Certified Community Behavioral Health Clinics: Accelerating California Advancing and Innovating Medi-Cal (CalAIM)

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Acknowledgements

For more information about Pacific Clinics visit, www.pacificclinics.org.

Executive Summary

The Certified Community Behavioral Health Clinic (CCBHC) is an innovative, federally funded model that the Biden-Harris administration has proposed to make permanent nationwide. CCBHCs are advancing the goals of California's Advancing and Innovating Medi-Cal (CalAIM) initiative by providing high-quality, coordinated, and integrated whole-person care to high-need populations. Like CalAIM, the CCBHC is **a whole-person care model that aims to provide integrated, 24/7 access to mental health, substance use, and physical health services, including addressing Social Determinants of Health (SDoH) for vulnerable populations.** While CalAIM focuses on the Medi-Cal population, CCBHCs are required to serve all individuals regardless of their level of need, insurance, ability to pay, or place of residence. They also combine primary care services with behavioral health, serving the whole person. Long-term, CCBHCs and CalAIM aim to prevent hospitalizations and recidivism and reduce health disparities for underserved populations. This paper will describe how **CCBHCs offer an established framework for delivering integrated care to a broader population and are an ideal way to advance the CalAIM vision as it begins to be implemented.**

As of July 2021, there are over 430 CCBHCs nationwide and 15 in California. This paper describes the implementation of *Operation No Wrong Door*, a CCBHC that serves as a model for accelerating the full implementation of CalAIM. Operation No Wrong Door operates under a joint venture agreement between a community-based behavioral health organization, Pacific Clinics (a merger of Uplift Family Services and Pacific Clinics) and a Federally Qualified Health Center (FQHC), School Health Clinics of Santa Clara County (SHC). Pacific Clinics augments the FQHC's existing primary care provision through Collaborative Care by integrating on-site and virtual mental health, substance use, and case management services. Individuals seeking services from the CCBHC do not have single system needs; instead, they come experiencing multiple needs, including behavioral health, primary care, housing, and an array of other needs in the social determinants of health. Through this model, each consortium partner brings its specific expertise and connections to the CCBHC to better meet the multiple needs of each consumer (e.g., primary care, behavioral health, housing). The consortium CCBHC has demonstrated impressive outcomes in providing effective, seamless, integrated care in its first year. This paper provides an operational blueprint of key considerations to understand the interworkings of a CCBHC better and for organizations interested in replicating this type of comprehensive, integrated care system. In addition, the paper calls for action recommendations for sustainability and integration across different organizations to successfully transform the health care system and accelerate the implementation of CalAIM. **To maximize existing momentum in a model that is already doing what CalAIM hopes to achieve, we must act now to protect California CCBHCs.**

Certified Community Behavioral Health Clinics: Accelerating CalAIM

Overview: Alignment between CCBHCs and CalAIM

Congress enacted the Certified Community Behavioral Health Clinic (CCBHC) model in 2014 to fill gaps in quality behavioral health care for all individuals in need. In parallel, California envisioned a disruption and transformation of its healthcare system. In December 2021, the State received federal approval for its five-year California Advancing and Innovating Medi-Cal (CalAIM) initiative. Similar to CalAIM, the CCBHC is **a whole-person care model that aims to provide coordinated, integrated, 24/7 access to mental health, substance use, and physical health services, including addressing social determinants of health (SDoH), for vulnerable populations.** While CalAIM focuses on the Medi-Cal population, CCBHCs are required to serve all individuals regardless of their level of need, insurance, ability to pay, or place of residence. They also combined primary care services with behavioral healthcare. Long-term, CCBHCs and CalAIM aim to prevent hospitalizations and recidivism and reduce health disparities for underserved populations. On a national level, CCBHCs have increased access, improved health outcomes, and lower costs for millions of Americans.[1][2] **CCBHCs inherently offer an established framework for delivering integrated care to a broad population and are ideal for advancing the CalAIM vision as it begins its five-year implementation.**
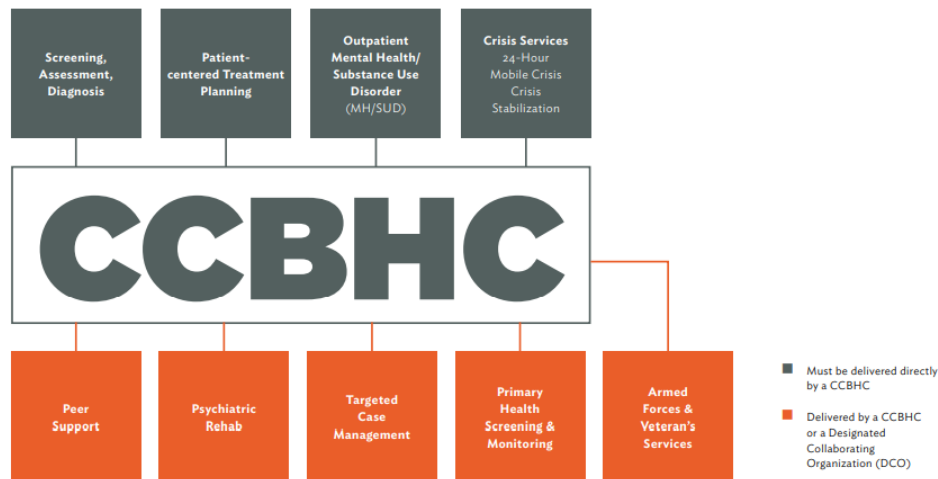

Figure 1. CCBHC required scope of services[3]

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[1] National Council for Mental Wellbeing (2021). *Leading a bold shift in mental health & substance use care: CCBHC impact report 2021.* https://www.thenationalcouncil.org/wp-content/uploads/2021/05/052421_CCBHC_ImpactReport_2021_Final.pdf?daf=375ateTbd56

[2] Breslau, J., Briscombe, B., Dunbar, M., Kase, C., Brown, J., Siegwarth, A.W., & Miller, R. (2020, September). *Preliminary cost and quality findings from the national evaluation of the Certified Community Behavioral Health Clinic demonstration.* Prepared for U.S. Department of Health and Human Services - Office of the Assistant Secretary for Planning and Evaluation & Office for Behavioral Health, Disability, and Aging Policy. https://aspe.hhs.gov/reports/preliminary-cost-quality-findings-national-evaluation-certified-community-behavioral-health-clinic-0

[3] National Council for Mental Wellbeing and National Association of Counties (2021). *Certified Community Behavioral Health Clinics and County Governments: A National Model Tailored for Local Mental Health and Substance Use Care.* https://www.thenationalcouncil.org/wp-content/uploads/2021/03/032421_CCBHCs_CountyGovernments_v2.pdf?daf=375ateTbd56

CCBHCs have been operating in California since April 2020. Today, California is home to 15 CCBHCs: 14 in Southern California counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Barbara) and one in Northern California (Santa Clara). Preliminary outcomes across the first California CCBHCs are promising.[4]

CCBHCs are required to cover nine types of services *(Figure 1)* and meet established criteria in six areas: 1) Staffing; 2) Availability and Accessibility of Services; 3) Care Coordination; 4) Scope of Services; 5) Quality and Other Reporting; and 6) Organizational Authority, Governance, and Accreditation. *Table 1* below illustrates the synergies between CCBHCs and CalAIM in key areas.

Table 1. CCBHC and CalAIM Alignment		
	CCBHC [5]	**CalAIM [6]**
Population of Focus	**All individuals,** regardless of their ability to pay, residence, or level of need (mild/moderate or moderate/severe).	Currently, members with severe mental illness/substance use disorder, high utilizers, justice-involved are the population of focus.
Current Funding	**1) Demonstration grants** funded by a Medicaid prospective payment rate with Medicaid overseeing certification, payment, and compliance; **2) Expansion grants** supplement existing payment sources (e.g., Fee for Service managed care contracts) and through which clinics self-certify as meeting CCBHC requirements. Unfortunately, all California CCBHC are funded as Expansions which means all grant funding ends with the term of the 2-year grant.	**Medi-Cal with specialty and managed care plans** (e.g., per member per month rate). The overarching aim is to implement behavioral health payment reform to incentivize outcomes and quality over volume and cost.
Staffing	Implementation of a **staffing plan based on a comprehensive needs assessmen**t of the population served; training plans addressing trauma-informed care, cultural competence, risk assessment; credentialed MAT providers and substance use specialists.	CalAIM will require change management for organizations to **transform their staffing and the system**. Requires that providers across programs be trauma-informed and culturally-competent.
Availability and Accessibility of Services	Services are **accessible to all at convenient times and modalities**; timely access standards are dependent on the level of need.	Seeks to **improve the timeliness of access** to appropriate services and address SDoH barriers that impede access. Takes a "no wrong door" perspective.
Crisis Services	**24/7 crisis services are required**, including mobile crisis teams, emergency	Aims to **increase availability and access to crisis interventions** and stabilization.

[4] California Primary Care Association (2022). *California Certified Community Behavioral Health Clinics: Data Profile: Year 1 Outcomes.*
[5] Department of Health and Human Services Substance Abuse and Mental Health Services Administration (2020). *FY 2020 Certified Community Behavioral Health Clinic Expansion Grants Funding Opportunity Announcement (FOA) No. SM-20-012.* https://www.samhsa.gov/grants/grant-announcements/sm-20-012
[6] State of California Health and Human Services Agency: Department of Health Care Services (2021). *California Advancing & Innovating Medi-Cal (CalAIM) Proposal, January 2021.* https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf

	crisis intervention services, and crisis stabilization.	
Mental Health Services	Requires **outpatient services** including screening, person-centered assessment and diagnosis, risk assessment, treatment and crisis planning, evidence-based practices and psychotherapy, monitoring of adverse effects of psychiatric medications, and psychiatric rehabilitation services.	The array of outpatient and inpatient mental health services will continue to be available with system-level changes to improve access and quality. Aims to **build out a full continuum of community-based mental health care in the least restrictive setting**.
Substance Use Services	Requires substance screening and **comprehensive recovery support services**, including Medication-Assisted Treatment (MAT).	Seeks to **expand access to and integrate Drug Medi-Cal substance use services**, including MAT, with specialty mental health and other services.
Physical Health Services	**Outpatient primary care screening and monitoring** key health indicators and health risks are required, including screening for HIV and viral hepatitis and vaccinations.	Proposes a **full integration pilot** that aims to provide a single point of accountability for payment & administration of members' physical, oral, behavioral, and developmental health needs. Other CalAIM reforms indirectly improve coordination between MH, SU & PH services.[7]
Social Determinants of Health (SDoH)	**System/Patient Navigators** identify formal and informal supports within the community to address individual needs.	Non-medical services that address SDoH are reimbursable through **Community Supports (CS).** Examples: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Meals/Medically Tailored Meals
Care Coordination	**Coordinate person-centered care across full spectrum of services**, including system navigation and linkage to social services; health information technology to support coordination and population health management; formal agreements with other providers (e.g., FQHCs, inpatient, criminal justice agencies) and tracking of discharge from programs.	Through **Enhanced Care Management (ECM)**, a high-touch care manager coordinates care across multiple health and social service systems to provide a seamless member care experience.

The most common CCBHC models in California are led by either: 1) Community-Based Organizations (CBO); or 2) Federally Qualified Health Centers (FQHCs). Currently, CBOs that provide mental health and substance use services are contracted through counties or managed care health plans and do not have prospective payment systems (PPS). In contrast to CBOs' fee-for-service contracts, a demand-based approach that focuses on volume, PPS pays organizations based on a predetermined, fixed amount, which allows for flexibility in services and staffing and prioritizes efficient and effective care over volume. FQHCs are federally certified organizations with PPS funding to provide primary and preventative care, including health, oral, mental health, and substance use services, to people of all ages, regardless of their ability to pay or health insurance status. CCBHCs with Demonstration grants receive a PPS rate.

[7]

Model Partnership: Operation No Wrong Door, A Consortium CCBHC Approach

The Pacific Clinics and School Health Clinics of Santa Clara County (SHC) consortium CCBHC model is a unique partnership in California that **builds on the expertise of each organization rather than any of the partners having to learn additional service areas without prior experience.** With fully integrated services launched in September 2020, the Operation No Wrong Door CCBHC Consortium operates under a **joint venture agreement** whereby integrated behavioral health and primary care services are available on-site or via telehealth at six SHC FQHCs across Santa Clara County. The aim of the consortium CCBHC is seamless, high-quality whole-person care for individuals with mild/moderate and moderate/severe behavioral health needs. See our previous white paper, Figure 1[8] for details on what services each organization brings to the consortium partnership.

Consortium CCBHC Outcomes

SHC consumers are considered a Medically Underserved Population for primary care by the Health Resources & Services Administration (HRSA). Consumers are primarily low-income, ~80% Latinx/a/o, and recent immigrants with limited English proficiency. While all ages are served, about two-thirds are youth under 18. Approximately one-third are uninsured.

Prior to the launch of CCBHC services in September 2020, SHC employed one full-time behavioral health provider with a caseload of roughly 30 patients with mild to moderate mental health needs across six clinics (serving 5,795 patients in 2019). Most patients were referred to the county call center. In contrast, with an expanded workforce, as described in Table 3, **in the first 12 months** as a CCBHC**, 77% more primary care consumers were screened for behavioral health,** and 74% of referred patients agreed to enroll in behavioral health services within 10 days. In addition, the CCBHC developed **six formal partnerships with supporting organizations** to meet a broad array of needs (e.g., intensive substance use, housing support, and early childhood development). Primary care and behavioral health staff expressed that the CCBHC model was beneficial for patients (*M* rating = 4.43 where 1=strongly disagree and 5=strongly agree).

At follow-up interview (6-months or discharge from CCBHC services):
- 83% reported positive functioning in everyday life, compared with 37% at enrollment.
- 83% reported good to excellent overall health, compared with 63% at enrollment.
- 100% were retained in the community, compared with 97% at enrollment.
- 90% reported high satisfaction with services.

Building A Consortium CCBHC: An Operational Blueprint Across Implementation Stages

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[8] Castillo Sumi, E., Stevens, K. I., & Guan, K. (2021). *The role of Certified Community Behavioral Health Clinics in California Advancing and Innovating Medi-Cal (CalAIM): Aligning federal and state initiatives to transform California's behavioral health system* [White paper]. Pacific Clinics.

Meeting criteria and sustaining the consortium CCBHC involves complex team effort. The stages of implementation, based on implementation science research[9], provide a valuable framework to organize activities and tasks to successfully launch new programs, including CalAIM. *Table 2* below outlines critical activities within each stage of implementing the consortium CCBHC.

Table 2. Key Activities to Implement a Consortium CCBHC		
Implementation Stage	**Activities and Milestones**	**Responsible Participants**
Exploration and Adoption	• Explore and identify **partners with strategic alignment**, congruent mission, vision, and cultural values • Confirm within-organization agreement and established partnership between executive leaders • Develop agreement between organizations on **roles and responsibilities** • Make final Go/No-Go Decision • Complete **SAMHSA application** outlining each organization's responsibilities towards achieving shared objectives	• Executive leaders of each organization
Program Installation	• Conduct formal **Launch Event** that includes relevant staff from the organizations • Establish **contracts/joint agreements**, including Business Associates Agreement • Agree upon **care models and practices** to be used (e.g., Collaborative Care model) • Develop **integrated policies and protocols** to fit chosen care models *(see Appendices A-C for examples)* • **Hire** staff members • Identify **training needs** (e.g., topics & structure) for integrated care • Agree upon **screening measures** (e.g., ACEs, PHQ-9, ASQ) and **key performance indicators** (KPIs) consistent with workflow and population needs • Identify **shared Electronic Health Record** (EHR) and enhance it to support new workflows • **Contract with health plans** for appropriate treatment codes • **Meet CCBHC criteria** per SAMHSA requirements	• Executive and senior leaders of each organization • CCBHC Leadership Team (e.g., Project Director, Evaluator, Medical Director, lead psychiatrists, clinical managers, and Project Manager)

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[9] Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Initial Implementation	• Normalize the difficulty of change • **Embrace shared vision and goals** to achieve compromise • Acknowledge successes and assume positive intent, esp. across organizations • Develop **relationships and consistent communication** between primary care and behavioral health direct service staff • Establish regular intra- and inter-agency forums to **conduct Plan-Do-Study-Act processes**; adjust workflows as needed based on staff feedback and initial KPI data • Identify and implement **additional training and decision support** technology needed for staff	• CCBHC Leadership Team • CCBHC direct service staff (consulting psychiatrists, behavioral care managers- BCMs, system navigators - SNs, primary care physicians- PCPs, medical assistants-Mas, peers)
Full Operation	• **Fully integrated services**- Implement workflows and strategies to bring the consortium CCBHC beyond co-location of services into **full integration, which requires an ongoing transformation of organizational culture, processes, structure, programming, practice, and financing to ensure seamless care.** Assess using the Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration[10] • Use data decision support tools *(see Table 3 below)* to conduct **continuous quality improvement** • Solicit ongoing **feedback from stakeholders** (e.g., direct service staff, consumers) to evaluate program • Assist direct service staff in **managing productivity** with a full caseload	• CCBHC Leadership Team • CCBHC direct service staff

Innovation	• **Enhanced service array**
	  ○ **Enhance substance use services-** e.g., Drop-in recovery support center for transition-aged youth; increase Medication-Assisted Treatment (MAT) capacity through training, consultation, and recruitment of additional PCPs/NPs to become X-waivered
	  ○ **Address social determinants of health (SDOHs)-** System Navigators' role is to link patients with community resources that affect their health (e.g., housing, childcare, etc.)
	• **Enhanced partnerships-** Strategically identify partners to develop a continuum of care (e.g., residential substance use services, school-based services, etc.) and agree upon referral/discharge criteria
	• **Interoperable technologies** (EHR, data visualization, etc.)
		• Executive leaders of each organization
		• CCBHC Leadership Team

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[10]SAMHSA-HRSA Center for Integrated Health Solutions (2014). *Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration.* Retrieved from https://www.thenationalcouncil.org/integrated-health-coe/resources/

	• Additional **grants** (e.g., private/corporate Foundations)	
Sustainability	• **Advocacy** to change legislation to support CCBHCs-partner with statewide and national organizations (e.g., National Council on Mental Well-being; California Primary Care Association; California Alliance for Children and Families; California Council of Community Behavioral Health Association) to educate stakeholders and publicize our successes • **Value-Based Contracts** with health plans • **Collaborative Care Model billing**: Advocacy with states and health plans to support full billing of CoCM CPT codes; need for EHR modules to support CoCM documentation	• Executive leaders of each organization

Implementation Drivers

As presented in Table 3, Implementation drivers supported the launch of an innovative consortium CCBHC program within four months of the grant award. Implementation Drivers are vital components of the capacity and infrastructure needed to implement an innovation successfully.[11] There are three categories of drivers: 1) Competency Drivers: the activities to develop, improve, and sustain practitioners' and leaders' ability to put programs and innovations into practice, so clients benefit; 2) Organizational Drivers: organizational, administrative and systems components that are necessary to create the organizational, local, and state environments for new ways of work; and 3) Leadership Drivers: in the context of *active implementation,* leadership approaches related to transforming systems and creating change. In tandem, Implementation Drivers are meant to be integrated and compensatory. More specifically, **integrated** means that the philosophy, goals, knowledge, and skills related to the program or practice are consistently expressed in each of the Implementation Drivers; **compensatory** means that the skills and abilities not acquired or supported through one driver can be compensated for using another driver.

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[11] Fixsen, D.L. & Blase, K.A. (2008). Implementation Drivers. National Implementation Research Network. Retrieved from https://nirn.fpg.unc.edu/module-2

Table 3. Core Drivers of Successful Implementation for the Consortium CCBHC	
Competency Drivers	
Selection	• Across all positions, recruit staff with experience/interest in whole-person care and the multidisciplinary **Collaborative Care Model (CoCM)**[121314] - an evidence-based approach that aims to improve consumer outcomes through inter-professional cooperation between BCMs, consulting psychiatrists, and primary care providers who prescribe psychiatric medications • **Key CCBHC personnel**: Project Director, Evaluator • **Behavioral health clinical team** to achieve CoCM: clinical program managers, consulting psychiatrists and psychiatric nurse practitioners, BCMs, system navigators (individuals with lived experience) • **Primary care staff** to achieve CoCM: PCPs, MAs • **Administrative staff**: project managers, IT and EHR support staff

Training	• All staff:
	   ○ Introduction to the **vision/aims of the CCBHC, including CoCM workflows**
	   ○ Behavioral health **screening and outcome measures**
	   ○ Compassion fatigue and **burnout**
	• BCMs:
	   ○ **Transitioning from specialty mental health to CoCM** (e.g., brief psychiatric assessment, promoting medication adherence, problem-solving treatment)
	• PCPs:
	   ○ General **psychiatry**, child and adolescent psychiatry, and management of substance use disorders, including **Medication-Assisted Treatment**

Coaching	• **Routine and ad-hoc supervision/consultation** to support all training topics above, including:
	   ○ Daily huddles and weekly individual/group supervision (BCMs, SNs)
	   ○ Psychiatric consultation (psychiatrists and BCMs)
	   ○ Curbside consultations (psychiatrists and PCPs)
	   ○ Formal didactics

Fidelity Assessment	• Regularly examine data on **workflow effectiveness** (e.g., % of consumers screening high for behavioral health who are referred to services) • Assess **quality of CoCM implementation** (e.g., briefer BCMs sessions, use of problem solving treatment)
Organization Drivers	
Decision Support Data Systems	• **Electronic Health Record**: gathers screening and treatment data • **AIMS Registry**: reports on caseload and individual processes and outcomes in CoCM • **Data Visualization** (Tableau): connects to EHR to report on key performance indicators for continuous quality improvement *(see Appendix D, for example)* • **Salesforce** Non-Profit Case Management Platform: assists with referral and documentation due to date tracking

[12] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*, *10*. https://doi.org/10.1002/14651858.CD006525.pub2

[13] Gilbody, S., Bower, P., Fletcher, J., Richards, D., Sutton, A. J. (2006). Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine*, *166*, 2314–2321. https://doi.org/10.1001/archinte.166.21.2314

[14] Jacob, V., Chattopadhyay, S. K., Sipe, T. A., Thota, A. B., Byard, G. J., & Chapman, D. P. (2012). Economics of collaborative care for management of depressive disorders: A community guide systematic Review. *American Journal of Preventive Medicine*, *42*, 539-549. Retrieved from https://www.thecommunityguide.org/sites/default/files/assets/CollabCare_EconEvidenceReview1.pdf

Facilitative Administration	• **Core**: internal weekly meeting of behavioral health leaders to discuss issues such as staffing, training, and fostering collaboration with primary care • **Implementation Review**: weekly inter-agency meeting to discuss issues such as primary care-BH workflows, BH training for FQHC staff, progress on grant/integration milestones • **Advisory Workgroup**: quarterly meeting to obtain feedback on the program from community members with lived behavioral health experience
System Intervention	• **Advocacy** for policies that facilitate the CCBHC model (e.g., LMFTs' ability to bill) • **Consulting** with other CCBHCs and outside experts on best practices (e.g., for meeting CCBHC criteria, billing CoCM)

| Leadership |
| --- |
| • **Steering Committee**: a monthly-to-quarterly inter-agency meeting with executives from each consortium organization to provide higher-level updates and discuss issues such as changes to policies and sustainability
• **Clinical Practices Committee**: clinical leadership responsible for developing integrated clinical workflows for child and adult CCBHC services *(see Appendix A)* and identifying, training, and reviewing fidelity to care models (e.g., CoCM)
• **Finance Committee:** executive leadership to develop financial models and support the clinical team on billing and claim issues. |

Conclusion

President Biden recently announced in his 2022-23 Budget Proposal a strategy to address our nation's mental health crisis by investing millions of dollars in expanding CCBHCs, a proven model of care that has been shown to improve health outcomes for any individual, no matter who they are or whether they can pay. Despite the time-limited grant funding for CCBHCs, preliminary outcomes of CCBHCs in California are just as promising. It is important to note that **CCBHCs are currently achieving the goals outlined by CalAIM**. In this paper, we described major strategies utilized to build a model CCBHC partnership that can accelerate the goals of the CalAIM initiative. Implementation Science provided a framework to initiate a CCBHC under a joint venture and can also be utilized to expedite CalAIM through the CCBHC model.

The process described here establishes a solid foundation to accelerate CalAIM by **expanding the system of care to comprehensively meet consumer needs in a coordinated manner.** However, California CCBHCs are funded by SAMHSA two-year Expansion grants instead of Demonstration grants with built-in Medicaid Prospective Payment Rates (PPS). As such, without sustained funding, clients are at risk of not receiving this model of care that has been so successful, and providers will need to revert to a system that inadvertently created barriers to accessing care (e.g., change providers as the level of care changes from mild-moderate to moderate-severe and vice versa) for sustainability. Despite the utility of additional grants to pilot new services, target new populations, and provide bridge funding, long-term financial viability is a priority. Without sustained PPS funding, California CCBHCs may no longer be able to offer their consumers much-needed, high-quality care. **To maximize existing momentum in a model that is currently achieving much of what CalAIM hopes to succeed, we must act now to protect California CCBHCs.** The healthcare crisis exacerbated by COVID-19 demands a comprehensive response, and CCBHCs are poised to accelerate CalAIM to meet the call of need.

Appendix A: Sample Collaborative Care Workflow

Sample collaborative care workflow for child behavioral health
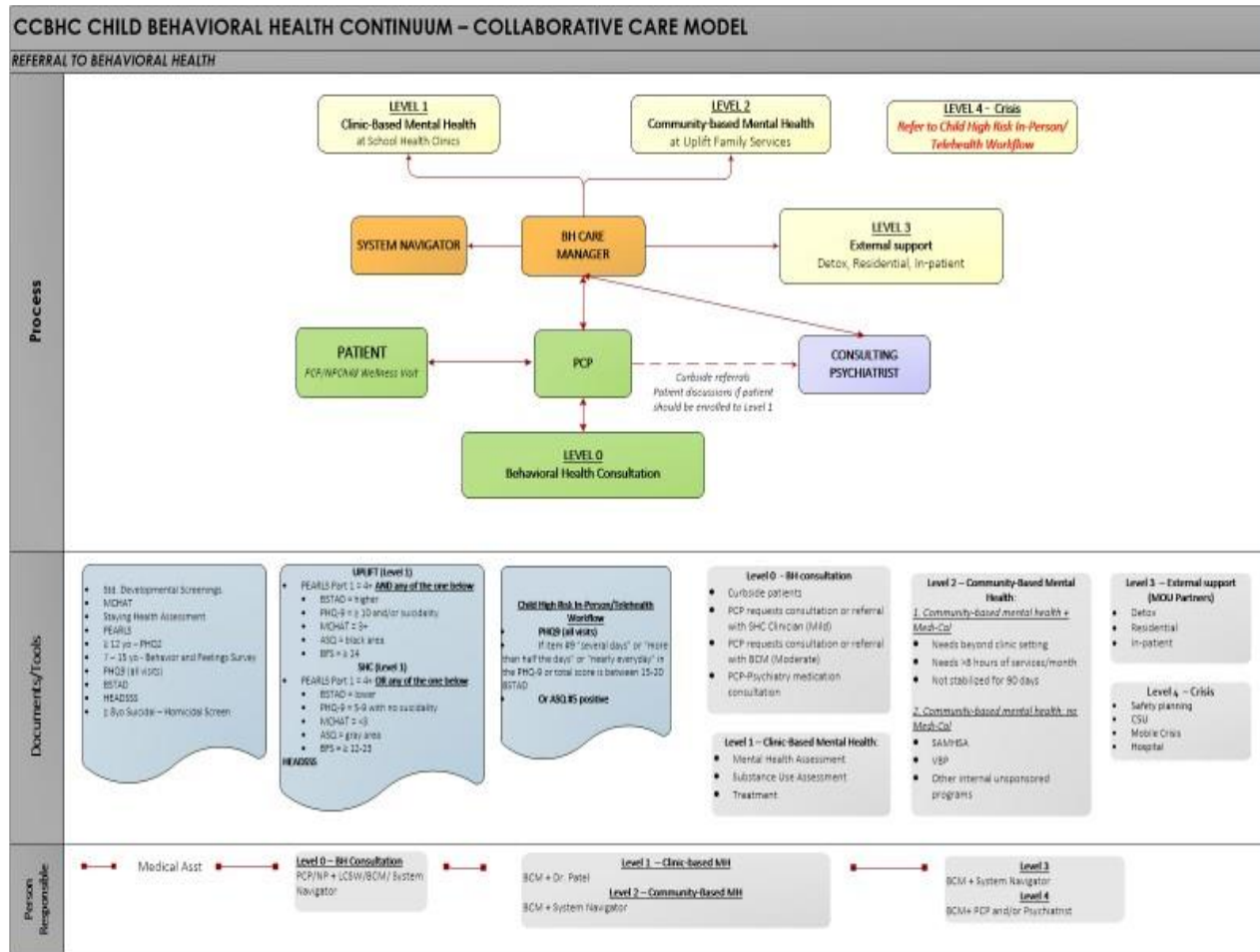
Appendix B: Sample CQI Dashboard

Sample CCBHC data visualization dashboard used for continuous quality improvement