	Hispanic/ Latino/a/x	White	All Other
Access to Services						
1st Period	0.01	0.13	-0.03	0.05	0.00	0.45
2nd Period	0.00	-0.02	0.03	0.07	-0.02	-0.29
Appropriateness						
1st Period	***0.12***	0.20	0.31	0.16	0.10	0.29
2nd Period	***0.22***	0.13	***0.60***	***0.36***	***0.17***	-0.12
Social Connectedness						
1st Period	0.02	-0.05	0.11	0.10	0.00	0.58
2nd Period	0.08	-0.15	0.13	0.09	0.07	0.05
Cultural Sensitivity						
1st Period	0.01	0.25	0.08	-0.07	0.01	0.06
2nd Period	0.06	0.01	0.35	-0.02	0.07	0.15
Daily Functioning						
1st Period	0.08	0.25	***0.63***	-0.04	0.09	0.98
2nd Period	***0.18***	0.13	***0.73***	0.00	***0.22***	0.35
Treatment Outcomes						
1st Period	0.06	0.14	0.42	0.08	0.03	0.66
2nd Period	***0.17***	0.07	***0.78***	0.11	***0.17***	0.25
Participation						
1st Period	0.07	0.00	0.39	0.08	0.05	0.00
2nd Period	***0.13***	0.05	***0.58***	0.16	0.11	-0.34

**Table A7.5e: MHSIP Survey Domains and Satisfaction Scores –
Adult Outpatient and Residential Services Overall and by Place of Residence**

	Overall		Rural		Urban	
MHSIP Domain	**Domain**	**Satisfaction**	**Domain**	**Satisfaction**	**Domain**	**Satisfaction**
Access to Services						
1st Period	0.11	0.07	0.26	***0.21***	-0.04	-0.03
2nd Period	0.19	0.10	0.22	0.15	0.19	0.10
Social Connectedness						
1st Period	-0.17	-0.02	0.03	0.05	-0.27	-0.04
2nd Period	0.04	0.08	0.11	0.11	0.07	0.10
General Satisfaction						
1st Period	-0.06	-0.06	0.12	0.10	-0.20	-0.12
2nd Period	0.05	-0.02	0.25	0.00	-0.09	-0.02
Daily Functioning						
1st Period	-0.16	-0.03	-0.06	-0.07	-0.22	0.01
2nd Period	-0.08	0.00	0.00	-0.05	-0.12	0.05
Quality						
1st Period	-0.02	0.04	0.07	0.04	-0.09	0.01
2nd Period	0.06	0.00	0.14	-0.01	0.00	-0.01
Treatment Outcomes						
1st Period	-0.12	-0.01	0.20	0.06	-0.35	-0.03
2nd Period	0.05	0.04	0.33	0.13	-0.14	0.01
Participation						
1st Period	0.08	0.02	***0.47***	0.20	-0.26	-0.14
2nd Period	0.12	0.04	***0.46***	0.17	-0.17	-0.09

Table A7.5f: Changes in MHSIP Survey Domains and Satisfaction Scores -- Children and Youth Outpatient and Residential Services Overall and by Place of Residence for CCBHC OHP Members

	Overall		Rural		Urban	
MHSIP Domain	**Domain**	**Satisfaction**	**Domain**	**Satisfaction**	**Domain**	**Satisfaction**
Access to Services						
1st Period	0.03	0.01	-0.07	-0.10	0.20	***0.17***
2nd Period	0.08	0.00	0.04	-0.07	0.14	0.10
Appropriateness						
1st Period	0.10	***0.12***	0.00	0.07	0.22	***0.18***
2nd Period	0.29	***0.22***	0.08	0.13	***0.56***	***0.34***
Social Connectedness						
1st Period	-0.05	0.02	-0.10	-0.04	0.03	0.10
2nd Period	0.13	0.08	0.02	0.00	0.26	***0.16***
Cultural Sensitivity						
1st Period	-0.09	0.01	-0.07	-0.02	-0.15	0.03
2nd Period	0.11	0.06	0.04	0.04	0.16	0.05
Daily Functioning						
1st Period	0.17	0.08	0.10	0.16	0.30	0.01
2nd Period	***0.35***	***0.18***	0.20	***0.26***	***0.57***	0.10
Treatment Outcomes						
1st Period	0.11	0.06	-0.02	0.03	0.30	0.11
2nd Period	***0.29***	***0.17***	0.11	***0.16***	***0.55***	0.19
Participation						
1st Period	0.16	0.07	0.12	0.05	0.22	0.10
2nd Period	***0.29***	***0.13***	0.19	0.11	***0.41***	0.14

Table A7.6a: Changes in Emergency Department Quarterly Use and Visits Overall and by Race/Ethnicity Services for CCBHC OHP Members

Emergency Department	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Mental Health						
Quarterly Use						
First CCBHC Period	***-14.1%***	-23.6%	-5.4%	5.9%	***-16.3%***	***61.9%***
Second CCBHC Period	***-10.5%***	-8.6%	-10.3%	-0.5%	***-13.5%***	29.5%
Visits per Person						
First CCBHC Period	***-15.0%***	-20.2%	-28.0%	-5.3%	***-16.5%***	***87.9%***
Second CCBHC Period	-6.1%	4.9%	-20.7%	7.2%	-7.3%	3.6%
Substance Use						
Quarterly Use						
First CCBHC Period	0.5%	15.1%	6.4%	56.4%	-0.6%	68.9%
Second CCBHC Period	13.9%	45.7%	23.2%	1.2%	9.7%	2.9%
Visits per Person						
First CCBHC Period	1.4%	38.1%	-11.0%	31.9%	10.0%	15.3%
Second CCBHC Period	9.6%	47.0%	-13.3%	65.0%	0.7%	-4.8%
Physical Health						
Quarterly Use						
First CCBHC Period	***-4.4%***	-4.1%	***-18.7%***	***11.7%***	***-4.8%***	20.0%
Second CCBHC Period	-2.5%	9.7%	***-29.2%***	***-11.7%***	-2.4%	23.6%
Visits per Person						
First CCBHC Period	-1.0%	-9.9%	-13.6%	14.7%	-3.0%	***72.3%***
Second CCBHC Period	2.4%	3.0%	-21.7%	30.5%	-0.5%	63.7%

Table A7.6b: Change in Emergency Department Quarterly Use and Visits Overall and by Place of Residence for CCBHC OHP Members

Emergency Department	All CCBHC	Urban	Rural or Remote
Mental Health			
Quarterly Use			
First CCBHC Period	***-14.1%***	***-15.3%***	***-11.8%***
Second CCBHC Period	***-10.5%***	-7.9%	***-16.3%***
Visits per Person			
First CCBHC Period	***-15.0%***	***-16.7%***	-10.8%
Second CCBHC Period	-6.1%	-5.7%	-6.3%
Substance Use			
Quarterly Use			
First CCBHC Period	0.5%	-1.6%	3.4%
Second CCBHC Period	13.9%	***18.8%***	0.2%
Visits per Person			
First CCBHC Period	1.4%	1.1%	2.5%
Second CCBHC Period	9.6%	18.2%	-9.2%
Physical Health			
Quarterly Use			
First CCBHC Period	***-4.4%***	***-6.0%***	-1.6%
Second CCBHC Period	-2.5%	-3.6%	0.1%
Visits per Person			
First CCBHC Period	-1.0%	***-17.8%***	-1.9%
Second CCBHC Period	2.4%	***22.9%***	-0.6%

Table A7.6c: Change in Inpatient Service Quarterly Use and Days Overall and by Race/Ethnicity Services for CCBHC OHP Members

Inpatient	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Mental Health						
Quarterly Use						
First CCBHC Period	***-22.4%***	***-40.8%***	-22.5%	-13.2%	***-24.7%***	100.6%
Second CCBHC Period	***-12.9%***	-7.7%	-27.2%	18.4%	***-14.2%***	-6.1%
Days per Person						
First CCBHC Period	***-22.9%***	***-46.3%***	***-55.8%***	-21.1%	***-21.5%***	-97.2%
Second CCBHC Period	-1.7%	-13.0%	-31.5%	33.8%	-3.8%	61.1%
Substance Use						
Quarterly Use						
First CCBHC Period	-9.6%	16.1%	-6.2%	-30.9%	-14.3%	94.0%
Second CCBHC Period	-4.6%	51.7%	-38.5%	-55.6%	-1.6%	47.9%
Days per Person						
First CCBHC Period	-9.2%	-12.5%	157.8%	21.3%	13.0%	NR
Second CCBHC Period	-33.2%	21.8%	288.8%	-97.7%	36.5%	NR
Physical Health						
Quarterly Use						
First CCBHC Period	-6.4%	-18.6%	-21.6%	-3.8%	-6.5%	53.6%
Second CCBHC Period	-4.3%	-4.8%	-8.1%	1.3%	-6.0%	23.2%
Days per Person						
First CCBHC Period	-7.0%	-23.7%	-17.3%	25.0%	-8.9%	156.5%
Second CCBHC Period	-8.3%	-9.3%	45.4%	28.3%	-14.1%	35.6%

Table A7.6d: Change in Inpatient Service Quarterly Use and Days Overall and by Place of Residence for CCBHC OHP Members

Inpatient	All CCBHC	Urban	Rural or Remote
Mental Health			
Quarterly Use			
First CCBHC Period	***-22.4%***	***-22.7%***	***-22.0%***
Second CCBHC Period	***-12.9%***	-9.8%	***-21.6%***
Days per Person			
First CCBHC Period	***-22.9%***	-15.2%	***-42.9%***
Second CCBHC Period	-1.7%	11.1%	***-29.4%***
Substance Use			
Quarterly Use			
First CCBHC Period	-9.6%	-18.3%	7.6%
Second CCBHC Period	-4.6%	-0.7%	-6.4%
Days per Person			
First CCBHC Period	-9.2%	37.7%	52.3%
Second CCBHC Period	-33.2%	-45.9%	45.9%
Physical Health			
Quarterly Use			
First CCBHC Period	-6.4%	-6.6%	-6.6%
Second CCBHC Period	-4.3%	-2.5%	-8.0%
Days per Person			
First CCBHC Period	-7.0%	-8.0%	-5.8%
Second CCBHC Period	-8.3%	-11.8%	-1.5%

Table A7.6e: Change in Residential Treatment Facility Service Quarterly Use and Days Overall and by Race/Ethnicity Services for CCBHC OHP Members

Resid. Trt. Facility (RTF)	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Mental Health						
Quarterly Use						
First CCBHC Period	***38.5%***	22.1%	38.1%	-14.7%	***44.2%***	***337.0%***
Second CCBHC Period	***49.3%***	-36.0%	***243.8%***	-35.1%	***51.6%***	84.0%
Days per Person						
First CCBHC Period	6.5%	6.8%	-11.4%	-59.9%	16.3%	NR
Second CCBHC Period	26.0%	-34.3%	252.7%	-59.9%	30.5%	68.0%
Substance Use						
Quarterly Use						
First CCBHC Period	***-19.0%***	-17.1%	-70.3%	-6.4%	-13.1%	***-66.4%***
Second CCBHC Period	***-26.4%***	-0.8%	-57.7%	23.6%	-28.5%	-29.0%
Days per Person						
First CCBHC Period	26.4%	5.5%	-58.8%	12.4%	7.6%	***-66.0%***
Second CCBHC Period	-0.8%	7.4%	-10.6%	***97.8%***	0.0%	69.3%

Table A7.6f: Change in Residential Treatment Facility Service Quarterly Use and Days Overall and by Place of Residence for CCBHC OHP Members

Resid. Trt. Facility (RTF)	All CCBHC	Urban	Rural or Remote
Mental Health			
Quarterly Use			
First CCBHC Period	***38.5%***	***53.9%***	7.6%
Second CCBHC Period	***49.3%***	***108.7%***	***-28.5%***
Days per Person			
First CCBHC Period	6.5%	3.7%	267.7%
Second CCBHC Period	26.0%	***51.0%***	-10.2%
Substance Use			
Quarterly Use			
First CCBHC Period	***-19.0%***	***-33.7%***	12.7%
Second CCBHC Period	***-26.4%***	***-41.5%***	10.4%
Days per Person			
First CCBHC Period	26.4%	-13.9%	20.3%
Second CCBHC Period	-0.8%	26.9%	***47.0%***

Table A7.7a: Change in Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services

Total Expenditures per Person	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Total						
First CCBHC Period	***9.3%***	2.8%	1.5%	***8.8%***	***10.2%***	***23.2%***
Second CCBHC Period	***14.9%***	-2.4%	22.8%	9.8%	***16.7%***	8.4%
Inpatient						
First CCBHC Period	***-16.1%***	-36.2%	***-48.0%***	-16.5%	-11.7%	71.4%
Second CCBHC Period	-7.3%	-32.2%	39.9%	-32.8%	-5.7%	-3.9%
Mental Health RTF						
First CCBHC Period	38.3%	NR	-51.0%	185.6%	19.8%	NR
Second CCBHC Period	***95.4%***	NR	NR	-85.6%	90.8%	NR
Substance Use RTF						
First CCBHC Period	***-45.3%***	NR	NR	81.6%	-28.8%	-60.3%
Second CCBHC Period	***-45.1%***	NR	NR	-99.7%	***-47.7%***	54.2%
Emergency Department						
First CCBHC Period	-2.1%	-5.4%	-21.8%	10.4%	-2.4%	33.5%
Second CCBHC Period	0.4%	1.5%	***-30.1%***	12.8%	1.0%	-0.1%
MH & SUD Outpatient						
First CCBHC Period	***24.9%***	***25.6%***	4.0%	***25.5%***	***27.2%***	***27.4%***
Second CCBHC Period	***44.1%***	***25.7%***	20.5%	***48.3%***	***48.9%***	***42.8%***
Primary Care						
First CCBHC Period	***9.1%***	6.5%	7.8%	***9.0%***	***9.6%***	-3.3%
Second CCBHC Period	***-4.6%***	-9.4%	***-18.8%***	-2.0%	***-2.8%***	***-16.6%***
Other Services						
First CCBHC Period	***20.2%***	8.9%	***51.9%***	***19.2%***	***17.6%***	***39.4%***
Second CCBHC Period	***15.6%***	-7.1%	18.1%	9.9%	***17.8%***	23.5%

Table A7.7b: Change in Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence

Total Expenditures per Person	All CCBHC	Urban	Rural or Remote
Total			
First CCBHC Period	***9.3%***	***8.8%***	***10.7%***
Second CCBHC Period	***14.9%***	***14.6%***	***16.6%***
Inpatient			
First CCBHC Period	***-16.1%***	***-17.3%***	-14.6%
Second CCBHC Period	-7.3%	0.8%	-14.4%
Mental Health RTF			
First CCBHC Period	38.3%	***78.9%***	13.3%
Second CCBHC Period	***95.4%***	***124.1%***	71.3%
Substance Use RTF			
First CCBHC Period	***-45.3%***	***-62.3%***	-34.6%
Second CCBHC Period	***-45.1%***	***-76.5%***	-23.9%
Emergency Department			
First CCBHC Period	-2.1%	-4.3%	2.1%
Second CCBHC Period	0.4%	-8.0%	***13.0%***
MH & SUD Outpatient			
First CCBHC Period	***24.9%***	***14.1%***	***41.3%***
Second CCBHC Period	***44.1%***	***36.8%***	***57.9%***
Primary Care			
First CCBHC Period	***9.1%***	***7.3%***	***12.1%***
Second CCBHC Period	***-4.6%***	***14.1%***	-1.8%
Other Services			
First CCBHC Period	***20.2%***	***37.2%***	0.7%
Second CCBHC Period	***15.6%***	***19.5%***	***11.8%***

Table A7.7c: Change in Mental Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services

Mental Health Expenditures per Person	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Total						
First CCBHC Period	***19.4%***	5.2%	6.8%	11.4%	***20.9%***	***77.6%***
Second CCBHC Period	***28.1%***	1.0%	35.3%	***19.4%***	***31.0%***	27.9%
Inpatient						
First CCBHC Period	***-19.8%***	162.0%	-43.7%	***-86.9%***	***-30.6%***	716.8%
Second CCBHC Period	***-29.5%***	168.6%	***-83.7%***	***-77.9%***	-14.6%	NR
Mental Health RTF						
First CCBHC Period	38.3%	NR	-51.0%	185.6%	19.8%	NR
Second CCBHC Period	***95.4%***	NR	NR	-85.6%	90.8%	NR
Emergency Department						
First CCBHC Period	***-13.4%***	-6.3%	-35.4%	25.6%	***-17.7%***	***111.5%***
Second CCBHC Period	***-14.6%***	-14.4%	-36.7%	30.4%	***-16.5%***	-29.3%
MH Outpatient						
First CCBHC Period	***23.1%***	***26.9%***	2.4%	***25.9%***	***24.2%***	36.6%
Second CCBHC Period	***39.9%***	***35.7%***	12.3%	***49.8%***	***41.9%***	***58.1%***
Other Services						
First CCBHC Period	***90.0%***	-2.8%	NR	***60.9%***	***82.6%***	NR
Second CCBHC Period	***56.8%***	-29.4%	86.8%	44.6%	***65.7%***	95.0%

Table A7.7d: Change in Mental Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence

Mental Health Expenditures per Person	All CCBHC	Urban	Rural or Remote
Total			
First CCBHC Period	***19.4%***	***21.2%***	***17.7%***
Second CCBHC Period	***28.1%***	***42.0%***	***14.9%***
Inpatient			
First CCBHC Period	***-19.8%***	-15.0%	***-40.6%***
Second CCBHC Period	***-29.5%***	19.0%	-30.5%
Mental Health RTF			
First CCBHC Period	38.3%	***78.9%***	13.3%
Second CCBHC Period	***95.4%***	***124.1%***	71.3%
Emergency Department			
First CCBHC Period	***-13.4%***	***-20.2%***	-1.4%
Second CCBHC Period	***-14.6%***	***-18.0%***	-6.4%
MH Outpatient			
First CCBHC Period	***23.1%***	***16.8%***	***32.6%***
Second CCBHC Period	***39.9%***	***43.3%***	***37.3%***
Other Services			
First CCBHC Period	***90.0%***	***229.8%***	8.3%
Second CCBHC Period	***56.8%***	***111.5%***	27.4%

Table A7.7e: Change in Substance Use Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services

Substance Use Expenditures per Person	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Total						
First CCBHC Period	***18.8%***	-2.8%	-3.1%	25.7%	***27.4%***	-5.0%
Second CCBHC Period	***32.7%***	10.0%	33.5%	16.0%	***40.8%***	***63.0%***
Inpatient						
First CCBHC Period	***-2.4%***	280.0%	49.6%	-56.1%	***-65.8%***	-16.1%
Second CCBHC Period	3.6%	NR	985.9%	***-95.7%***	92.3%	328.4%
Substance Use RTF						
First CCBHC Period	***-45.3%***	NR	NR	81.6%	-28.8%	-60.3%
Second CCBHC Period	***-45.1%***	NR	NR	-99.7%	***-47.7%***	54.2%
Emergency Department						
First CCBHC Period	15.8%	NR	-88.8%	-47.9%	18.1%	NR
Second CCBHC Period	***52.0%***	NR	-98.9%	NR	32.2%	NR
SUD Outpatient						
First CCBHC Period	***31.0%***	-3.5%	39.8%	22.5%	***39.2%***	11.0%
Second CCBHC Period	***48.9%***	7.1%	***56.9%***	15.7%	***68.3%***	65.5%
Other Services						
First CCBHC Period	14.9%	38.5%	-57.7%	-27.7%	31.3%	***-95.7%***
Second CCBHC Period	-6.6%	-10.5%	***-77.7%***	-49.1%	5.1%	-17.5%

Table A7.7f: Change in Substance Use Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence

Substance Use Expenditures per Person	All CCBHC	Urban	Rural or Remote
Total			
First CCBHC Period	***18.8%***	-7.5%	***77.7%***
Second CCBHC Period	***32.7%***	-9.1%	***136.8%***
Inpatient			
First CCBHC Period	***-2.4%***	***-98.4%***	NR
Second CCBHC Period	3.6%	-6.4%	NR
Substance Use RTF			
First CCBHC Period	***-45.3%***	***-62.3%***	-34.6%
Second CCBHC Period	***-45.1%***	***-76.5%***	-23.9%
Emergency Department			
First CCBHC Period	15.8%	***-41.1%***	***261.2%***
Second CCBHC Period	***52.0%***	25.2%	***169.0%***
SUD Outpatient			
First CCBHC Period	***31.0%***	4.9%	***73.5%***
Second CCBHC Period	***48.9%***	7.0%	***121.4%***
Other Services			
First CCBHC Period	14.9%	0.5%	***62.3%***
Second CCBHC Period	-6.6%	***-34.9%***	***78.9%***

Table A7.7g: Change in Physical Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Race/Ethnicity Services

Physical Health Expenditures per Person	All CCBHC	Am Ind/ Al Native	Black/ Afr Am	Hispanic/ Latino/a/x	White	All Other Race/ Ethnicity
Total						
First CCBHC Period	***3.7%***	-7.1%	8.4%	***13.4%***	2.5%	16.8%
Second CCBHC Period	1.8%	***-13.0%***	-0.7%	6.8%	2.7%	3.4%
Inpatient						
First CCBHC Period	***-15.3%***	***-48.3%***	-31.6%	40.1%	***-16.2%***	101.4%
Second CCBHC Period	***-19.7%***	***-50.1%***	2.0%	12.3%	***-19.0%***	-28.7%
Emergency Department						
First CCBHC Period	2.9%	-6.9%	-19.3%	12.7%	0.2%	33.4%
Second CCBHC Period	-13.4%	1.6%	***-30.0%***	***16.1%***	4.3%	23.6%
Primary Care						
First CCBHC Period	***9.1%***	6.5%	7.8%	***9.0%***	***9.6%***	-3.3%
Second CCBHC Period	***-4.6%***	-9.4%	***-18.8%***	-2.0%	***-2.8%***	***-16.6%***
Other Services						
First CCBHC Period	***14.3%***	9.9%	23.7%	***24.4%***	***9.2%***	19.0%
Second CCBHC Period	***90.0%***	1.4%	8.2%	***16.4%***	***15.4%***	19.7%

Table A7.7h: Change in Physical Health Related Expenditure Levels per Person for CCBHC OHP Members by Service Type Overall and by Place of Residence

Physical Health Expenditures per Person	All CCBHC	Urban	Rural or Remote
Total			
First CCBHC Period	***3.7%***	***6.4%***	0.2%
Second CCBHC Period	1.8%	-0.6%	**5.0%**
Inpatient			
First CCBHC Period	***-15.3%***	***-21.2%***	-4.8%
Second CCBHC Period	***-19.7%***	***-29.6%***	-5.7%
Emergency Department			
First CCBHC Period	2.9%	-0.4%	2.7%
Second CCBHC Period	-13.4%	-4.9%	16.9%
Primary Care			
First CCBHC Period	***9.1%***	***7.3%***	***12.1%***
Second CCBHC Period	***-4.6%***	***14.1%***	-1.8%
Other Services			
First CCBHC Period	***14.3%***	***20.3%***	***0.8%***
Second CCBHC Period	***90.0%***	***15.6%***	***11.3%***