Part 2: Program Narrative

Section A. Solicitation of Input by Stakeholders in Developing Certified Community Behavioral Health Clinics (CBHCs)

The applicant agency is the Pennsylvania Department of Human Services/Office of Mental Health and Substance Abuse Services (DHS/OMHSAS). DHS/OMHSAS is responsible for public behavioral health services in Pennsylvania. DHS/OMHSAS has worked in partnership with the DHS Office of Medical Assistance Programs (OMAP) which is the Single State Medicaid Agency, and the Department of Drug and Alcohol Programs (DDAP) on the Planning Grant. This collaboration will continue for the Demonstration Program. OMHSAS will also continue to utilize the expertise of Mercer, Drexel University, the Pennsylvania Mental Health Consumer Association (PMHCA), and the Mental Health Association of Pennsylvania (MHAPA) to bring the subject matter expertise critical to the implementation of the CCBHCs within the Commonwealth of Pennsylvania.

In addition to the Planning Grant, DHS/OMHSAS has been awarded several relevant SAMHSA grants, including a Co-Occurring Disorders Grant, a System of Care Cooperative Agreement, a System of Care Expansion Planning Grant, and several grants focused on expanding the use of recovery-oriented services including self-directed care and peer supports. The successful implementation of these grants speaks to the current capacity within Pennsylvania to undertake transformative efforts in the behavioral health (BH) system as well as the investment and support for improving recovery-oriented services across the commonwealth. These efforts have been closely planned and implemented in collaboration with consumers, family, and other key stakeholders. Inclusion of these key stakeholders facilitates the delivery of services that are consumer driven, culturally and linguistically appropriate, and directed toward improved outcomes for those individuals served.

OMAP oversees the eight physical health Medicaid managed care organizations (MCOs) and the fee-for-service program. Over the past ten years OMAP has participated in a multi-payer medical home collaborative, initiated three pay for performance programs, developed a multi-state application for the Medicaid electronic health record (EHR) incentive program, established nonpayment policies for readmissions and preventable serious adverse events in hospitals, developed telemedicine payment policies, implemented a pharmacy preferred drug management program, and expanded the HealthChoices mandatory physical health managed care program statewide. OMAP and OMHSAS have been working on initiatives to integrate BH and physical health (PH) by participating on the Medicaid Innovation Accelerator Program – Substance Abuse Disorders High Intensity Learning Collaborative, establishing the Person-Center Medical Home Advisory Council, and developing a pay-for-performance incentive for the integration care for joint BH and PH MCOs beneficiaries.

DDAP is the single state agency for substance use services, with responsibility for the planning, direction, and coordination of statewide efforts related to substance use disorders (SUDs). DDAP's mission is to engage, coordinate, and lead Pennsylvania's efforts to prevent and reduce drug, alcohol, and gambling addiction and abuse and to promote recovery, thereby reducing their human and economic impact. Collectively, the above organizations work closely to lead Pennsylvania's BH innovations, and do so in part through the Mental Health Planning Council.

Pennsylvania Mental Health Planning Council (PMHPC)
The PMHPC is DHS/OMHSAS' Advisory Committees and includes youth, adults, and older adults who have been served by the BH system, their family members, providers, advocates, professionals, and their respective organizations, as well as governmental organizations. At least 51% of the members of the Council are current or prior BH consumers and family members.

The purpose of the PMHPC is to provide counsel and guidance to the DHS/OMHSAS in order to ensure an infrastructure and full array of mental health and substance use services that comply with the Mission, Vision and Guiding Principles of OMHSAS, as well as core principles of the Community Support Program (CSP), Child and Adolescent Service System Program (CASSP), Cultural Competency, and DDAP. The PMHPC utilizes three committees and two sub-committees: *Children's Advisory Committee, Adult Advisory Committee, Older Adult Advisory Committee, Transition Age Youth Sub-Committee, and Persons in Recovery Sub-Committee*. These committees advise on a broad behavioral mandate that includes, but is not limited to, mental health, substance use disorders (SUDs), and cross-system disability.

DHS created a new sub-committee focusing on CCBHCs for the Planning Grant. The sub-committee, which will continue throughout the Demonstration, includes representatives from each of the existing Council sub-committees, plus statewide and regional consumer and family organizations (see list of collaborative stakeholder organizations below). The CCBHC sub-committee provides regular reports and information exchanges with the Council-at-large and with its other committees and sub-committees.

Description of Outreach, Recruitment, and Engagement of the Target Population
Pennsylvania has cast a wide net to engage stakeholders in the CCBHC program. In the planning year, there have been four live Communication Forums in four regions of the state (West, Central, Northeast, and Southeast) to solicit input. Public notices were utilized to inform communities of the opportunity to participate and the forums were open to everyone, including community members, clinic representatives, consumers and their families, county representatives, MCOs, and statewide groups including the Rehabilitation Community Providers Association (RCPA), the Pennsylvania Psychiatric Leadership Council (PPLC), the PA Department of Human Services Operations Team, the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS), and the PMHPC. Additional engagement occurred when the Program Director traveled to sites throughout Pennsylvania (Erie, Philadelphia, and Pittsburgh) and discussed the CCBHC process to interested groups of stakeholders. PA has

a strong regional Community Support Program (CSP) in place and the CCBHC was discussed at this important local level. A statewide Steering Committee meeting was held on January 29, 2016, with 25 invited stakeholders representing consumers/families and youth, providers, MCOs, county representatives, and state entities such as the Department of Military & Veteran Affairs, DDAP, Office of Children, Youth, and Families (OCYF), and the Department of Corrections (DOC). In addition, DHS lead three webinars to further communicate information about the CCBHC project. PA has honored the spirit of transparency throughout the planning process and has opened meetings to all stakeholders. To facilitate such open communication, DHS/OMHSAS set up a resource account for e-mail correspondence to encourage discussion and input about the CCBHC project.

In addition, DHS/OMHSAS has worked on an ongoing basis during the planning year with the following stakeholders through meetings and forums convened by DHS/OMHSAS:

☐**PMHCA,** described above, recognizes the expertise that comes out of lived experience with mental health problems, and promotes and supports recovery through advocacy and education with the goal of eliminating stigma and discrimination around mental health issues.

☐**MHAPA** is a nonprofit organization that reflects the ethnic and cultural diversity of the commonwealth and works on behalf of the mental health of its citizens, instilling principles that facilitate recovery and resiliency through advocacy, education, and public policy.

☐**RCPA** is one of the largest state health and human services trade associations in the nation with more than 325 members serving well over one million Pennsylvanians annually.

☐**PACA MH/DS,** an affiliate of the County Commissioners Association of Pennsylvania (CCAP), represents county mental health and intellectual disability program administrators from all of Pennsylvania's counties.

☐**National Alliance on Mental Illness of Southwestern Pennsylvania** is a regional affiliate of the National Alliance on Mental Illness (NAMI), the nation's largest grassroots mental health organization dedicated to building better lives for Americans affected by mental illness.

☐**Community Support Program (CSP)** of Pennsylvania is a coalition of mental health consumers, family members, and professionals working to help adults with serious mental illnesses and co-occurring disorders live successfully in the community.

☐**Pennsylvania Recovery Organizations Alliance (PRO-A)** works with regional organizations to develop a statewide organizational structure, identifying recovery groups throughout the commonwealth that work together on behalf of the recovery community.

☐**Pennsylvania Department of Military and Veterans Affairs (DMVA)** collaborates with DHS/OMHSAS on issues related to the BH needs of military personnel, veterans, and their family members. DMVA contributes knowledge and resources to assist CCBHCs that serve members of the military community (e.g., DMVA recommended Col. Stokes, the speaker for our two CCBHC workshops on Military Culture in September). DMVA also serves as a link to benefits and supports that are available to military families.

☐**Pennsylvania DOC** collaborates with DHS/OMHSAS on issues related to the BH needs of individuals incarcerated with mental health concerns.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

☐**Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA)** is a professional association that represents the Single County Authorities (SCAs) across the commonwealth who receive state and federal dollars through contracts with DDAP.

☐**Youth MOVE PA**, a statewide chapter of National Youth MOVE, is comprised of youth, young adults, youth organizations, system advisors, and youth allies who support youth empowerment in the services delivery system.

PMHCA and **MHAPA**, in particular, have provided ongoing technical assistance and resources to ensure the input and engagement of service recipients and family members in the design and implementation of the CCBHC initiative and at each local clinic that has been certified as a qualifying CCBHC. They continue to provide input during the Demonstration Program.

Given that DHS values regular input from stakeholders representing the diverse population of Pennsylvania, DHS/OMHSAS has used a four-part strategy to connect with consumers, family members, providers, and other stakeholders for the CCBHC Planning Grant:

a. Special Planning Task Forces, Public Forums and Focus Groups convened by DHS/OMHSAS. The CCBHC Steering Committee is a subcommittee of the DHS/OMHSAS Planning Council. The Steering Committee has 29 members, of which 15 (52%) are either consumers/persons in recovery or family members (e.g., PMHCA, MHAPA, PRO-A, Youth Move, individual consumers and family members representing diverse BH problems, and representatives from the PMHPC's Adult, Older Adult, and Children's committees). Agency partners included representatives from the DMVA, DOC, DHS' Office of Long Term Living, OMAP, OCYF, DDAP, and OMHSAS. In addition, county and provider representatives from PACDAA, PACA MH/DS, RCPA, the Drug and Alcohol Service Providers Organization of Pennsylvania, Magellan Health, Pennsylvania Association of Community Health Centers, and the Pennsylvania Public Psychiatry Council serve on the Steering Committee. Committee meetings and workgroups are open to the public to ensure wide spread participation.

With valuable input from the CCBHC Steering Committee, DHS/OMHSAS convened regional forums to gather input from a broad array of external stakeholders, in addition to those who serve on the Council or other standing committees, during the past two years. DHS/OMHSAS invited numerous stakeholders to participate in the planning process to assess and address the BH needs of Pennsylvania residents. Over 500 stakeholders participated in the twenty forums, including those from regional Community Support Programs, individuals receiving services, family members, advocates, providers, county personnel, community members, and others to review our current system and to initiate planning steps. Feedback from the forums as to how DHS/ OMHSAS can best build connections with stakeholders included conducting regional meetings, surveys, e-mail blasts, more drop-in centers, webinars, forums, and website communication. These suggestions directed our efforts to solicit input from the diverse group of stakeholders across Pennsylvania. DHS/OMHSAS will continue to convene regional forums to meet with government stakeholders in communities across the commonwealth to receive

feedback about accessibility and availability of services of all clinical programs, including CCBHCs.

b. Establishment of Expectations that CCBHCs will Increase Consumer Engagement in Services. In addition to working closely with the above stakeholder organizations to facilitate consumer engagement, each CCBHC must have policies and procedures to ensure outreach to and engagement of the target population. Strategies utilized include group education, mass media, and social media campaigns. Moreover, to effectively engage consumers the CCBHCs are:

☐*Assisting consumers and families* in accessing benefits and formal or informal services to address BH problems and needs; and

☐*Enhancing health literacy* as each CCBHC has a communication plan specifying procedures to enhance health literacy in their clinic.

To optimize the availability and accessibility of services for consumers, each CCBHC will also:

☐*Serve any individual* presenting for services and provide them with a welcoming environment, regardless of their ability to pay or their place of residence. The CCBHCs will also serve individuals whose treatment is court-ordered.

☐*Maintain evening and/or weekend hours* because many individuals are unable to access services during traditional business hours. CCBHCs will have clearly established relationships with local emergency departments and other sources of crisis care to facilitate care coordination, discharge, and follow-up. CCBHCs will also have established relationships with local hospitals to facilitate post-discharge follow-up within seven days of an inpatient stay. CCBHCs will utilize peer, recovery, and clinical supports in the community and increase access through the use of telehealth/telemedicine and mobile in-home supports.

☐*Screen and conduct a risk assessment* for all new consumers requesting or being referred for BH services during their first contact, followed by an initial evaluation. Screening will include the Patient Health Questionnaire (PHQ 9). A more comprehensive person-centered and family-centered diagnostic and treatment planning evaluation will be completed within 60 calendar days of the request for services and updated at least every 90 days. Outpatient clinical services for CCBHC consumers seeking an appointment for routine needs must be provided within 10 business days of the requested date of service. Crisis management services will be available and accessible 24-hours a day and delivered within three hours.

c. Coordination with Other Local, State, and Federal Agencies to Ensure that Services are Accessible and Available. DHS/OMHSAS has had extensive discourse with partnering governmental agencies to ensure that services are available and accessible. With 939,000 veterans, Pennsylvania has the fourth highest number of veterans in the nation. To meet their health care needs, there are eight VA Medical Centers, twelve Veterans Centers, two Mobile Veterans Centers, and thirty eight Community Based Outpatient Centers throughout the state (see map in Part 2 Attachment 1 DMVA Centers). DHS/OMHSAS works closely with Veteran's agencies to coordinate BH care. The DMVA actively participated on the CCBHC Steering Committee and provided technical assistance to the

clinics on accessing care for veterans and how to connect them with Veterans benefits through care coordination.

d. Engagement with Commonwealth and County Government Offices and Related Organizations. DHS/OMHSAS also continues to interact with other governmental departments and related organizations through a recurring schedule of meetings and forums, including the:

☐ MHAPA, PACDAA, PACA MH/DS, PPLC, RCPA, and CCAP
☐ Medical Assistance Advisory Committee
☐ System of Care State Leadership and Management Team
☐ Drug and Alcohol Service Providers Association of Pennsylvania (DASPOP)
☐ Hospital Association of Pennsylvania (HAP)
☐ Pennsylvania Suicide Prevention Coalition
☐ Pennsylvania Association of Psychiatric Rehabilitation Services
☐ Commonwealth Prevention Alliance (CPA)
☐ Pennsylvania Association of Human Service Administrators (PACHSA)
☐ PA Commission on Crime and Delinquency, Mental Health & Justice Advisory Committee
☐ Pennsylvania DOC
☐ Pennsylvania DMVA

In addition to the above processes that have ensured broad participation by key stakeholders throughout the commonwealth, each CCBHC has verified that their corporate boards have at least 51% membership consisting of consumer or family members or a verified plan to receive substantial and meaningful input and ongoing guidance from program consumers and family members. As an example, one clinic established a consumer advisory board with the chair being appointed to the clinic's governance board. DHS/OMHSAS has also reached out to engage other interested parties including individuals representing at-risk and underserved populations such as members of the LGBTQI community, service members and their families, transition age youth, and individuals involved in the criminal justice system. Thus, we have successfully solicited and received valuable input from Pennsylvania's extensive pool of stakeholders, and in so doing have improved the process of developing CCBHCs, which we describe below.

Section B. Certification of CCBHCs

Description of the Processes and Review Procedures Used to Certify Clinics:
Pennsylvania has 16 Community Mental Health Centers that are certified by Medicare and 267 facilities licensed to provide outpatient mental health services. Over 650,000 individuals are served by this system. There are 49 Federally Qualified Health Centers (FQHCs) and look-a-likes in Pennsylvania caring for approximately 700,000 individuals. For the Planning Grant, DHS issued a request for letters of interest and received letters from 76 clinics. Following feedback from members of the Steering Committee and from county stakeholders, a subsequent request for applications (RFA) was released that required completion of a survey tool and the Certified Clinic Readiness Tool (CCRT) to help determine which of these clinics were best prepared in terms of existing infrastructure

and leadership to make the commitment to work toward meeting certification criteria during the planning year. Only clinics established prior to April 1, 2014, were considered eligible to become a CCBHC. Receipt of accreditation by a nationally-recognized organization such as The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, and/or the Accreditation Association for Ambulatory Health Care was considered, but not required.

The selection committee reviewed the applications, including how well agencies met federally established criteria, and received input from each county in which the clinics currently operate. On April 4, 2016, DHS announced the selection of 16 clinics to participate in the CCBHC Planning Grant. Each application included a completed cost report, letters of support from the Single County Authority and Mental Health Administrator, and a CCRT. In addition, all clinics participated in a learning community focused on the CCBHC requirements including governance, Designated Collaborating Organization (DCO) agreements, care management, needs assessments, and the nine required services.

DHS chose to have each of the 16 CCBHC candidates complete a needs assessment determining the BH needs of the local community. Input for the needs assessment came from a variety of sources including surveys of the general community, consumers, families and staff, forums, the county, MCOs and the local hospital. Information was also included from the previous county health department, foundation, or hospital needs assessments if done within the past three years. These assessments were completed by May 2016. The assessments focused on the gaps in services as well as staffing, clinic hours, and transportation. A Readiness Tool was developed with our consultant, Mercer, which took into account the 173 criteria as detailed in Section 223 and the certification readiness guide and checklist. The readiness process consisted of a desk review of policies and procedures followed by an on-site review. The desk review was conducted by teams from Mercer and DHS. Each clinic completed a Readiness Review Tool by June 2016, to provide an overview of their readiness to be certified. This information was reviewed by members of our CCBHC Certification Planning Group. In July 2016, each CCBHC was then visited by a team of members from the Certification Planning Group. The on-site review teams consisted of DHS, Mercer, county mental health, BH managed care, and consumer members from the CCBHC Steering Committee. During these fullday verification site visits, the Evaluation Tool was used to complete the CCBHC Certification Checklist, assessing clinics' readiness on each of the 173 criteria required to be certified. Six CCBHCs were found to have only minor areas in need of improvement, with the others having some major areas in need of remediation that needed to be addressed. Oral feedback was given to clinics at the time of the site visit, with written feedback provided within a week of the visit. All clinics had four weeks to address areas in need of remediation. The final results of the Certification Checklist are presented in Attachment 1 for the ten clinics meeting certification criteria and demonstrate the high level of readiness of Pennsylvania's CCBHCs.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

The ten clinics met criteria and were certified as a CCBHC in August 2016 (see Appendix 3 for a list of participating clinics). These 10 CCBHCs were selected for their ability to meet the Demonstration Program criteria of providing community-based mental health and substance use disorder services; advancing integration of BH with PH care; assimilating and utilizing evidence-based practices (EBPs) on a more consistent basis; and promoting improved access to high-quality care. The ability of each of the CCBHCs to meet criteria in the following domains was evaluated: 1) staffing; 2) availability and accessibility of services; 3) care coordination; 4) scope of services; 5) quality and other reporting; and 6) organizational authority. See our Compliance with CCBHC Criteria Checklist for further documentation of clinic's ability to meet specific criteria in each of these domains.

Throughout the process, DHS/OMHSAS was highly collaborative and worked to support all qualified clinics throughout the process, rather than to create a competitive process in which only a few of the absolute top clinics continued on. DHS felt that doing so was important to best capture the broad diversity of clinics and their target populations throughout the commonwealth. In working with a broad group of clinics, substantial collaborative learning has occurred that better positions Pennsylvania to expand the CCBHC program to a much larger number of clinics following the Demonstration Program. In addition, we continue to work with clinics that did not meet certification criteria as each is interested in continuing the certification process, although these clinics will *not* be included in the Demonstration Program.

Description of the Diversity of Pennsylvania's CCBHCs
Pennsylvania's CCBHCs are highly diverse in terms of geography, population density, ethnicity/race, socioeconomic status, and the inclusion of medically underserved areas. The 10 CCBHCs serve a diverse population that is reflective of Pennsylvania's citizens and, in many ways, of the broader U.S. population. Prevalence rates for BH problems in Pennsylvania are similar to national rates, with unique features based on geography and ethnic/racial characteristics (e.g., SAMHSA, Center for Behavioral Health Statistics and Quality. (February 28, 2014). The NSDUH Report: State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health. Rockville, MD). Pennsylvania is a mix of urban and rural areas, with approximately 63% of Pennsylvanians living in urban or suburban areas.

DHS utilized the Center for Rural Pennsylvania's population density-based definition of rural to determine which CCBHCs service area is located in an urban or rural area of the Commonwealth. According to the Center's definition, Pennsylvania has 48 rural counties and 19 urban counties. In 2010, nearly 3.5 million residents, or 27% of the state's 12.7 million residents, lived in a rural county. As shown in the map (Part 2 Attachment 2 Pennsylvania's CCBHCs), CCBHCs are located throughout Pennsylvania, with four representing urban areas and six representing rural areas. To illustrate the diversity of CCBHC communities in Pennsylvania, we highlight three of our clinic locations. Berks Counseling Center, a CCBHC located in Berks County, serves a largely rural community with a large Hispanic/Latino population (16%). In contrast, the Safe Harbor CCBHC is

located in Erie, a small city within a county that is 66% rural, with an active refugee relocation center whose largest populations come from Bhutan, Somalia, and Iraq. Philadelphia, home of two of our CCBHCs, is the nation's fifth largest city with the highest poverty rate among the ten largest cities in America, and has a racially and ethnically diverse population that is 44% Black/African American, 36% White, 14% Hispanic/Latino, and 7% Asian. In addition to possessing considerable geographical, urban/rural, racial, and ethnic diversity, three of Pennsylvania's CCBHCs are located in mental health professional shortage areas. Accordingly, while only two CCBHCs are required for the Demonstration Program, DHS felt that including a larger number of CCBHCs is critical to best capture the diversity of Pennsylvania's clinics and population.

How Pennsylvania has Facilitated Cultural, Procedural, and Organizational Changes to CCBHCs Resulting in High-Quality Services

DHS/OMHSAS has facilitated many important changes to enhance the implementation of high-quality services. DHS has assisted the CCBHCs as they worked to meet certification standards by: facilitating access to training, providing technical assistance, assessing gaps in staffing and services, building partnerships and formal relationships, implementing evidenced-based practices (EBPs) with fidelity, assisting the development of care coordination performance measurement and reporting practices, recommending continuous quality improvement processes, and implementing and optimizing health information technology infrastructure. DHS has coordinated training for CCBHCs on the certification criteria that consisted of 39 sessions provided via webinar over a three month period. Military cultural training was provided to each CCBHC, and each clinic was given the opportunity to participate in Recovery-To-Practice training which is delivered jointly by a psychiatrist and a consumer. The CCBHC Steering Committee and the clinics were involved in the vetting and final selection of the EBPs selected by the state. These EBPs will be used by the CCBHCs based on their specific needs assessment; however, they will also be considered as the core treatment practices endorsed by DHS/OMHSAS to be used throughout the behavioral health delivery system.

Review of the CCBHC needs assessments reflects the geographical diversity of the state. The urban clinics have staff generally reflective of their community while rural areas have a more difficult time recruiting and retaining a diverse workforce. This is particularly true for clinics working with refugee populations, as it is challenging to recruit staff familiar with the culture and language of refugee groups. The clinics have accepted the expectation that CCBHCs will continue to expand the diversity of the workforce whenever possible. Strategies to do so include: recruiting and promoting from diverse pools of candidates, supporting flexible work arrangements, providing leadership education, and ongoing evaluation of diversity and inclusion.

DHS/OMHSAS has also helped CCBHCs to improve the cultural diversity and overall competence of their workforces by:
☐ Verifying that CCBHCs had a mechanism for and commitment to meaningful input from consumers, persons-in-recovery, and family members.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

☐ Ensuring that CCBHCs have the capacity to accept, utilize, and collaborate with all service systems and funding sources necessary to meet the needs of persons with mental illness and SUDs presenting for services independent of where the payment sources originate, i.e., self-pay, Medicaid/Medicare, private insurance, federal block grant funds, state or local funds, Department of Defense, Department of Veterans Affairs, social security or other sources.

☐ Establishing scope of service requirements that encourage CCBHCs to expand the availability of high-quality, integrated, person-centered, and family-centered care and to ensure the continual
integration of new EBPs. Pennsylvania required that CCBHC services include the following:

- Crisis BH services that include 24 hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis that includes a comprehensive person- and family-centered diagnostic and treatment planning evaluation completed within 60 days by licensed BH professionals.
- Screening and assessment using validated tools that are culturally and linguistically appropriate.
- Brief motivational interviewing techniques where appropriate.
- Person-centered and family-centered treatment planning during which an individualized treatment plan will integrate prevention, medical, and BH needs, and service delivery that is developed in collaboration with the individual and the family.
- Outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management services that include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an emergency room or psychiatric hospitalization.
- Psychiatric rehabilitation services that include, but are not limited to, medication education, self-management, training in personal care skills, individual and family/caregiver psycho-education, community integration services, recovery support services including illness management and recovery, financial management, and dietary and wellness education.
- Peer supports, peer counseling, and family/caregiver supports, including but not limited to peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services; &
- Intensive community-based mental health care for members of the armed forces and veterans.

Crisis services, screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services will be provided directly by the CCBHCs. The other services may be provided through a contract with a DCO.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

To further facilitate cultural, procedural, and organizational changes among CCBHCs, DHS/ OMHSAS is using a five part strategy to transition from planning activities and proposal preparation to CCBHC implementation:

a. *DHS/OMHSAS is using the PMHPC and CCBHC-interested stakeholder groups* to maintain effective communication and to solicit continuing input on CCBHC project developments from the planning phase through implementation. The PMHPC's three committees and two sub-committees, as mentioned on p. 4, will monitor CCBHC implementation with the assistance of the CCBHC Steering Committee. The Sub-Committee receives ongoing staff updates on CCBHC progress and in turn provides regular reports and information exchanges with the Council-at-large and its other committees and sub-committees.

b. *DHS/OMHSAS has leveraged the existing HealthChoices BH-MCO contracting framework to engage and fund selected CCBHCs and serve as the structure for the CCBHC prospective payment system.* HealthChoices contracts are built on recovery and resiliency principals. Consumers and families serve on a Quality Management Committee established under each BH-MCO contract. Counties and BH-MCOs maintain Consumer/Family Satisfaction Teams (C/FSTs) that conduct face-to-face surveys to determine if the program is meeting the needs of people served. The HC-BH Performance report, published annually, presents the results of the C/FST survey questions and 29 quality indicators. The program is reviewed annually by an external quality management organization which submits a report to the Center for Medicare and Medicaid Services (CMS) regarding the effectiveness of the state's oversight. The PHMPC and the DHS Medical Assistance Advisory Committee (MAAC) receive at least quarterly updates about the CCBHC program and provide feedback from stakeholders about how the program is working. Each contract has a DHS/OMHSAS contract monitoring team in the DHS/OMHSAS regional field office.

c. *Use of HealthChoices actuarial resources to assure effective Certified Clinic Prospective Payment System [CC PPS-1] rate setting bases are actuarially sound.* DHS and CMS receive a certification from DHS' actuaries that ensures that the capitation rates were developed using actuarial standards and that the rate setting meets the CMS requirements. The HealthChoices actuarial resources are responsible for creating the CCBHC PPS rate setting methodology. DHS/OMHSAS plans to use the CC PPS-1 rate structure.

d. *Use of established HealthChoices resources to manage CCBHC Quality Assurance and Quality Management functions*. The OMHSAS Quality Management program ensures public accountability and continuous quality improvement of OMHSAS programs and services. The PMHPC includes consumers, advocates, providers, counties, and MCOs in addition to OMHSAS staff, with representation for adults, children, and older adults as well as for persons with mental health and SUDs. It also ensures participation by members of ethnicities and minority groups served by DHS/OMHSAS. The MHPC reviews results from the quality assurance and quality management programs and provides guidance and feedback to DHS/OMHSAS for input in the DHS/OMHSAS Quality Strategy. Quality results are posted on the PaRecovery.org website for stakeholder comment and feedback throughout the year. DHS/OMHSAS has engaged

families and consumers to develop and establish Guiding Principles for the provision of quality services and supports that:

☐ Facilitate recovery for adults and resiliency for children

☐ Are responsive to individuals' unique strengths and needs throughout their lives

☐ Focus on prevention and early intervention

☐ Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation

☐ Ensure individual human rights and eliminate discrimination and stigma

☐ Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family

☐ Are developed, monitored, and evaluated in partnership with consumers, families, and advocates

☐ Represent collaboration with other agencies and service systems

e. *DHS/OMHSAS has established an overarching quality framework* that relies on consumers and families, combined with the participation of the counties, providers, and BH-MCOs to continuously improve services and supports. Key objectives of the DHS/OMHSAS (Plan-Do-Act-Check; P-D-C-A) Quality framework include:

☐ Increasing access to community and family-based services and supports

☐ Providing high-quality services

☐ Improving consumer satisfaction

☐ Obtaining stakeholder feedback to continuously improve DHS/OMHSAS services

In addition to these five strategies to facilitate the transition from planning activities and proposal preparation to CCBHC implementation, the Bureau of Quality Management and Data Review measures HealthChoices' success in improving the value and quality of BH services and will provide technical quality management and data support throughout the CCBHC implementation phase.

How CCBHC Needs Assessment Reflects Behavioral Health Needs, Resources, and Barriers in Pennsylvania:
After selecting sites to serve as CCBHCs, but before issuing certifications, the clinics completed community needs assessments in close collaboration with DHS/OMHSAS, pulling data from a number of resources including but not limited to: previous assessments done within the past two years by the county, hospitals, foundations, local health department, community forums, consumer and family surveys, and staff surveys. The needs assessment sought to identify any unmet service needs by: major diagnostic groups (e.g., SUD, MH) and special populations (e.g., cultural and linguistic competency needs), EBP needs, and the presence of a trauma-informed, non-four walls service delivery model. DHS then completed a needs and gap analysis for the target consumer population and formulated a staffing plan for each prospective CCBHC.

The most common needs identified were: 1) Trauma treatment; 2) Substance use treatment; 3) Spanish speaking therapists and other personnel; and 4) Suicide intervention. The most common barrier identified was transportation, which was noted to be problematic in rural

areas as well as within urban centers. Child care also was identified as a consumer need, particularly in urban centers. The clinics have looked at innovative methods to address these concerns, including ridesharing and in some cases on-site child care services.

Based on the needs identified, the prospective CCBHCs then implemented their staffing plan, which included Medicaid-enrolled providers who can adequately address the needs of the consumer population served. The management team for each CCBHC consists of a Chief Executive Officer (CEO) or Executive Director/Project Director and a Medical Director. The Medical Director is a psychiatrist who is responsible for ensuring the medical component of care and the integration of BH and primary care at their CCBHC.

The CCBHCs are expected to maintain a core staff comprised of employed and/or contracted staff as appropriate to meet the needs of the CCBHC consumers. DHS will ensure that staffing includes medically-trained BH care providers including, but not limited to: providers who can prescribe and manage medications, credentialed substance use specialists, individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI) and those with SUDs, psychiatrists (child/adolescent, general adult, and geriatric as appropriate), psychologists, licensed independent clinical social workers, licensed marriage and family therapists, licensed occupational therapists, staff trained to provide case management, certified peer specialists/ recovery coaches, certified recovery specialists, licensed addiction counselors, staff trained to provide family support, medical assistants, nurses trained to work with consumers across the lifespan, Certified Registered Nurse Practitioners (CRNP)/Advanced Nurse Practitioners (ANP), community health workers, and any other qualified personnel as determined by the needs assessment. Staffing will consist of credentialed, certified, and licensed professionals trained in person-centered, family-centered, trauma informed, culturally-competent, and recovery-oriented care.

Each CCBHC has developed staff training plans for all employed and contract staff, as well as for providers with which the CCBHC has an agreement to provide indirect services to consumers or their families. Training plans include cultural competency (including information related to military culture as appropriate); person- and family-centered, recovery-oriented, evidence-based, and trauma-informed care; and primary care with BH integration. Staff training will be provided as part of initial orientation and at least annually, with some training requiring more frequent updates. Additional training provided at orientation and annually will include, but not be limited to: risk assessment, suicide prevention, and suicide response.

The CCBHCs have established and will maintain health information technology (HIT) systems that include electronic health records and have the capacity to capture structured information in consumer records, provide clinical decision support, and electronically transmit prescriptions to the pharmacy. DHS has leveraged dollars through federal HiTech funding. These HIT systems are assisting the CCBHCs with population health management, quality improvement through data collection and quality reporting, reducing disparities, and research, and outreach. CCBHC Treatment Teams consist of the individual in treatment, the family/caregiver of a child-in-

treatment, the adult individual's family to the extent the individual does not object, and any other person the individual chooses. The CCBHCs designate interdisciplinary treatment teams that work in collaboration with the individual or family/ caregiver to direct, coordinate, and manage care and services for the individual. These teams are also coordinating medical, psychosocial, emotional, therapeutic, and recovery support needs of individuals served by the CCBHCs.

Evidence Based Practices (EBPs) Required by Pennsylvania
The selection of EBPs for inclusion in the Demonstration Program was highly stakeholder driven. As part of the planning process, the certification subcommittee developed a preliminary list of potential EBPs during the initial Steering Committee meetings. To be considered, the practice was required to be listed on the National Registry of Evidence-based Programs and Practices. This list was vetted through several additional meetings with input from other stakeholders including the PA Psychiatric Society, the BH managed care companies, the clinics, and consumers and their families. The final list was approved by the CCBHC Steering Committee after more than two months of review and discussion. In selecting EBPs, we considered themes of recovery-oriented care and support. The CCBHCs will offer EBPs that are person- and family-centered and trauma informed, while the integration of PH and BH care will serve the health needs of the whole person. Care coordination, such as community-based mental health and SUD services, integration of BH with PH care, assimilating and utilizing evidence based practices on a more consistent basis, and promoting improved access to high-quality care will serve as the centerpiece of all aspects of CCBHC care in Pennsylvania.

We selected 31 EBPs for the Demonstration Program (Part 2 Attachment 3 EBPs). These included 16 adult practices and 15 child/youth practices. The adult practices are: Alcohol and Substance Abuse Services, Education, and Referral to Treatment (ASSERT); Cognitive Behavioral Social Skills Training; Cognitive Behavioral Therapy for Late-life Depression (CBT); Cognitive Enhancement Therapy (CET); Cognitive Processing Therapy for PTSD (CPT-PTSD); Community Reinforcement and Family Training (CRAFT); Dialectical Behavior Therapy (DBT); Eye Movement Desensitization Reprocessing (EMDR); MATRIX Model for stimulant abuse and dependence; Medication-Assisted Treatment (MAT); Motivational Enhancement Therapy; Motivational Interviewing (MI); Prolonged Exposure Therapy for PTSD (PE); Seeking Safety; Trauma Focused CBT (TF-CBT); and Wellness Recovery Action Plan (WRAP).

The child and youth practices are: Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT); ASSERT; Attachment-Based Family Therapy (ABFT); CBT for Adolescent Depression; Child Parent Psychotherapy (CPP); CET; Community Reinforcement and Family Training (CRAFT); Coping Cat (CBT for anxiety); Functional Family Therapy for Adolescent Alcohol and Drug Abuse (FFT); Multidimensional Family Therapy (MDFT); Multisystemic Therapy (MST); Parent Child Interaction Therapy (PCIT); TF-CBT; Treatment Foster Care Oregon (TFCO); and Wellness Recovery Action Plan (WRAP).

This broad array of EBPs was selected to reflect the common practices used by Pennsylvania's clinicians in meeting the needs of our target population. The specific EBPs utilized at a particular clinic reflect the needs of the community based on their needs assessment. The list of EBPs is considered an evolving document that will require updating based on the literature and in response to ongoing changes in the needs of Pennsylvanians. The list is expected to influence practice beyond the two year Demonstration. CCBHCs, of course, can and will use other EBPs that are not on the list.

Guidance to Pennsylvania's CCBHCs Regarding Organizational Governance to Ensure Meaningful Input
The guidance to CCBHCs was that at least 51% of their board membership must include consumers, persons in recovery, and/or family members with the expectation that those not currently meeting this criteria move in the direction of greater consumer and family involvement. This is particularly a challenge for CCBHCs with large boards and a more legally-oriented board structure. Guidance was given to CCBHCs not meeting the 51% criteria to develop a remediation plan to ensure substantial and meaningful input from individuals and family members. Such a plan might include, for example, having an advisory council (the chair of whom would be on the larger board) to develop new consumer/family board members and to provide increased input, while also moving toward the 51% target for board governance.

Section C: Development of Enhanced Data Collection and Reporting Capacity

Data Collection and Reporting Capacity
Adult Medicaid enrollees with SMI and children and youth with SEDs in the CCBHC catchment area will be the primary recipients of CCBHC services. Most Medicaid BH services in the commonwealth are provided through managed care contracts for enrollees in the Behavioral Health HealthChoices (BH-HC) program. The commonwealth has 30 BH-HC Primary Contractors. Twenty-eight of the BH-HC contracts are with five BH-Managed Care Organizations (BH-MCOs) and the two remaining are direct contracts between the commonwealth and two of the five BH-MCOs. Providers of BH services contract with the BH-MCOs and submit claims for payment for services. Seven PH-MCOs manage the PH and pharmacy benefits. The PH-MCOs and the BH-MCOs pay their contracted providers and submit encounters to the commonwealth's Medicaid Management Information System (MMIS), PROMISe™. PROMISe receives and edits encounter data including Medicaid member eligibility and provider data. Detailed person-level fee-for-service (FFS) claims and MCO encounters are stored in the Enterprise Data Warehouse (EDW).

Health Effectiveness and Data Information Set (HEDIS) measures are calculated following National Committee for Quality Assurance (NCQA) specifications and are based on encounter and claims data from the EDW. The commonwealth's contracted External Quality Review Organization (EQRO) validates and reports these measures following standard validation protocols. These standard protocols include validation that all eligible members are included in the denominator, with validation of compliance of numerator positive cases against member

level data and review of processes and source code against the specifications provided for the measures.

Prospective Payment System Requirements
The PROMISe datasets include extensive details of CCBHC encounters, including provider identification, enrolled member identification, date of service, payment rate, and other details. In addition to encounter data, all potential CCBHC providers completed the standard Center for Medicare and Medicaid Services (CMS) cost report that details historical expenditures and projected costs, and calculates the Prospective Payment System (PPS) rate.

CCBHC-Reported Quality Measures
The required CCBHC Quality Measures will be reported annually by the CCBHCs to the state using EHR-generated data. These measures will be validated by DHS/OMHSAS and by the EQRO to ensure consistency in reporting across clinics and accuracy of reporting in the program as a whole. Validation will be conducted following the standard validation protocols used for validating HEDIS measures as described above. The CCBHCs will be required to submit a description of their data collection and reporting processes, as well as any available source code, for all quality measures. Use of non-standard codes by the clinic and data collection procedures will be reviewed by the EQRO as part of data validation. Clinics will be provided with technical assistance as needed in implementing the required measures.

State-Reported Quality Measures
The EQRO will collect and validate the state-reported quality measures for each of the individual CCBHCs. In addition, the EQRO will produce rates based on the CY, baseline period, Demonstration Year 1 (DY1) and Demonstration Year 2 (DY2) to allow for comparisons that align with the Demonstration schedules. The production of the results for Housing Status and Perception of Care surveys will differ, and are detailed below. Table A identifies reporting processes for each of the State-Reported measures in the *Metrics and Quality Measures for Behavioral Health Clinics: Technical Specifications and Resources Manual*, Volume 1, published in April, 2016*.*

Table A. Reporting Processes for Each State-Reported Quality Measure

Quality Measure	Reporting Process
Plan All Cause Readmission	The EQRO will begin in CY 2016 to report rates based on HEDIS specifications using PH and BH encounter data. A break-out by CCBHC will be provided in addition to the statewide, BH-MCO, and HC-BH Contractor rates.
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	The EQRO will begin in CY 2016 to report rates based on HEDIS specifications using PH and BH encounter data. A break-out by CCBHC will be provided in addition to the statewide, BH-MCO, and HC-BH Contractor rates.
Adherence to Antipsychotic	Reported by the PH-MCOs with member level data. The EQRO

Medications for Individuals with Schizophrenia	augments the denominator with BH eligibility and encounter data and will generate statewide and CCBHC level rates. CCBHC rates will be produced by the EQRO.
Follow-Up after Hospitalization for Mental Illness, ages 21 and over	BH-MCOs report rates based on HEDIS methodology and submit member level files to the EQRO for validation. The EQRO will validate and generate CCBHC-level rates.
Follow-Up after Hospitalization for Mental Illness, ages 6–21	BH-MCOs report rates based on HEDIS methodology and submit member level files to the EQRO for validation. The EQRO will validate and generate CCBHC-level rates.
Follow-Up Care for Children receiving ADHD Medication	PH-MCOs report rates based on HEDIS specifications and provide member level files. The EQRO will validate and generate CCBHC-level rates.
Follow-Up after Emergency Department for Mental Illness	The EQRO will begin in CY 2016 to report rates based on HEDIS specifications using PH and BH encounter data. A break-out by CCBHC will be provided in addition to the statewide, BH-MCO, and HC-BH Contractor rates.
Follow-Up after Emergency Department for Alcohol and other Drug Dependence	The EQRO will begin in CY 2016 to report rates based on HEDIS specifications using PH and BH encounter data. A break-out by CCBHC will be provided in addition to the statewide, BH-MCO, and HC-BH Contractor rates.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The EQRO reports rates based on HEDIS specifications using PH and behavioral encounter data. A break-out by CCBHC will be provided in addition to the statewide, BH-MCO, and HC-BH Contractor rates.
Housing status comparison from start to end of reporting period (social determinants measure)	OMHSAS to generate biannual housing status reports at the CCBHC level based on data from the Client Information System (CIS), a dataset with eligibility information for a variety of social programs.
Antidepressant Medication Management	The EQRO will begin in CY 2016 to report rates based on HEDIS specifications using physical health and behavioral health encounter data. A break-out by CCBHC will be provided in addition to the Statewide, BH-MCO, and HC-BH Contractor rates.
Patient Experience of Care (PEC) Surveys	The EQRO will provide a sampling protocol for the individual CCBHCs to send adult members the PEC surveys. The EQRO will receive the survey, analyze and aggregate the data, and report results to the State for uploading to Tables 11 and 11a of the URS reporting template (Table 22A for the Mental Health Block Grant). The state will identify a comparison control Behavioral Health Clinic (BHC) per individual CCBHC. The EQRO uses a random sampling protocol to send the surveys to members that received services in that clinic during DY1 & DY2. The EQRO will receive

	the survey, analyze and aggregate the data, and report results to the State for uploading to Tables 11 and 11a of the URS reporting template (Table 22A for the Mental Health Block Grant).
Youth/Family Experience of (Y/FEC) Care Surveys	The EQRO will provide a sampling protocol for the individual CCBHCs to send youth/family members the Y/FEC surveys. The EQRO will receive the survey, analyze and aggregate the data, and report results to the state for uploading to Tables 11 and 11a of the URS reporting template (Table 22A for the Mental Health Block Grant). The state will identify a comparison BHC per individual CCBHC. The EQRO will use a random sampling protocol to send the surveys to children/youth that received services in that clinic during DY1 & DY2. The EQRO will receive the survey, analyze, aggregating the data and report results to the State for uploading to Tables 11 and 11a of the URS reporting template (Table 22A for the Mental Health Block Grant).

Data Collection and Reporting Capacity Enhancements

PPS Reporting

Collection and reporting capacity enhancements to support the PPS reporting requirements build on Pennsylvania's existing processes. After the CCBHCs completed the CMS cost report for their respective clinics, the reports went through an extensive desk review process that included cost validation against provider financial reports, cost allocation methodology, reasonableness of anticipated costs, and a review of the visit counting methodology.

The purpose of this review was to ensure that the PPS rate accurately reflected current and anticipated costs, including the distinction between CCBHC and non-CCBHC services. Special consideration was paid to visit count methodology to ensure daily visits were defined consistently across all providers and that services were not double-counted. The agencies received feedback that allowed them to adjust their cost reporting processes to comply with expected standards. During the Demonstration, the cost reports will be validated biannually in desk reviews in which the total costs are compared with the total CCBHC costs based on encounter data.

Quality and Program Evaluation Measures

Because CCBHCs will submit encounters for a fixed payment rate that does not vary by participant type, provided service, or overall costs associated with a particular service, system enhancements will be developed in PROMISe to capture the data elements on the PPS payment claim necessary to measure the quality measures for which the state is responsible within the submitted encounters. DHS/OMHSAS will collect all quality measures annually from the EQRO and provide them to the national evaluators.

Additionally, a Quality Dashboard was developed to capture process measures required by DHS/OMHSAS for the Implementation Evaluation (described in Section E). The data elements captured by the Dashboard include the clinic's name, address, measurement period, data source, reporting month, reporting quarter, and year-to-date performance. The dashboard will be used to generate charts to track data month-to-month. A data dictionary will be provided to the CCBHCs that includes a description of how to submit data to the Dashboard and procedures for conducting medical record chart abstraction for hybrid measures. The EQRO will validate the Dashboard data. National evaluators contracted by SAMHSA will be provided access to the measures on the Quality Dashboard.

Data Collection Systems

EHRs. The EHRs of each CCBHC was evaluated during onsite certification reviews. Eight of the CCBHCs use one of three robust EHR Office of the National Coordinator for Health Information Technology (ONC)-certified systems. Although these systems will require some modifications to configure the additional data elements required to generate all of the CCBHC reported quality measures, PPS reporting requirements, and the state level program evaluation reporting requirements described in Section E, these clinics will be able to adhere to the reporting requirements in the CCBHC Demonstration. The clinics either have the ability to make the needed adjustments in-house, or with the support of the EHR vendor. Reviewers noted that collecting lab results electronically may require a manual process.

The two other CCBHCs currently use older billing and reporting systems that are unable to collect the data elements needed for the reporting requirements. These clinics are proposing to adopt an EHR ONC-certified system for implementation prior to July 1, 2017. If they do not adopt a newer EHR ONC-certified system, then manual processes will need to be developed by the clinic to collect the data to meet the reporting requirements. DHS will leverage funds from the Medical Assistance (MA) EHR incentive program to onboard the CCBHCs to a Health Information Organization (HIO) in Pennsylvania. Connecting to a HIO will allow the clinics to submit data to the commonwealth and also query patient data available within the HIO. During the onsite review, reviewers noted that these two CCBHCs fully understand the data collection and reporting requirements and, if they do not update their systems with an ONC-certified system, have the capacity (and will be required) to draft and implement Policies and Procedures to operationalize the manual data collection requirements, as well as all requisite templates and procedures.

Enterprise Data Warehouse (EDW). PROMISe, the MMIS, sends person-level data to the EDW. Each encounter record in the EDW includes the Recipient ID number as well as specific information related to the provider and the provided services. Member details, such as age, gender and race, can be linked to the state's Consumer Information System (CIS) file extracts contained within the EDW. The encounter records also include billing and rendering provider information, including national provider identifier (NPI), service location, and specialty information. Other fields include, but are not limited to: procedure codes, modifiers, diagnoses, transaction control number, service start and end dates, days or other quantity of units delivered, provider billed amount, and the amount paid by the contractor to the provider.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

Technical Assistance in Using Data in Continuous Quality Improvement Processes

DHS/OMHSAS contracted with MTM Services to provide a technical assistance program for the CCBHC program areas. MTM is a consulting organization that assists community BH organizations to transform their health delivery systems. This program included learning communities, one of which focused on Program Area 5: Quality and Reporting. The Quality and Reporting track included the use of data in creating continuous quality improvement (CQI) initiatives. In addition to the self-paced training modules, regularly scheduled virtual meetings provided support for each of the learning communities. The Quality and Reporting learning community met two times in May 2016, and three times a month in June, July and August of 2016. The learning community was facilitated by a subject matter expert from MTM.

Ongoing support for data driven CQIs will be provided during the Demonstration by use of the Quality Dashboard. As described in Section E, the clinics will be expected to create CQI initiatives based on outlying process measures reported quarterly to the Quality Dashboard.

Data Format and National Evaluator Access

Clinic and commonwealth-generated quality indicators will be submitted to SAMHSA and the national evaluators in the format specified by the Demonstration 233 Templates as provided on June 13, 2016. SAMHSA and the national evaluators will also have ongoing access to the Quality Dashboard.

Section D. Participation in the National Evaluation of the Demonstration Program.

DHS has the capacity and willingness to assist HHS in assessing the costs, quality, and scope of PH, BH, and SUD services provided by the CCBHCs in Pennsylvania. From a data analytics standpoint DHS has multiple capacity options including: internal resources with senior medical economists well equipped to pull large data sets and perform analyses, relationships with the University of Pittsburgh and the University of Pennsylvania to perform analyses on Medicaid data, and experience with our EQRO in performing analyses across the entire spectrum of health care delivery.

Our senior medical economists have developed medical cost categories that are used for internal cost reporting. They have worked with Mathematica and the Center for Health Care Strategies (CHCS) to provide large data sets for independent analysis of CHCS and DHS' Rethinking Care program focused on improving care for those living with Persistent SMI (PSMI): http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/. They have provided data analytic support for DHS' participation in the recent Center for Medicare and Medicaid Innovation Innovations Accelerator Program focused on Substance Use Disorder (IAP-SUD). As part of the IAP-SUD program, they have analyzed SUD costs across the entire spectrum of the health care delivery system. They are currently working with the Urban Institute to provide data for intervention and control cohorts to help analyze the Pennsylvania programs that participated in the Strong Start program. They have experience in extracting large data sets provided to the Universities of Pittsburgh and Pennsylvania. DHS will

have the capability of transmitting the Transformed Medicaid Statistical Information System (T-MSIS) data files to the Centers for Medicare & Medicaid Services (CMS) before the end of 2016.

DHS has collaborative data agreements with the University of Pennsylvania for more than a decade that have resulted in multiple publications. One such recent publication evaluated Pennsylvania's Medical Home Chronic Care Initiative and demonstrated significant cost savings to the Medicaid program for individuals with PSMI (http://link.springer.com/article/10.1007/s11606-016-3734-y). Additionally, DHS has collaborative data agreements in place with the University of Pittsburgh to evaluate: hepatitis C drug treatment costs, disparities in obstetrical care, neonatal abstinence syndrome, quality and costs associated with buprenorphine treatment, impacts on the implementation of the future Community Health Choices managed care program for long term living and supports, and a recent $3 million dollar AHRQ grant to improve access to SUD treatment in rural Pennsylvania. See the following links for more information on the AHRQ grant as well as the SUD related publications done in collaboration with DHS and the University of Pittsburgh:
a) http://www.ahrq.gov/professionals/systems/primary-care/increasing-access-to-opioid-abuse-treatment.html; b) http://www.pubfacts.com/detail/26662858/Associations-between-trajectories-of-buprenorphine-treatment-and-emergency-department-and-inpatient- ; c) http://www.pubfacts. com/detail/26517324/Patterns-and-Quality-of-Buprenorphine-Opioid-Agonist-Treatment-in-a-Large-Medicaid-Program .

DHS believes that the methodology selected to evaluate the CCBHC program effectiveness in Pennsylvania can be replicated at the national level for the national evaluation.

Pennsylvania's Participation in Data Collection Planning Group Calls and Identification of a Comparison Group
The selection of DHS to receive the CCBHC Planning Grant allowed DHS/OMHSAS to consult internally with OMAP, their senior medical economists, the EQRO and our Technical Assistance Contractor, Mercer, for input in the development of a comparison group methodology in the state evaluative design. DHS/OMHSAS and its contracted EQRO have participated on all of the Data Collection calls. Most importantly, all of the selected CCBHCs collaborated with DHS/OMHSAS about their ability to meet the data collection requirements during their onsite visits for this CCBHC Demonstration Program.

DHS/OMHSAS has created a CCBHC quality improvement project within the EQRO work objectives to further its capacity in state and local CCBHC data collection, data validation, and to meet the reporting requirements for this project. The EQRO will report the aggregate CCBHC results, the aggregate comparison group results, the individual results from each CCBHC, and the individual results of each comparison group for its state evaluative design (see Section E, Table C. *Outcome Measures and Preliminary Data for the Demonstration Outcome Evaluation*).

DHS/OMHSAS has elected to control for regional effects by using the HC-BH Primary Contractor as its comparison group. Each CCBHC lies within an urban or rural setting within the catchment area of an HC-BH Primary Contractor. A rate setting process produces individual rates for each

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

HC-BH Primary Contractor, and the EQRO validates performance measure reporting. We anticipate that this methodology will assist in controlling for regional effects, in order to make rural, urban and cost comparisons. In the anticipation of the national evaluator's needs, the EQRO will provide the member level files for each required State Measure (see Section C, *State Reported Quality Measures*) by each CCBHC and the aggregate CCBHC member level file, with their matched HC-BH Primary Contractor member level file and aggregate HC-BH Primary Contractor member level file. This will allow the national evaluator to make decisions about the national comparison group design with the greatest flexibility.

Description of How Group Discussions Impacted Identification of Potential Comparison Groups and Data Plan
DHS/OMHSAS, as noted above, has reviewed many strategies with our stakeholders, medical economists, and EQRO to develop our comparison group strategies. Through those discussions we identified two sources of data. The primary source of data would be via claim and encounter data. From this data we can identify service type, providers, age, sex, race, and ethnicity. We can then leverage data to set costs, report on quality outcomes at a local HC-BH Primary Contractor level, and then roll up into the managed care organization and state level reporting.

The second level of data would be ad hoc reports that include EHR records, surveys, and secure data submissions such as Excel spreadsheets. As a result of our readiness review we identified that all participating CCBHCs will have the capability to design and submit EHRs at the time of implementation. DHS/OMHSAS has created a Quality Dashboard (see Section E, Table B. *Process Measures for the Demonstration Implementation Evaluation*) that will provide timely analysis and ongoing feedback to our CCBHCs to meet the Planning Grant requirement of a Continuous Quality Improvement (CQI) Plan. The Dashboard, refreshed quarterly, will give CCBHC providers feedback on numerous access and quality metrics. Additionally, DHS/OMHSAS has historically worked with our HC-BH Primary Contractors on numerous data draws using Excel and Access formats to augment claim and encounter data.

Thus, the feasibility to conduct broad program reviews as well as specific and timely quality and access studies are within the capabilities of DHS. Furthermore, national evaluators will have the broadest ability to access data available within the DHS/OMHSAS system to make local, BH system, and state level comparisons (http://www.dhs.pa.gov/publications/healthchoicesbehavioralhealthpublications/index.htm; http://parecovery.org/omhsas_qm.shtml). Hence, DHS has the capacity, willingness, and expertise to work with HHS in evaluating Pennsylvania's CCBHC program.

Institutional Review Board (IRB)
DHS/OMHSAS' version of an IRB is the Data Governance Committee. This committee is responsible for review of all outgoing data to assure that all rules and regulations regarding data sharing are in compliance.

Section E: Project the Impact of the State's Participation in the Demonstration Program

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

HealthChoices Behavioral Health Program Description and the CCBHC Demonstration Program

Implemented in 1997, the HealthChoices (HC) BH program is the commonwealth's Medicaid managed care program for BH services. HC-BH's driving vision is to increase access to services, improve quality of care, and contain costs. The ultimate goal of the HC-BH program is for every individual receiving HC-BH services to have the opportunity for growth, recovery, inclusion in their community, access to culturally competent services, to be supported in their choices, and to enjoy a high quality of life that includes family members and friends.

The commonwealth elected to pursue the CCBHC Demonstration Program in order to further the vision and goals of the HC-BH program. Consequently, the commonwealth's CCBHC plan is designed to create maximum impact in promoting HC-BH goals through three inter-related design components. The first component of the CCBHC plan is to certify ten clinics from nine agencies, divided among both urban and rural areas. By certifying multiple, carefully chosen agencies to be part of the Demonstration, the commonwealth intends to maximize the impact of the Demonstration by identifying cultural and demographic factors that vary regionally and to identify local strategies for success.

A second design component that will maximize the impact of the CCBHCs and advance the HC-BH program's goals involve two state-level evaluations. An Implementation Evaluation will be used to guide improvements during the CCBHC Demonstration, while an Outcome Evaluation will assess the value and cost effectiveness of the CCBHC program. Lessons learned from each evaluation will be used in future decision-making concerning the HC-BH program, such as whether primary care screening should be extended statewide or whether more effective integrated care with value-based purchasing strategies should be implemented.

The third design component is to adopt three of the four SAMHSA goals in assessing the Demonstration's impact. The commonwealth selected Goals 1, 2 and 4 to project the impact of the Demonstration. By adopting three goals, the impact assessment addresses multiple aspects of the CCBHC model and will provide more detailed information such as the impact of increasing ambulatory detoxification services in rural vs. urban communities.

Goals and Rationale Used to Project the Impact of the CCBHCs

Three goals were chosen for the Implementation Evaluation because each goal provides necessary information for the successful implementation of the CCBHC program. In addition, the third goal was chosen for the Outcome Evaluation because it aligns with HC-BH's vision to increase access to services, improve quality of care, and contain costs.

Goal 1: Provide the most complete scope of services required in the CCBHC Criteria to individuals that are eligible for Medical Assistance under the State Medicaid program. Although the HC-BH program offers a comprehensive service array, the CCBHC Demonstration provides several opportunities to expand both services not currently in the State Plan as well as those in the current State Plan. For example, Psychiatric Rehabilitative Services (PRS) are currently available

on a limited basis through the use of reinvestment funds or as a cost-effective alternative to State Plan services. By including PRS in the CCBHCs, the commonwealth can increase access to PRS and examine the impact of PRS when routinely integrated into other ambulatory services.

A second opportunity pertains to primary care screening and monitoring. The commonwealth recognizes that individuals receiving BH services may have unaddressed risk factors that result in poorer health and higher mortality risk due to lack of an ongoing relationship with a primary care provider. Consequently, a small number of performance improvement initiatives have incorporated primary care screening as a means to promote integrated care and decrease PH issues and costs. Under the CCBHC program, the commonwealth will be able to build on those initiatives and to establish routine PH screening and monitoring activities in BH settings as the new norm. Through the CCBHCs, individuals will come to expect BH providers to check vital signs, facilitate preventive care visits and screenings, and encourage participation in health risk assessments and promote healthy lifestyle choices.

A third opportunity will enhance needed drug and alcohol (D&A) services through the increased capacity for medication assisted treatment (MAT) and medical detoxification services in the CCBHCs, many of which do not currently offer either of these important services. A study performed by the University of Pittsburgh indicated that 80% of buprenorphine prescribers were primary care providers and only 40% of those individuals in treatment attended a BH appointment. By embedding MAT and medical detoxification services within a clinic setting that provides both D&A and mental health services, the commonwealth hopes to establish a more robust and effective model for recovery.

By expanding PRS, establishing integrated primary care services as the new norm, and increasing MAT availability with ready access to supportive BH services, the commonwealth can advance the quality of these key services within the CCBHC catchment areas. The outcomes and "lessons learned" by pursuing this goal will provide important information concerning how to expand these services throughout the commonwealth.

The measures used to assess the scope of the CCBHC services that are being offered focuses on the number of clinical staff, FTEs dedicated to each of CCBHC core and required services, and the number of referrals to specialty providers. These measures allow the commonwealth to quantify and track the extent to which each service is available in the clinic catchment areas.

Goal 2: *Improve availability of, access to, and participation in services described in subsection (a)(2)(D) to individuals eligible for Medical Assistance under the state Medicaid program.* This goal supports increasing the capacity and availability of all BH services with expanded hours of operation, which is one of the measures used to assess this goal.

This goal also provides the commonwealth with an opportunity to focus on increasing capacity for the following targeted services:
- Drug and alcohol certified recovery specialist services.
- Specialty peer support services (e.g., from forensic and veterans' peer support specialists).

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

- Expanding the use of telehealth to provide psychiatric consultation and specialty consultation for those areas with limited psychiatric availability.

A 2015 analysis indicated that the most frequently occurring diagnoses among adults age 22 to 64 receiving HC-BH services were episodic mood disorders and drug dependence.[1] Adopting Goal 2 allows the commonwealth to focus clinic attention on screening for depression and assessing and improving the initiation and engagement of alcohol and other drug dependence treatment. Two of the performance measures used to assess progress toward this goal evaluate access to depression screening and the number of individuals that access and engage in D&A treatment services. Ongoing measurement of these areas promotes therapeutic activities that target these two frequently occurring BH problems in the HC-BH program.

Goal 4: *Demonstrate the potential to expand available mental health services in a demonstration area and increase quality of such services without increasing net federal spending*. This goal reflects the commonwealth's expectations for improved quality due to the CCBHC program. The PPS payment model allows clinics more flexibility in providing services to support health and independence that is not available when billing with the traditional fee-for-service (FFS) model. It is anticipated that this payment model will result in more effective treatment, increased patient satisfaction, and improved outcomes due to the clinics' increased flexibility to incorporate non-billable, but helpful, activities into services.

In doing so, improved BH services quality will be emphasized through the appropriate use of EBPs and EBP fidelity monitoring, a longstanding goal of the HC-BH program. Measures in the Implementation Evaluation will assess and promote ongoing quality improvement in the provision of EBPs, as well as increased emphasis on satisfaction with services.

Adoption of Goal 4 will also allow the commonwealth to demonstrate that the CCBHC model of care is cost neutral for federal and state funds. It is anticipated that the Demonstration Outcome Evaluation will show a decrease in higher cost, inpatient services with a simultaneous increase in lower cost, ambulatory services.

State-Level CCBHC Demonstration Implementation Evaluation
The first of the two state-level evaluations to assess the impact of the CCBHC Demonstration on the health delivery system targets the successful implementation of the ten CCBHCs and includes measures for all three goals. The fulcrum for this evaluation is the Quality Dashboard, an online Dashboard that allows the CCBHCs to upload process performance measures and receive near real-time feedback on their performance as measured against the performance of the other CCBHCs.

Measures and Data Collection

---

[1] HealthChoices Behavioral Health Program Annual Report: Calendar Year 2015. Office of Mental Health and Substance Abuse Services

The process performance measures selected for this evaluation are summarized in Table B (see next page). The selected measures evaluate progress towards each of the goals. The process performance measure specifications are included in the data dictionary described in Section C (see Table A above). The CCBHCs, following the technical specifications in the data dictionary, will calculate each measure on a monthly basis using data elements captured by their EHR. The CCBHCS will upload quarterly the monthly results for all but one of the measures to the Quality Dashboard (see Section C). The commonwealth's contracted EQRO will post two client satisfaction measures to the Quality Dashboard (Perception of Care (PEC) survey and the Youth/Family Experience of Care (Y/FEC) survey). Using the Medical Assistance identification numbers and demographic information of individuals receiving services provided by the CCBHCs, the CCBHCs will choose a random sample of recipients to receive the appropriate mailed survey.

The EQRO will provide technical assistance to the CCBHCs, including providing the sampling technique to create a random sample of consumers. The survey will be mailed out the day after the service and will be mailed back to the EQRO. The EQRO will aggregate the responses in the Quality Dashboard for each CCBHC on a quarterly basis, as well as provide summary data across all CCBHCs. Survey questions will focus on satisfaction with location, services, and appointment timeliness. Within 30 days of the quarterly upload by the CCBHCs, the EQRO will calculate and post the monthly averages across all CCBHCs for each of the measures on the Dashboard. The individual CCBHC will be able to review their results as well as CCBHC aggregated averages. Viewing rights will be made available to all of the CCBHCs, the National Evaluators, SAMHSA, and to the commonwealth. The survey process to meet the requirements of the annual reporting of PEC and Y/FEC surveys, with the comparison BH Clinics (BHCs) can be found in Section C, State-Reported Quality Measures.

The process performance measures were chosen to monitor and promote the successful implementation of the CCBHCs and to determine the extent to which the CCBHCs are meeting commonwealth goals for the Demonstration. Because the commonwealth selected robust measures to align with the goals of the Demonstration, baseline data was not readily available. The initial data upload to the Quality Dashboard is scheduled for October 1, 2017, following the first quarter of DY1. That data will serve as the baseline for the Demonstration Implementation Evaluation, to which subsequent results will be compared.

Table B below describes each of the measures used to assess different aspects of each of the three goals of the Demonstration Implementation Evaluation. The anticipated impact of the Demonstration on each of those measures for all individual CCBHCs will be reviewed after DY1. The anticipated impact noted in Table B represents the annual percentage change for each clinic (the difference between DY2 and DY1 divided by DY1).

Table B. Process Measures for the Demonstration Implementation Evaluation

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

Goal	Measure Name	Measure Definition	Anticipated Impact [2]
Goal 1: Provide the most complete scope of services required in the CCBHC Criteria			
Expand scope of services	Clinical staff.	Number of clinical staff providing the nine core services/month	10% increase in number of clinical staff.
	Clinical staff FTEs by professional category providing the nine core services.	Staff FTEs/profesional category/month	10% increase in staff FTEs.
Expand scope of referrals to specialty providers	Referrals to speciality providers.	Number referrals/month	15% increase in specialty referrals.
	Referral to Veterans Health Administration (VHA).	Number VHA referrals/month	15% increase in VHA referrals.
Goal 2: Improve availability of, access to, and participation in, CCBHC services.			
Increase availability of CCBHC services	Number of hours provided, based on needs assessment, provided beyond Mon.-Fri., 8am to 5pm.	Number of hours outside of core business hours/month. *Excludes:*Crisis services, Peer support services, Psychiatric Rehabilitation, and Case Management	100% of clinics will offer hours of operation in addition to clinical services provided Mon.-Fri. from 8am to 5pm.
Increase availability of targeted services	Peer support services (MH)	Number of units of each targeted service provided/month.	15% increase in units of targeted service.
	Certified Recovery Specialist services		
	Telehealth		
Increase access to CCBHC services	Children receiving CCBHC services.	Number of children (0 – 17) who receive at least one CCBHC service in most recent 12 mos.	10% increase in number of children receiving at least one CCBHC service in most recent 12 mos.
	Adults receiving CCBHC services.	Number of adults (18+) who receive at least one CCBHC service in most recent 12 mos.	10% increase in number of adults receiving at least one CCBHC service in most recent 12 mos.

---

[2] Represents the annual percentage change for each clinic (the difference between DY2 and DY1 divided by DY1)

Goal	Measure Name	Measure Definition	Anticipated Impact [2]
Increase access to CCBHC services through timely evaluation	Initial contacts.	Number of new individuals (without prior engagment for six months) contacting the CCBHC/month.	10% increase in the number of new individuals who contact the CCBHC in the most recent 12 mos.
	Initial evaluations within ten days.	Number of new individuals who receive an initial evaluation within ten days/month.	Increase in number of timely evaluations by 15%.
	Percentage of timely initial evaluations.	Number of timely initial evaluations (per month)/Number of new individuals (per month)	Increase timely evaluation rate 15%.
	Days from contact to evaluations.	Average number of days between contact and initial evaluation/month.	Decrease average number of days by 10%.
Increase access to depression screening	Initial depression screenings (members 12-17) using a validated tool.	Number of initial depression screenings/month for members 12-17 years usng a validated child depression tool.	15% increase in the number of initial depression screenings for ages 12-17 years.
	Initial depression screenings (members ≥18) age using a validated tool.	Number of initial depression screenings/month for members ≥ 18 using a validated adult tool.	15% increase in the number of initial depression screenings for ages ≥18.
	Positive depression screenings.	Number of initial depression screenings with positive results (members ≥12 age).	15% increase in the number of depression screenings with a positive result.
	Number of initial positive screenings with a follow-up plan documented.	Number of initial positive screens (members > age 12) with a follow-up plan documented the same day in the record.	15% increase in the number of depression screenings with a follow-up plan.
Increase participation in drug	Outpatient D&A services recipients.	Number of unique individuals receiving outpatient D&A services/month.	15% increase in the number of individuals receiving outpatient D&A services.

Goal	Measure Name	Measure Definition	Anticipated Impact [2]
and alcohol services	Percentage D&A outpatient services recipients.	Number of unique individuals receiving <20 hours of services in a month; Number of unique individuals receiving outpatient D&A services.	Average number of outpatient D&A attendees will increase by 15%.
	Intensive outpatient (IOP) D&A services recipients.	Number of unique individuals receiving IOP D&A services/month.	Number of individuals receiving IOP D&A services will increase by 15%.
	Percentage D&A IOP services recipients.	Number of unique individuals receiving $\geq$ 20 and $\leq$ 40 hours services in a month; Number of unique individuals receiving IOP D&A services.	Average number of IOP D&A attendees will increase by 15% change.
Goal 4: Demonstrate the potential to expand available mental health services in a demonstration area and increase quality of such services without increasing net federal spending.			
Enhance quality with increased satisfaction among CCBHC service recipients	Individual and family satisfaction with services received at the CCBHC.	For adults, individual experience of care, and for children/adolescents, family experience of care in each of the following domains: • Convenience of provider location • Satisfaction with provider services • Timeliness and availability of appointments	Scores for each domain $\geq$ 80% at end of first year, and higher than previous year in second year of Demonstration.
Enhance quality by increasing availability of Evidence Based Practices (EBPs)	All EBPs	Number of EBPs provided/month	10% increase of individuals receiving each of the EBPs.
	Cognitive Behavioral Therapy (CBT)[3]	Number of individuals receiving CBT/month	
	Trauma Focused CBT (TF-CBT)	Number of individuals receiving TF-CBT/month	
	Medication Assisted Treatment (MAT)	Number of individuals receiving MAT/month	
	Parent-Child Interaction Therapy (PCIT)	Number of families receiving PCIT/month	
	Wellness Recovery	Number of individuals receiving	

---

[3] All types of CBT modalities except TF-CBT.

Goal	Measure Name	Measure Definition	Anticipated Impact [2]
	Action Plan (WRAP)	WRAP services/month	
Enhance quality by increasing fidelity to EBP model	CBT Credentialed Staff.	Number of staff credentialed for each of the EBPs; Number of staff providing that EBP.	100% of the staff providing each EBP is credentialed for that EBP.
	TF-CBT Credentialed Staff.		
	MAT Credentialed Staff.[4]		
	PCIT Credentialed Staff.		
	WRAP Credentialed Staff.[5]		

Analytic Approach and Purpose of the Demonstration Implementation Evaluation
The purpose of this evaluation is to promote self-evaluation by the CCBHCs on their progress relative to other CCBHCs, to allow the commonwealth to monitor the implementation process, identify effective implementation practices, and apply lessons learned to future implementations.

The commonwealth will conduct no less than a quarterly review of the CCBHC's implementation and process performance measurements to identify those areas in which the program is being successfully implemented, as well as identify any program areas that are not being implemented as designed. Any noted successes in implementation or processes will be highlighted to all clinics, and concerns will be reviewed with the particular clinic.

The commonwealth will provide technical assistance to those CCBHCs with noted anomalies. These quarterly reviews will also allow the commonwealth to uncover and address any systemic issues or barriers early in the implementation period. Early detection of system barriers will allow the commonwealth to evaluate options for either developing a process to accommodate the barrier or to dismantle the barrier. Each of the CCBHCs will be expected to compare their results with the aggregate CCBHC average on each of the measures and adjust their processes accordingly. The CCBHCs will also be expected to use this data to create Continuous Quality Improvement initiatives that address issues identified by outlier performance measures.

The Dashboard will be administered and hosted by the EQRO. Beginning with the initial data upload, the display will provide a run chart for each of the individual CCBHC's measures and the average of all the CCBHC measures. The median will be used to detect shifts, trends or outliers in the Dashboard measures on an annual basis. This information will be used to guide DHS/OMHSAS quality initiatives and technical assistance to the CCBHCs during the year. This review may also result in a modification of targets for the process measures in the second year.

---

[4] Credentialed substance use specialist.
[5] Certified WRAP facilitator certification.

A final purpose of the CCBHC Demonstration Implementation Evaluation is to acquire information that can be used in implementing future CCBHC or CCBHC-like programs. At the end of the Demonstration period, the commonwealth will conduct an analysis of the run charts and Dashboard data to determine if some aspects or forms of the program were implemented more efficiently and effectively than others, to identify the factors that contributed to successful implementations, and to identify any barriers to successful implementation. The analysis may include comparisons on variables such as the location of the CCBHCs (rural vs. urban), size of the CCBHCs (i.e., number of individuals served), staffing models or training and implementation of EBPs. Information derived from this analysis will be used to plan more effective, statewide implementations.

State-Level CCBHC Demonstration Outcome Evaluation
The purpose of the second of the two state-level evaluations is to assess the impact of the CCBHC on outcomes associated with Goal 4 while maintaining cost neutrality.

Performance Measures and Baseline Data
The measures selected for the Demonstration Outcome Evaluation are a portion of the required state-generated CCBHC quality measures. These performance measures are currently collected and validated by the EQRO. Baseline outcome measures for the CCBHCs were developed from the data used in past EQR activities. Future outcome measures will be generated for each of the CCBHCs for use in the Outcome Evaluation. For the purpose of the measures used in this evaluation, "clinic participation" will be used to determine the universe of individuals out of which the performance measure's denominator will be built. "Clinic participation" is defined as receiving one of the nine CCBHC services within a 12 month period for each of the two years of the Demonstration period[6].

Table C (below) includes performance measures and preliminary baseline data from Calendar Year (CY) 2015. This data is the most recent available and serves as an indicator of performance at the clinics prior to CCBHC program initiation. Fiscal Year (FY) 2017 (12 months ending June 2017) is the year immediately prior to CCBHC implementation. Updated outcome baseline data will be developed from this time period for use in the Outcome Evaluation. The measures will be collected annually. At the end of the two-year Demonstration Program, the EQRO will collect and validate the data from encounter data and construct the measures for the outcome evaluation.

Table C. Outcome Measures and Preliminary Data for the Demonstration Outcome Evaluation

Goal	Measure Name	Age Cohort	CCBHC Baseline Data[7]	Non-CCBHC Baseline Data

---

[6] If an individual receives a crisis service, then they must also receive a second core service during the specified time period. A single crisis service received from the state sanctioned crisis provider without an additional CCBHC core service is not sufficient for "client participation".

[7] Baseline data from Calendar Year (CY) 2015. Actual baseline data for purposes of the evaluation will be Fiscal Year (FY) 2016/2017.

Expand availability and access to mental health services	Follow-up after Hospitalization for Mental Illness	7 days	6-20	61.92%	50.84%
		30 days		80.78%	70.11%
		7 days	21-64	43.86%	35.51%
		30 days		64.61%	53.17%
		7 days	65+	N/A	33.33%
		30 days		N/A	44.59%
		7 days	All ages	47.81%	39.63%
		30 days		68.18%	57.64%
Expand availability and initiation in drug and alcohol services	Initiation of Alcohol and Other Drug (AOD) Treatment		13-17	59.20%	35.97%
			18-64	36.14%	26.48%
			65+	0.00%	12.50%
			All ages	38.59%	27.16%
Expand availability and engagement in drug and alcohol services	Engagement of Alcohol and Other Drug (AOD) Treatment		13-17	49.43%	24.59%
			18-64	27.44%	18.41%
			65+	N/A	7.81%
			All ages	29.78%	18.84%
Increase quality of mental health services	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)		19-64	- -	- - [8]
Sustain Cost Neutrality	Cost Effectiveness Analysis		All ages	Unavailable	Unavailable

N/A: Denominator less than 30.

Analytic Approach

The Outcome Evaluation will entail a pre-test/post-test quasi-experimental design with a comparison group. This design evaluates the impact of the Demonstration by comparing the differences in the outcome measures between the pre- and post-period in the CCBHC group to the differences in the study outcomes between the pre- and post-period in the comparison group.

The comparison group will consist of the enrollees of the HC-BH Contractor associated with the CCBHC, excluding the members in the CCBHC. The use of a comparison group will control for regional differences in performance and costs between the CCBHCs. The CCBHC and non-CCBHC HC-BH Contractor's measures will be analyzed to detect any significant differences in the measures over the two year Demonstration program.

After the data is collected and validated at the end of the Demonstration program period, an estimate of the impact of the CCBHCs relative to the comparison group will be made using the Difference in Difference (DID) method. A DID test attempts to decrease the confounding effect of non-random assignment by measuring the Demonstration impact in two ways: difference in

---

[8] For this measure, CY 2015 data is not available, but FY 2016/2017 baseline data will be available for the actual outcome evaluation.

the outcome measure before and after the Demonstration within each CCBHC location, as well as difference in the outcome measure between the CCBHC and the comparison group.

The DID test uses the comparison group to separate out changes that occurred from the Demonstration from changes that would have happened without the Demonstration. If the analysis indicates that the pre/post differences between CCBHC scores are significantly different from the differences between those scores from the comparison group, then it suggests that the Demonstration program had an impact on that measure. Separate DID analyses will be conducted for each of the eighteen measures, and will be adjusted for multiple comparisons using the Bonferroni correction or similar methodology.

The EQRO will analyze the differences between the CCBHCs and the HC-BH system to determine if the pre/post differences between CCBHC scores are significantly different, and to identify any differences between the pre/post scores on those same measures in the HC-BH system. The comparison of the CCBHC pre/post scores with the HC-BH pre/post scores is intended to help the commonwealth understand the impact of the CCBHCs relative to the trends in the larger system. This comparison will also provide the commonwealth with the ability to identify and support changes within the HC-BH program.

The final component of the Demonstration Outcomes Evaluation is a cost-effectiveness analysis to determine if the program has been cost neutral for PH and BH Medicaid dollars. The cost-effectiveness analysis will follow a similar process as the outcome evaluation and compare average monthly costs across all services for each user to average monthly service costs for each user in the HC-BH system. By looking at the full range of services, a more complete picture will emerge of how the CCBHC affected utilization of other services. If necessary, consideration will be given to high cost statistical outliers and normalizing their impact. A measure of variability will be used to identify any outlying data points which will then be modified to normalize the distribution of cost per user.
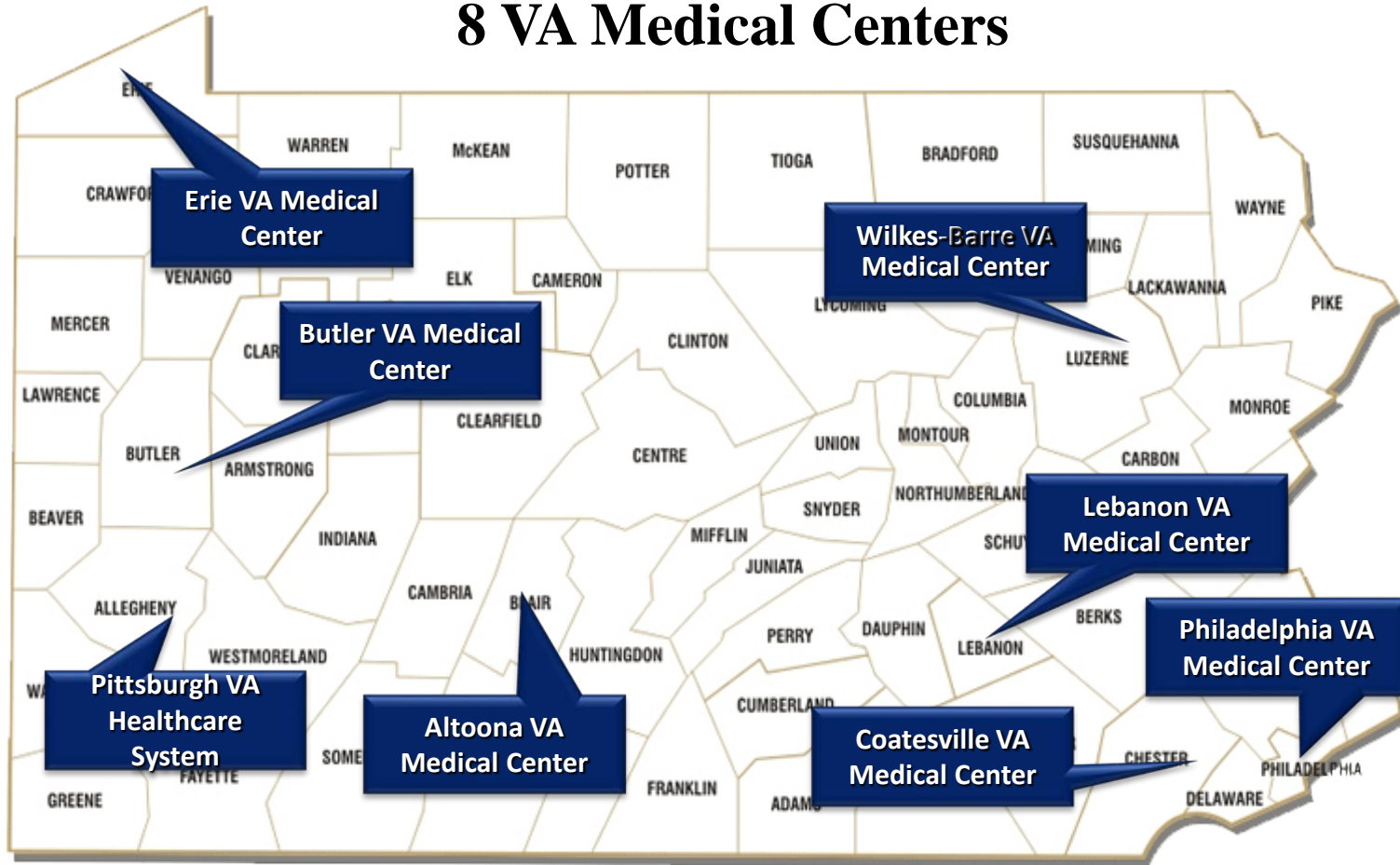
Purpose of the Demonstration Outcomes Evaluation
One purpose of the Demonstration Outcomes Evaluation is to assess the impact of the Demonstration on outcome data. Demonstration impact may be inferred if an increase between pre- and post-Demonstration periods on the performance measures is statistically significant.
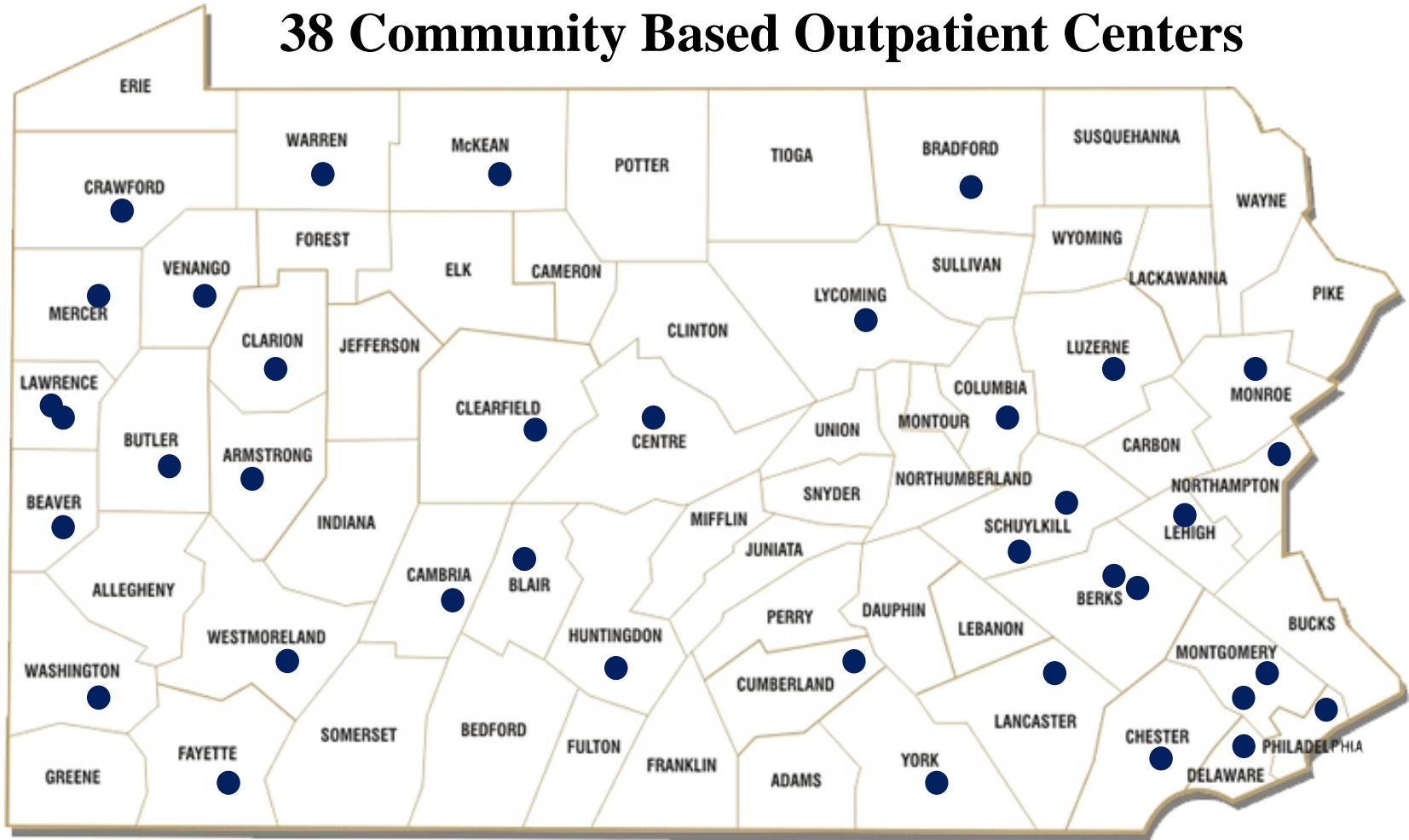
An objective of this evaluation is to compare CCBHC performance with the state wide HC-BH program performance on the same measures. This comparison allows the commonwealth to determine if the CCBHC model improves the availability and quality of BH services relative to other models throughout the HC-BH program. The commonwealth can use this information to make data-based decisions about future improvements to the HC-BH program. A final goal of this evaluation is to determine the Demonstration's impact, if any, on health care costs.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

At the conclusion of the Demonstration, the commonwealth will review the data and results of the Implementation Evaluation and the Outcomes Evaluation, as well as information acquired during the certification process and stakeholder meetings. From the results of this review, the commonwealth will compile a report with lessons learned, strengths and opportunities for improvement, and more and less successful practices in both the CCBHC program, as well as CCBHC program implementation. The analysis will examine any differences in location (rural vs. urban), staffing models, and clinic size, among other variables. The results of this analysis and review will be made available to SAMHSA and will be used as a reference document in state-level deliberations concerning the ongoing transformation of the HC-BH program.

Part 2. Solicitation of Input by Stakeholders in Developing CBHCs

8 VA Medical Centers

- Erie VA Medical Center
- Wilkes-Barre VA Medical Center
- Butler VA Medical Center
- Lebanon VA Medical Center
- Philadelphia VA Medical Center
- Pittsburgh VA Healthcare System
- Altoona VA Medical Center
- Coatesville VA Medical Center

Office of Veterans Affairs

38 Community Based Outpatient Centers

pennsylvania
DEPARTMENT OF MILITARY
AND VETERANS AFFAIRS

12 Veterans Centers + 2 Mobile Vet Centers

Scranton Veterans'
Center
(1 Mobile Center)

Erie Veterans'
Center
(1 Mobile Center)

Williamsport
Veterans' Center

Pittsburgh Veterans'
Center

Harrisburg Veterans'
Center

Bristol Veterans'
Center

Dubois Veterans'
Center

Montgomery
County Veterans'
Center

McKeesport
Veterans' Center

Lancaster Veterans'
Center

2 Philadelphia
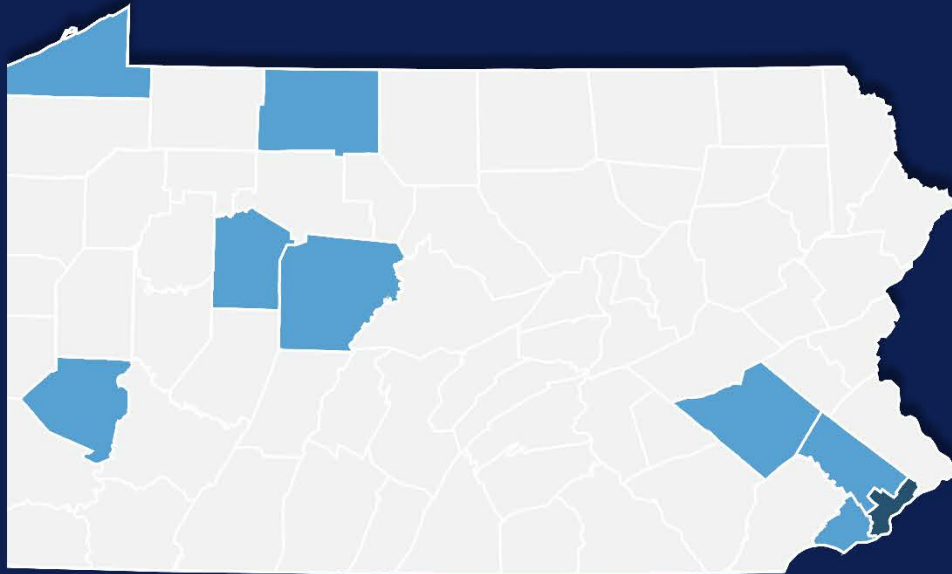Veterans' Centers
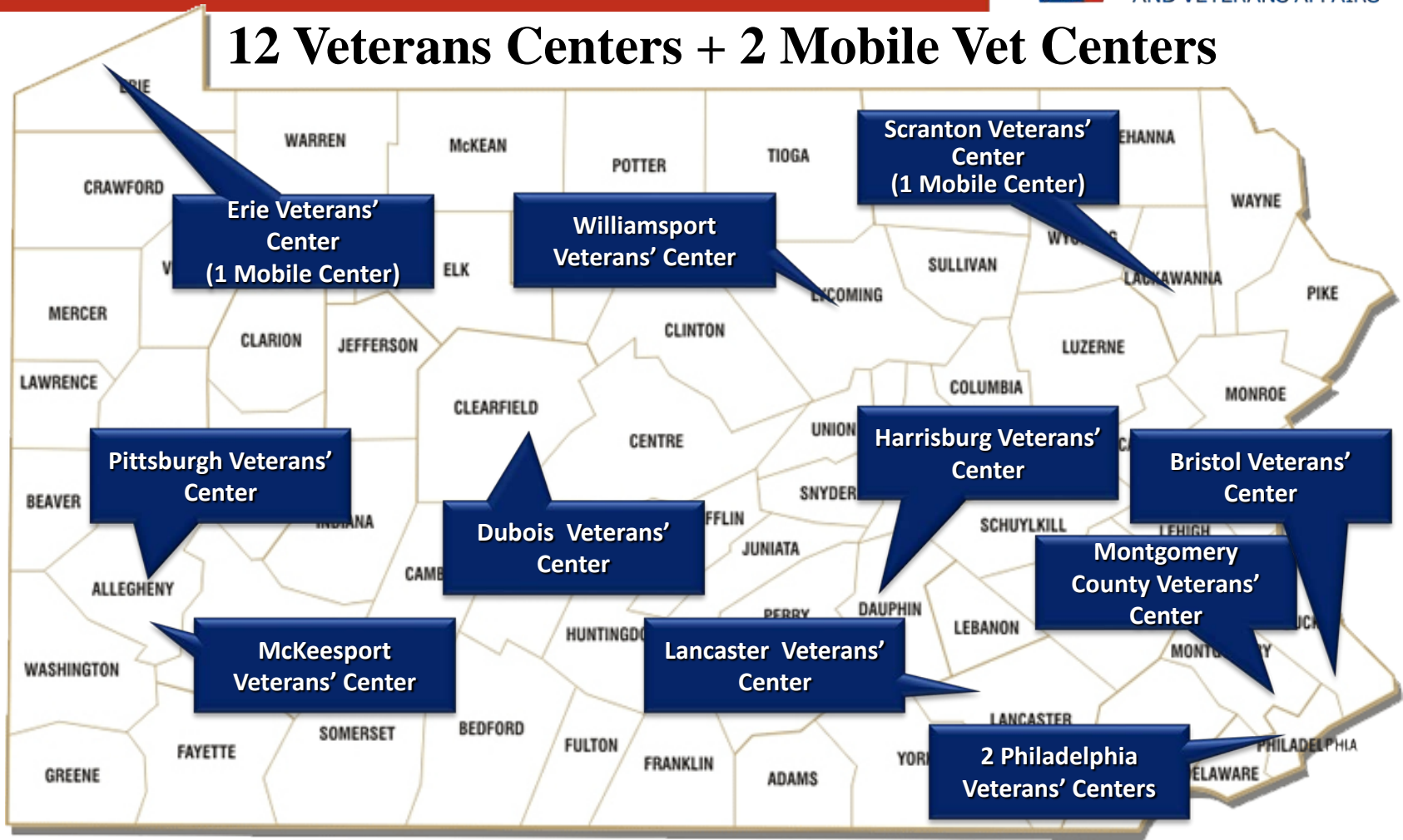
PA DEPT. OF HUMAN SERVICES IS PROUD TO ANNOUNCE

10 Certified Community Behavioral Health Clinics are coming to PA

COUNTY LOCATIONS

Berks • Clearfield • Jefferson • Philadelphia (2)
Montgomery • Delaware • Allegheny • Erie • McKean

LIST OF FACILITIES: WWW.DHS.PA.GOV

Attachment 3. Pennsylvania Evidence-Based Practices

Pennsylvania's Steering Committee, with input from many community stakeholders, has selected the following Evidence-Based Practices (EBPs). EBPs are listed separately for Children and Youth and for Adult populations, with the number of CCBHCs currently offering the EBP or planning to offer the EBP during the Demonstration Program listed in the columns.

Table 1. *Pennsylvania's EBPs for Children and Youth*

	Number of CCBHCs:	
Children & Youth EBPs:	Currently Offering	Planning to Offer[1]
1. Alternatives for Families: A Cognitive Behavioral Therapy	0	0
2. ASSERT (SBIRT)	3	2
3. Attachment-Based Family Therapy	1	0
4. CBT for Adolescent Depression	1	6
5. Child Parent Psychotherapy	0	0
6. Cognitive Enhancement Therapy	0	0
7. Community Reinforcement and Family Training	0	1
8. Coping Cat	0	1
9. Functional Family Therapy for Adolescent Alcohol & Drug Abuse	2	1
10. Multidimensional Family Therapy	0	1
11. Multisystemic Therapy	1	1
12. Parent-Child Interaction Therapy	7	0
13. Trauma Focused CBT	5	3
14. Treatment Foster Care Oregon	0	0
15. Wellness Recovery Action Plan	2	0

[1] Some EBPs that are not currently offered or currently planning to be offered were included due to enthusiasm for their use. These EBPs may be added in Year 2 of the Demonstration Program.

Table 2. *Pennsylvania's EBPs for Adults*

Adult EBPs:	Number of CCBHCs:	
	Currently Offering	Planning to Offer[1]
1. ASSERT (SBIRT)	3	2
2. Cognitive Behavioral Social Skills Training	0	0
3. Cognitive Behavioral Therapy for Late-life Depression	0	1
4. Cognitive Enhancement Therapy	0	1
5. Cognitive Processing Therapy for PTSD	1	3
6. Community Reinforcement and Family Training	0	0
7. Dialectical Behavior Therapy	5	4
8. Eye Movement Desensitization Reprocessing	1	0
9. MATRIX Model	0	0
10. Medication-Assisted Treatment	1	1
11. Motivational Enhancement Therapy	0	0
12. Motivational Interviewing	6	0
13. Prolonged Exposure Therapy for PTSD	3	4
14. Seeking Safety	1	3
15. Trauma Focused CBT	5	3
16. Wellness Recovery Action Plan	2	0

[1] Some EBPs that are not currently offered or currently planning to be offered were included due to enthusiasm for their use. These EBPs may be added in Year 2 of the Demonstration Program.

Attachment 3. Pennsylvania Evidence-Based Practices

Evidence-Based Practices: Children & Youth

Note: EBPs are listed in alphabetical order.

1. **Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT):** AF-CBT is an intervention for families who exhibit or are at risk for problems with anger, aggression, and/or child physical abuse. AF-CBT seeks to improve relationships between school-aged children and their parents/caregivers using a comprehensive family-centered approach that targets the risks for and clinical consequences of exposure to conflict and coercion.

   Outcomes targeted by AF-CBT include decreasing: (1) family conflict; (2) anger, verbal aggression, and hostility; (3) threats of or actual use of physical force and aggression; (4) child behavior problems; and (5) risk for child physical abuse and repeated abuse. The intervention also aims to improve child social competence and child safety/welfare.

   AF-CBT draws elements from several conceptual or treatment models, including cognitive therapy, behavioral and learning theory, family therapy, developmental victimology, and the psychology of aggression. Caregivers and children receive joint and individual skills-training sessions to promote a set of complementary inter- and intra-personal competencies. Many of the families receiving the intervention are scheduled for weekly services that are delivered over a 6- to 9-month period; however, the duration of treatment and number of sessions vary, due to factors such as the complexity of the case and resources available. AF-CBT has been applied in outpatient clinics, homes, residential treatment programs and hospitals, schools, and other community-based settings.

   Clinicians implementing AF-CBT must have a minimum of a master's degree in mental health or related field and must be certified as a clinician, have a license, or be supervised by a licensed clinician who received training. Training in AF-CBT follows a learning community model that includes various requirements and activities (e.g., training and booster sessions, delivery of AF-CBT to at least two cases, consultation calls, submission of audio files for review, case presentations, and caseload metrics).

2. **ASSERT (SBIRT):** Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a screening, brief intervention, and referral to treatment (SBIRT) model designed for use in health clinics or emergency departments (EDs). Project ASSERT targets three groups:

   - Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
   - Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
   - Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate consumers to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

Adolescents, young adults, and adults visiting a participating health clinic or ED for medical care are screened for substance use by Project ASSERT interventionists--peer educators or ED staff members who have been trained to deliver the intervention. Consumers with a positive screening result are engaged by interventionists with the Brief Negotiated Interview (BNI), a semi-scripted, motivational interviewing counseling session that focuses on the negative consequences associated with drug use and unhealthy drinking. Using the BNI, the interventionist builds rapport with the consumer; asks the consumer for permission to discuss drug and alcohol use; explores the pros and cons of the behavior associated with drug and alcohol use; discusses the gap between the consumer's real and desired quality of life; assesses the consumer's readiness for change in the targeted behavior; and develops an action plan, which includes direct referrals and access to substance abuse treatment.

When a peer educator delivers the intervention to an adolescent or young adult who uses marijuana, or to an adult who uses cocaine and/or opiates, he or she follows up with each consumer by telephone 10 days after the health clinic or ED visit. This call serves as a 5- to 10-minute booster session to discuss what has transpired since the BNI and to find out whether new service referrals are needed. When ED staff members deliver the intervention to an adult with high-risk and/or dependent alcohol use, a follow-up booster session is not provided.

On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the consumer's substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during the course of medical care, while the consumer is waiting for the doctor, laboratory results, or medications.

3. **Attachment-Based Family Therapy (ABFT):** ABFT is a treatment for adolescents age 12 to 18, and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. The model is based on an interpersonal theory of depression, which proposes that the quality of family relationships may precipitate, exacerbate, or prevent depression and suicidal ideation. In this model, problems in family relationships, such as those due to abandonment, neglect, or abuse or a harsh and negative parenting environment, influence the development of adolescent depression. Families with these attachment problems lack the normative secure base and safe haven context needed for an adolescent's healthy development, including the development of emotion regulation and problem-solving skills. These adolescents may experience depression resulting from the attachment problems themselves or from their inability to turn to the family for support in the face of trauma outside the home. ABFT aims to strengthen or repair parent-adolescent attachment bonds and improve family communication. As the normative secure base is restored, parents become a resource to help the adolescent cope with stress, experience competency, and explore autonomy.

ABFT is typically delivered in 60- to 90-minute sessions conducted weekly for 12-16 weeks. Treatment follows a semi-structured protocol consisting of five sequential therapy tasks, each of which has clearly outlined processes and goals.

- The Relational Reframe Task, with the adolescent and parents (or parent) together, sets the foundation of the therapy. After an assessment of the history and nature of the depression, the therapist focuses on relational problems. This shift pivots on the therapeutic question, "When you feel so depressed or suicidal, why don't you go to your parents for help?" The progression of this conversation leads parents and the adolescent to agree that improving the quality of their relationship would be a good starting point for treatment.

Attachment 3. Pennsylvania Evidence-Based Practices

- The Adolescent Alliance Task, with the adolescent alone, identifies relational problems in the family and links them to the depression. The adolescent is encouraged and prepared to discuss these often avoided feelings and memories with his or her parents.
- The Parent Alliance Task, with the parents alone, explores their current stressors and their own history of attachment disappointments. These conversations activate parental caregiving instincts to behaviorally and emotionally protect their child, which helps motivate parents to learn and use new attachment-promoting parenting skills.
- The Attachment Task, with the adolescent and parents together, creates an opportunity for the adolescent to directly express his or her thoughts and feelings about past and current relational injustices. Rather than defending themselves, parents help the adolescent fully express and explore these emotionally charged topics. This conversation helps the adolescent work through trauma, address negative patterns in the relationship, and practice new conflict resolution and emotion regulation skills.
- The Autonomy Task, with the adolescent and parents together, helps consolidate the new secure base. In solving day-to-day problems, parents provide support and expectations and the adolescent seeks to develop autonomy while remaining appropriately attached to his or her parents.

ABFT is usually delivered by trained therapists with at least a master's degree in one of a number of mental health disciplines.

4. **CBT for Adolescent Depression**: Cognitive Behavioral Therapy (CBT) for Adolescent Depression is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing consumers to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs. To adapt CBT for adolescents, more emphasis is placed on (1) the use of concrete examples to illustrate points, (2) education about the nature of psychotherapy and socialization to the treatment model, (3) active exploration of autonomy and trust issues, (4) focus on cognitive distortions and affective shifts that occur during sessions, and (5) acquisition of problem-solving, affect-regulation, and social skills. As teens frequently do not complete detailed thought logs, internal experiences such as monitoring cognitions associated with in-session affective shifts are used to illustrate the cognitive model. To match the more concrete cognitive style of younger adolescents, therapists summarize session content frequently. Abstraction is kept to a minimum, and concrete examples linked to personal experience are used when possible. The treatment program is delivered in 12 to 16 weekly sessions.

5. **Child Parent Psychotherapy (CPP):** CPP is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in

treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent. When the parent has a history of trauma that interferes with his or her response to the child, the therapist (a master's- or doctoral-level psychologist, a master's-level social worker or counselor, or a supervised trainee) helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways. Mother-child dyads typically participate in weekly sessions for about 1 year, with therapists who principally use a CPP treatment manual (e.g., "Don't Hit My Mommy!").

6. **Cognitive Enhancement Therapy (CET):**

7. **Community Reinforcement and Family Training (CRAFT):**

8. **Coping Cat:** Coping Cat is a cognitive behavioral treatment that assists school-age children in (1) recognizing anxious feelings and physical reactions to anxiety; (2) clarifying cognition in anxiety-provoking situations (i.e., unrealistic expectations); (3) developing a plan to help cope with the situation (i.e., determining what coping actions might be effective); and (4) evaluating performance and administering self-reinforcement as appropriate. The intervention uses behavioral training strategies with demonstrated efficacy, such as modeling real-life situations, role-playing, relaxation training, and contingent reinforcement. Throughout the sessions, therapists use social reinforcement to encourage and reward the children, and the children are encouraged to verbally reinforce their own successful coping. Coping Cat consists of 16 sessions. The first eight sessions are training sessions in which each of the basic concepts are introduced individually and then practiced and reinforced. In the second set of eight sessions, the child practices the new skills in both imaginary and real-life situations varying from low stress/low anxiety to high stress/high anxiety, depending on what is appropriate for each child.

9. **Functional Family Therapy (FFT) for Adolescent Alcohol and Drug Abuse:** FFT is a behaviorally based intervention for youth ages 13-19 years with substance abuse and delinquency, HIV risk behaviors, and/or depression (or other behavioral and mood disturbances) and their families. The intervention is grounded in family systems theory (i.e., all family members are connected through a system of overlapping and intertwining relationships) and views a youth's substance abuse problem in the larger context of dysfunctional interrelationship patterns within the family's social structure. By involving the entire family, as well as the youth, FFT for Adolescent Alcohol and Drug Abuse aims to reduce the youth's substance abuse, decrease the youth's delinquent behavior, and increase family cohesion through improvements in family interaction patterns and parent-youth relationships. The intervention uses a strengths-based, nonjudgmental therapeutic approach that integrates cognitive behavioral strategies within a comprehensive, family systemic model. FFT for Adolescent Alcohol and Drug Abuse is organized around five therapeutic phases:
    - Engagement, which focuses on engaging the family in therapy and developing a therapeutic relationship.
    - Motivation, which emphasizes enhancing the family's readiness and motivation for change, strengthening family cohesion by reducing blaming and hostility, instilling hope through a relational focus, reframing individual-oriented complaints, and actively managing negative family interactions.
    - Assessment, which involves the identification of relevant, maladaptive aspects of individual and family functioning to guide the design and implementation of a behavior change plan.
    - Behavior change, which involves the implementation of various techniques to improve family relationships (e.g., communication, problem solving) and to avoid substance use (e.g., coping with urges and cravings, substance-refusal skills, mood management).

Attachment 3. Pennsylvania Evidence-Based Practices

- Generalization, which emphasizes the consolidation and maintenance of new skills and behaviors, relapse prevention, and community systems available to support the family and recovering youth.

A trained, certified therapist delivers the intervention through 12-16 sessions, lasting 60-75 minutes each, over a period of 4-5 months. Sessions are initially held twice weekly, then tapered to once weekly to space out learning and allow time between sessions for practice and homework, which is tailored to the tasks in each phase. When families are able to maintain new behaviors independently, sessions are scheduled several weeks apart. Following the 12-16 sessions, 2 months of biweekly aftercare booster sessions may be delivered by telephone. The sessions, which are no more than 30 minutes each, reinforce treatment gains and offer general support to families.

10. Multidimensional Family Therapy (MDFT): MDFT is a comprehensive and multi-systemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision-making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems.

Delivered across a flexible series of 12 to 16 weekly or twice weekly 60- to 90-minute sessions, MDFT is a manual-driven intervention with specific assessment and treatment modules that target four areas of social interaction: (1) the youth's interpersonal functioning with parents and peers, (2) the parents' parenting practices and level of adult functioning independent of their parenting role, (3) parent-adolescent interactions in therapy sessions, and (4) communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).

11. Multisystemic Therapy (MST): MST-Psychiatric is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar disorder, depression, anxiety, and impulsivity. Youth receiving MST-Psychiatric typically are between the ages of 9 and 17. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations while allowing youth to spend more time in school and in home-based placements. Like standard MST on which it is based, MST-Psychiatric has its foundation in social-ecological and social learning theories. It includes specific clinical and training components for staff designed to address

12. Parent-Child Interaction Therapy (PCIT): PCIT is a treatment program for children ages 2 to 7 with disruptive behavior disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging prosocial behavior and discouraging negative behavior. This treatment has two phases, each focusing on a different parent-child interaction: child-directed interaction (CDI) and parent-directed interaction (PDI). In each phase, parents attend one didactic session to learn interaction skills and then attend a series of coaching sessions with the child in which they apply these skills. During the CDI phase, parents learn nondirective play skills similar to those used in play therapy and engage their child in a play situation with the goal of strengthening the parent-child relationship. During the PDI phase, parents learn to direct the child's behavior with clear, age-appropriate instructions and consistent

consequences with the aim of increasing child compliance. During coaching sessions, the therapist observes the interaction from behind a one-way mirror and provides guidance to the parent through a "bug-in-the-ear" hearing device. PCIT is generally administered in 15 weekly, 1-hour sessions in an outpatient clinic by a licensed mental health professional with experience working with children and families. The treatment manual provides written outlines in checklist form for each session.

13. ## Trauma Focused CBT (TF-CBT): TF-CBT is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents ages 3 to 18 years. Initially developed to address problems associated with childhood sexual abuse, TF-CBT has been modified and tested with children who have experienced a wide array of traumas, including domestic violence, traumatic loss, war, commercial sexual exploitation, and the often multiple and complex traumas experienced by children who are placed in foster care. TF-CBT is appropriate for use with children exposed to trauma whose parents or caregivers did not participate in the abuse.

The program integrates cognitive, behavioral, interpersonal, and family therapy principles as well as trauma interventions. It is designed to be delivered by trained and certified TF-CBT therapists. The therapy approach is highly collaborative and the therapist works with both the child and the child's non-offending parents or caregivers to identify and attain common goals. Initially, therapists provide parallel individual sessions with children and their parents or primary caregivers; joint parent–child sessions then become increasingly incorporated over the course of treatment. Each TF-CBT session is aimed at building the therapeutic relationship while also providing education and skills development in a safe environment, in which the child is able to address and process traumatic memories. Joint parent–child sessions are aimed at helping parents and children practice the skills learned during therapy and enabling the children to share their stories of trauma, while also nurturing more effective parent–child communication about the abuse and related issues.

The acronym PRACTICE summarizes the components of the model:

    P - Psychoeducation and parenting skills
    R - Relaxation skills
    A - Affective expression and modulation skills
    C - Cognitive coping and processing skills
    T - Trauma narration and processing
    I - In vivo mastery of trauma reminders
    C - Conjoint child–parent sessions
    E - Enhancing safety and future developmental trajectory

Other components are available for children who develop posttraumatic stress symptoms and maladaptive grief responses, following the death of an important attachment figure. Group and complex trauma applications are also available. Standard individual or group TF-CBT treatment is typically delivered over 12 to 16 sessions and TF-CBT for complex trauma is typically delivered over 16 to 25 sessions.

14. ## Treatment Foster Care Oregon (TFCO): TFCO, formerly known as Multidimensional Treatment Foster Care (MTFC), is a community-based intervention for adolescents (12-17 years of age) with severe and chronic delinquency and their families. It was developed as an alternative to group home treatment or State training facilities for youths who have been removed from their home due to conduct and delinquency problems, substance use, and/or involvement with the juvenile justice system. Youths are typically referred to TFCO after previous family preservation efforts or other out-of-

home placements have failed. Referrals primarily come from juvenile courts and probation, mental health, and child welfare agencies. TFCO aims to help youth live successfully in their communities while also preparing their biological parents (or adoptive parents or other aftercare family), relatives, and community-based agencies to provide effective parenting and support that will facilitate a positive reunification with the family.

TFCO is based on social learning theory. Four key elements are targeted during foster care placement and aftercare:

- Providing youth with a consistent reinforcing environment where they are mentored and encouraged to develop academic and positive living skills.
- Providing youth with daily structure that includes clear expectations and limits and well-specified consequences delivered in a teaching-oriented manner.
- Providing close supervision.
- Helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships.

Youths are individually placed with highly trained and supervised foster parents and are provided with intensive support and treatment in a setting that closely mirrors normative life. TFCO typically lasts 6-9 months and relies on coordinated, multimethod interventions conducted in the TFCO foster home, with the youth's biological or aftercare family, and with the youth. Involvement of the youth's family is emphasized from the outset of treatment to facilitate the youth's return to the family and maximize training and preparation for posttreatment care. Progress is tracked through daily telephone calls with the foster parents.

A program supervisor with a caseload of 10 or fewer youth oversees and coordinates the interventions and supervises and supports the foster parents throughout treatment through the daily telephone calls and weekly foster parent group meetings. The program supervisor also coordinates the work of family and individual therapists (for therapy conducted with the youth and his or her parents), skills trainers, and a foster parent liaison/trainer.

15. Wellness Recovery Action Plan (WRAP):

Evidence-Based Practices: Adults

1. ASSERT (SBIRT):

2. Cognitive Behavioral Social Skills Training (CBSST): CBSST is a psychosocial rehabilitation intervention designed to help middle-aged and older outpatients with schizophrenia and other forms of serious mental illness achieve their functioning goals related to living, learning, working, and socializing in their community of choice. The intervention integrates two components:

   - Cognitive behavioral therapy (CBT). Through the CBT component, consumers learn thought-challenging skills to help them correct inaccurate dysfunctional beliefs, including defeatist expectancies ("it won't be fun"), low self-efficacy ("I always fail"), anomalous beliefs ("spirits will harm me"), and ageist beliefs (e.g., "I'm too old to learn") that interfere with goal-directed

Attachment 3. Pennsylvania Evidence-Based Practices

activities. This component includes compensatory aids to address the cognitive impairment associated with both aging and schizophrenia.

- Social skills training (SST). Through the SST component, consumers learn communication skills and problem-solving skills, with a focus on using these skills to achieve their functioning goals. This component includes symptom management, communication role-play (including age-relevant situations, such as talking to a doctor about eyeglasses), and the use of social skills in problem solving (including age-specific scenarios, such as finding transportation and coping with hearing and vision problems).

CBSST is delivered by therapists primarily through 2-hour group psychotherapy sessions that occur once a week over 24-36 weeks, but the intervention also can be delivered through individual sessions or a combination of individual and group sessions. The intervention consists of three modules: cognitive skills, social skills, and problem-solving skills. The sequence of modules is delivered twice to compensate for cognitive impairment experienced by consumers and to provide them with a greater opportunity to practice and master skills; module repetition also improves self-efficacy for more experienced consumers who help newcomers.

CBSST should be delivered by mental health therapists who have experience working with the intervention's target population. A therapist training workshop and follow-up consultation are recommended to ensure that CBSST is delivered with the highest possible fidelity.

3. **Cognitive Behavioral Therapy for Late-life Depression (CBT-LLD):** CBT-LLD refers to several treatment programs that are rooted in traditional CBT, developed by Aaron Beck and colleagues, which have been modified to meet the needs of older adults. This conceptual model integrates case conceptualization (and treatment planning) with information about the consumer's medical and functional status, social support network, role engagement, and coping strategies that have been successful in the past. Training programs include: 1) 1- and 2-day, in-person workshops for clinicians from a variety of disciplines who want an introduction to the topic; 2) 2- to 3-day, in-person workshops followed by review of audiotaped CBT sessions and weekly individual and/or small-group case consultations in person, by phone or by skype; and 3) individualized "skill training" programs that are more time intensive, depending on the clinician's training and clinical experience, as assessed by portions of the Pike's Peak model of competency for geropsychologists. Typically, those with limited knowledge and clinical experience will need a more extensive program, including reading basic books and watching videos on CBT for LLD; discussing their understanding of the program (by phone, skype, or in person); and reviewing their audiotaped sessions with two of their consumers.

This program generally requires a 3- to 6-month time commitment of 2–4 hours/week. For mental health clinics or agencies that have multiple practitioners learning CBT-LLD, a combination of individual and small-group case consultation is available.

4. **Cognitive Enhancement Therapy (CET):** CET is a cognitive rehabilitation training program for adults and older adolescents with chronic or early-course schizophrenia or schizoaffective disorder (per DSM-III-R or DSM-IV criteria) who are stabilized and maintained on antipsychotic medication and not abusing substances. CET is designed to provide cognitive training to consumers to help them improve impairments related to neurocognition (including poor memory and problem-solving abilities), cognitive style (including impoverished, disorganized, or rigid cognitive style), social cognition (including lack of perspective taking, foresight, and social context appraisal), and social adjustment

(including social, vocational, and family functioning), which characterize these mental disorders and limit functional recovery and adjustment to community living. Through CET, consumers learn to shift their thinking from rigid serial processing to a more generalized processing of the core essence or gist of a social situation and a spontaneous abstraction of social themes.

CET is manual driven and delivered over a period of 18 months, beginning with approximately 3 months of weekly 1-hour sessions of computer-assisted neurocognitive attention training conducted with pairs of consumers. As the treatment proceeds over 18 months, consumers engage in 60 hours of targeted, performance-based neurocognitive training exercises to improve their attention, memory, and problem-solving abilities. After approximately 3 months of neurocognitive training, consumers start to attend social-cognitive group sessions, which last for 1.5 hours each and are held weekly; there are a total of 45 social-cognitive group sessions in the program. In these sessions, clinicians help groups of six to eight consumers improve social-cognitive abilities (e.g., taking perspectives, abstracting the main point in social interactions, appraising social contexts, managing emotions) and achieve individualized recovery plans. Consumers also use experiential learning and real-life cognitive exercises to facilitate the development of social wisdom and success in interpersonal interactions; enhance social comfort; respond to unrehearsed social exchanges; present homework and lead homework reviews; provide feedback to peers; and receive psychoeducation on social cognition and schizophrenia. Clinicians provide active, supportive coaching to keep each consumer on task and to encourage greater understanding of social cognition and greater elaboration, organization, and flexibility in thinking and communication. After social-cognitive group sessions begin, neurocognitive training and social-cognitive training proceed concurrently throughout the remainder of the program.

Both neurocognitive training and social-cognitive group sessions are facilitated by master's-level clinicians who have at least 2 years' experience in the treatment of schizophrenia. Social-cognitive group sessions require a minimum of two master's-level clinicians, who follow a comprehensive structured curriculum. CET is designed to be implemented in agency- and center-based treatment settings.

5. Cognitive Processing Therapy for PTSD (CPT-PTSD): CPT is a cognitive behavioral therapy for posttraumatic stress disorder (PTSD), which is used for older adolescent and adult consumers with a PTSD diagnosis. In CPT, PTSD is conceptualized as a disorder of "non-recovery" in which the natural process of recovery from trauma stalls out. This can happen when avoidance of painful memories or reminders prevents the accurate processing of the trauma memory. Erroneous beliefs about the causes and consequences of the trauma are maintained and tend to produce strong negative emotions.

    CPT for PTSD is primarily a cognitive therapy. The therapy initially focuses on distorted beliefs about the trauma such as denial and self-blame, then shifts to overgeneralized beliefs about oneself and the world. Throughout this process, consumers are taught to challenge their beliefs and assumptions through Socratic questioning and the use of daily worksheets. Once dysfunctional beliefs are deconstructed, more balanced self-statements are generated and practiced. CPT may or may not involve having consumers write detailed accounts of the most traumatic incidents in their lives. The goal in CPT is that consumers learn to make sense of their trauma and incorporate this understanding into their beliefs about themselves, others, and the world in a balanced way.

    Treatment can be delivered in individual or group format conducted by social workers, psychologists, psychiatrists, and other mental health therapists licensed to provide psychotherapy. Treatment

consists of typically 12 sessions (range 10-15) conducted once or twice weekly for 60 minutes each (90 minutes in a group setting).

6. Community Reinforcement and Family Training (CRAFT): CRAFT is an intervention designed to help a concerned significant other/family member (CSO) facilitate treatment entry/engagement for a treatment-refusing individual who is abusing drugs or alcohol (the family member). CRAFT was developed with the belief that CSOs, who often have substantial information about their family member's substance abuse behavior patterns, can play a powerful role in helping him/her to enter treatment.

Delivered one on one or in groups of CSOs, CRAFT aims to influence the substance-abusing family member's behavior by changing the way the CSO interacts with him or her. The intervention incorporates the clinical style of motivational interviewing and emphasizes learning new skills to cope with a substance-abusing family member (e.g., using positive reinforcement, letting the loved one face the natural consequences of his or her behavior). CRAFT is also designed to help the CSO become more independent and feel more empowered in his or her relationship with the substance-abusing family member.

The twelve to fourteen 1-hour CRAFT counseling sessions are typically delivered twice weekly for the first 4 weeks and once weekly for the next 6 weeks. However, the CRAFT program moves as fast or as slow as the CSO is able, and the CRAFT therapist may use any procedure at any time. CRAFT therapists are typically counselors with master's degrees who are trained in the intervention. The sessions cover the following topics:

- Handling dangerous situations with the substance-abusing family member.
- Remembering the family member's positive attributes that were evident before he or she was abusing substances.
- Communicating with the family member using nonjudgmental feedback and reflective listening, and discontinuing communication that is not effective in positively influencing substance abuse.
- Using positive reinforcement to support abstinence and increase positive interactions (i.e., scheduling activities the family member enjoys that do not involve substances, participating only when no substances are used that day).
- Practicing non-reinforcement of substance abuse (extinction) by ignoring or avoiding the family member when he or she is abusing substances.
- Suggesting and initiating counseling during opportune times.
- Developing interests and social supports independent of the family member.

7. Dialectical Behavior Therapy (DBT): DBT is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder. DBT is recognized as the gold standard psychological treatment for this population. In addition, research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders.

DBT focuses on four sets of behavioral skills:
- Mindfulness: the practice of being fully aware and present in this one moment.
- Distress Tolerance: how to tolerate pain in difficult situations, not change it.
- Interpersonal Effectiveness: how to ask for what you want and say no while maintaining self-respect and relationships with others.

Attachment 3. Pennsylvania Evidence-Based Practices

- Emotion Regulation: how to change emotions that you want to change.

In its standard form, there are four components of DBT: skills training group, individual treatment, DBT phone coaching, and consultation team. The DBT skills training group is focused on enhancing consumers' capabilities by teaching them behavioral skills. The group is run like a class where the group leader teaches the skills and assigns homework for consumers to practice using the skills in their everyday lives. Groups meet on a weekly basis for approximately 2.5 hours and it takes 24 weeks to get through the full skills curriculum, which is often repeated to create a 1-year program. Briefer schedules that teach only a subset of the skills have also been developed for particular populations and settings. DBT individual therapy is focused on enhancing consumer motivation and helping consumers to apply the skills to specific challenges and events in their lives. In the standard DBT model, individual therapy takes place once a week for as long as the consumer is in therapy and runs concurrently with skills groups. DBT phone coaching is focused on providing consumers with in-the-moment coaching on how to use skills to effectively cope with difficult situations that arise in their everyday lives. Consumers can call their individual therapist between sessions to receive coaching at the times when they need help the most. The DBT therapist consultation team is intended to be therapy for the therapists and to support DBT providers in their work with people who often have severe, complex, difficult-to-treat disorders. The consultation team is designed to help therapists stay motivated and competent so they can provide the best treatment possible.

8. **Eye Movement Desensitization Reprocessing (EMDR):** EMDR is a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning. Treatment is provided by an EMDR therapist, who first reviews the consumer's history and assesses the consumer's readiness for EMDR. During the preparation phase, the therapist works with the consumer to identify a positive memory associated with feelings of safety or calm that can be used if psychological distress associated with the traumatic memory is triggered. The target traumatic memory for the treatment session is accessed with attention to image, negative belief, and bodily sensations. A series of repetitive 30-second dual-attention exercises are conducted in which the consumer attends to a motor task while focusing on the target traumatic memory and then on any related negative thoughts, associations, and body sensations. The most common motor task used in EMDR is side-to-side eye movements that follow the therapist's finger; however, alternating hand tapping or auditory tones delivered through headphones can be used. The exercises are repeated until the consumer reports no emotional distress. The EMDR therapist then asks the consumer to think of a preferred positive belief regarding the incident and to focus on this positive belief while continuing with the exercises. The exercises end when the consumer reports with confidence comfortable feelings and a positive sense of self when recalling the target trauma. The therapist and consumer review progress and discuss scenarios or contexts that might trigger psychological distress. These triggers and positive images for appropriate future action are also targeted and processed. In addition, the therapist asks the consumer to keep a journal, noting any material related to the traumatic memory, and to focus on the previously identified positive safe or calm memory whenever psychological distress associated with the traumatic memory is triggered.

The underlying mechanism for how this process works to reduce trauma-related stress, anxiety, and depression is unknown. Researchers have theorized that the positive effect is due to adaptive information processing, the theoretical model behind EMDR. Through adaptive information processing, the dual-attention exercises disrupt the consumer's stored memory of the trauma to allow for an elimination of negative beliefs, emotions, and somatic symptoms associated with the memory as it connects with more adaptive information stored in the memory networks. Once recall of the trauma

no longer elicits negative beliefs, emotions, or somatic symptoms and the memory simultaneously shifts to a more adaptive set of beliefs, emotions, and somatic responses, it is stored again, overwriting the original memory of the trauma.

EMDR is typically delivered in 60- to 90-minute sessions, although shorter sessions have been used successfully. The number of sessions varies with the complexity of the trauma being treated. For an isolated, single traumatic event, one to three sessions may be sufficient for treatment. However, when the trauma involves repeated traumatic events, such as combat trauma and physical, sexual, or emotional abuse, many more sessions may be needed for comprehensive treatment.

9. MATRIX Model: The Matrix Model is an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period. Consumers learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction. The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the consumer and using that relationship to reinforce positive behavior change. The interaction between the therapist and the consumer is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the consumer's self-esteem, dignity, and self-worth.

10. Medication-Assisted Treatment (MAT): MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. The use of FDA-approved medications to treat opiate dependence and accompanying evidence-based therapies and recovery supports. (Currently 3 drugs: suboxone, methadone, and buprenorphine.)

11. Motivational Enhancement Therapy: MET is an adaptation of motivational interviewing (MI) that includes normative assessment feedback to consumers presented and discussed in a non-confrontational manner. Motivational interviewing is a goal-oriented, client-centered counseling style for facilitating behavior change by helping consumers to resolve ambivalence across a range of problematic behaviors. MET uses an empathic and strategic approach in which the therapist provides feedback that is intended to strengthen and consolidate the consumer's commitment to change and promote a sense of self-efficacy. MET aims to elicit intrinsic motivation to change substance abuse and other behaviors by evoking the consumer's own motivation and commitment to change, responding in a way that minimizes defensiveness or resistance.

12. Motivational Interviewing (MI): Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping consumers to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Although many variations in technique exist, the MI counseling style generally includes the following elements:

- Establishing rapport with the consumer and listening reflectively.

Attachment 3. Pennsylvania Evidence-Based Practices

- Asking open-ended questions to explore the consumer's own motivations for change.
- Affirming the consumer's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals.
- Asking permission before providing information or advice.
- Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
- Encouraging the consumer's self-efficacy for change.
- Developing an action plan to which the consumer is willing to commit.

13. **Prolonged Exposure Therapy for PTSD (PE):** PE Therapy for Posttraumatic Stress Disorders is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help consumers process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: (1) psychoeducation about common reactions to trauma and the cause of chronic post-trauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the traumatic memory, and (3) in vivo exposure, gradually approaching trauma reminders (e.g., situations, objects) that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90 minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the consumer and his or her rate of progress.

14. **Seeking Safety:** Seeking Safety is a present-focused coping skills model for consumers with a history of trauma and/or substance abuse. The treatment was designed for flexible use: group or individual format, male and female consumers, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on psychoeducation and coping skills and has five key principles: (1) safety as the overarching goal (helping consumers attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both PTSD and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

15. **Trauma Focused CBT (TF-CBT):**

16. **Wellness Recovery Action Plan (WRAP):** Wellness Recovery Action Plan (WRAP) is a manualized group intervention for adults with mental illness. WRAP guides consumers through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. WRAP has the following goals:

- Teach consumers how to implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day-to-day lives.
- Help consumers organize a list of their wellness tools--activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising.

Attachment 3. Pennsylvania Evidence-Based Practices

- Assist each consumer in creating an advance directive that guides the involvement of family members or supporters when he or she can no longer take appropriate actions on his or her own behalf.
- Help each consumer develop an individualized post-crisis plan for use as the mental health difficulty subsides, to promote a return to wellness.

WRAP groups typically range in size from 8 to 12 consumers and are led by two trained co-facilitators. Information is imparted through lectures, discussions, and individual and group exercises, and key WRAP concepts are illustrated through examples from the lives of the co-facilitators and consumers. The intervention is typically delivered over eight weekly 2-hour sessions, but it can be adapted for shorter or longer times to more effectively meet the needs of consumers. Consumers often choose to continue meeting after the formal 8-week period to support each other in using and continually revising their WRAP plans.

Although a sponsoring agency or organization may have its own criteria for an individual's entry into WRAP, the intervention's only formal criterion is that the person must want to participate. WRAP is generally offered in mental health outpatient programs, residential facilities, and peer-run programs. Referrals to WRAP are usually made by mental health care providers, self-help organizations, and other WRAP consumers. Although the intervention is used primarily by and for people with mental illnesses of varying severity, WRAP also has been used with people coping with other health issues (e.g., arthritis, diabetes) and life issues (e.g., decision making, interpersonal relationships) as well as with military personnel and veterans.

Attachment 3. Pennsylvania Evidence-Based Practices