2023

Strategic Leadership Steps for New Certified Community Behavioral Health Clinics

Keisha Stacy-Ann Davis

Walden University

College of Management & Human Potential

This is to certify that the doctoral study by

Keisha S. Davis

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Derek Rohde, Committee Chairperson, Psychology Faculty
Dr. Debra McIntyre, Committee Member, Psychology Faculty
Dr. Aundrea Harris, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

Strategic Leadership Steps for New Certified Community Behavioral Health Clinics (CCBHCs)

Keisha S. Davis

MBA, Liberty University, 2016

MSW, Clark Atlanta University, 2010

BA, Methodist University, 2004

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

Walden University

May 2023

Abstract

States grapple with how to address the opioid epidemic and the growing need for behavioral health (BH) services. Certified Community Behavioral Health Centers (CCBHCs) are a new industry solution to address the need for integrated and coordinated physical and BH care. New CCBHCs are funded by the Federal 223 Substance Abuse and Mental Health Services Administration's (SAMHSA) grant. However, they must be certified by states to meet the SAMHSA criteria for continued funding. This qualitative study presents a single-case study of a Southern state's behavioral health department's (SSBHD) leadership strategy for certifying the CCBHCs in its state and creating a future reimbursement rate for continued services. Implementing CCBHCs benefits SSBHD's constituents because they will increase access to coordinated whole-health services in a value-based system of care. The Baldrige framework of Excellence assessed the BH organization's strategic steps for implementing the new CCBHCs. A thematic content analysis of the data revealed the following themes: consultation, review of other states' CCBHC process, collaboration, and the divergence in SSBHD's CCBHC certification/reimbursement process. The findings revealed that the SSBHD had a good leadership strategy in place. Recommendations are offered for how to make their strategy more efficient. Executing an efficient strategy for certifying CCBHCs and helping them establish a sustainable reimbursement rate contributes to positive social change because CCBHCs may be the BH service model of the future. Successful implementation of CCBHCs in SSBHD's state creates a model for the efficient implementation of future CCBHCs.

Strategic Leadership Steps for New Certified Community Behavioral Health Clinics (CCBHCs)

Keisha S. Davis

MBA, Liberty University, 2016

MSW, Clark Atlanta University, 2010

BA, Methodist University, 2004

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

Walden University

May 2023

Acknowledgments

I would like to thank Jesus for sustaining me through this endeavor. He and I spent many hours crafting this work, and I could not have done it without his motivation and Spirit of excellence. I thank my family and friends for being patient and supporting me through the process. Their understanding of my unavailability because "I had to write" gave me the space to excel; that was appreciated. Thanks to my classmates for their feedback and many interactions on the discussion boards that helped me to grow and gave me ideas to think through. I thank the behavioral health organization that allowed me to study their process, ask questions, review their documents, attend their meetings, and learn from them so I can share their work with others. It was a privilege and an honor. I thank my chairs for their investment in the success of this study and their wise and patient feedback during the revision process. Lastly, I thank Walden University for the platform to learn while being a mother, a wife, and a full-time employee. The available support and the many resources at Walden helped me along this journey.

Table of Contents

List of Tables

Section 1a: The Behavioral Health Organization

States across the United States continue to grapple with the ongoing and growing opioid epidemic (Fassbender et al., 2019; Hu et al., 2021; Implementation, 2020; National Council for Behavioral Health [NCBH], 2017; Scanlon & Hollenbeak, 2019). Additionally, stress and increasing disparities brought on by the COVID-19 pandemic contribute to a growing need for behavioral health (BH) agencies to find evidence-based ways to address the mental health and substance use challenges in their communities (Brown, 2021; Caton et al., 2020; Hu et al., 2021; Implementation, 2020; Plough, 2019). Certified community behavioral health clinics (CCBHCs) are an emerging approach to addressing the BH needs in communities (Hu et al., 2021). CCBHCs are anticipated to provide communities with more access to comprehensive care in BH settings (Hu et al., 2021; Implementation, 2020; NCBH, 2017).

The organization that I studied was a Southern state behavioral health department (SSBHD) located in a growing city in the United States. I gathered information from the organization's website, interviews, documentation, and attendance in meetings. The organization's exact name and website address are withheld from this study for anonymity. Per information on their website, the SSBHD was established by the Governor and General Assembly in 2009 and serves as the State's health authority. The SSBHD has a nine-member board appointed by the Governor to serve 3-year terms. Additionally, the board members' credentials, purpose, required meetings, and role in selecting, approving, and setting SSBHD commissioner's salary is covered in its membership board's bylaws. The SSBHD's purpose is to provide easy access to high-

quality care that leads to a life of recovery and independence for the people served. Its mission is to lead an accountable and effective continuum of care to support constituents with BH challenges and intellectual/developmental disabilities (I/DD) in a dynamic healthcare environment. The SSBHD's competencies match that of other BH organizations. Its professional staff and partnering providers have the required competencies (degrees, experience, licensure, collaboration, care coordination, cultural competence, technology, etc.) to deliver needed services with quality and accessibility (Johnson & Rossow, 2019; NCBH, 2014).

The SSBHD operates three main program divisions: Behavioral Health, Intellectual/Developmental Disabilities (I/DD), and Hospital Services. The divisions, in turn, direct the work of around 7,000 staff who cover constituents' services and provider needs for the State's 159 counties. The SSBHD and partnering providers offer a range of treatment services to the State's populations who need them. Those services include BH, I/DD, and inpatient psychiatric hospital services. Hence, the SSBHD has partnership responsibilities with providers who were issued new grants by the Substance Abuse and Mental Health Services Administration (SAMHSA) to create CCBHCs (Hu et al., 2021; NCBH, 2020; SAMHSA, 2021a).

The SSBHD experienced staffing challenges because of the industry-wide shortage of professionals like nurses, social workers, psychiatrists, and direct care professionals, exacerbated by the COVID-19 pandemic and the increased demand for BH services (Bryant, 2021). The successful implementation of CCBHCs in the state will help facilitate integrated care and help SSBHD to realize its vision and mission (Brown, 2021;

Hu et al., 2021; Implementation, 2020; NCBH, 2020; SAMHSA, 2021a, 2021b). The SSBHD's services are primarily funded by Medicaid, Federal grants, and/or state-approved/appointed monies. The SSBHD has responsibilities to adhere to federal and State laws/regulations (Centers, n.d.; SAMHSA, n.d.; The Joint, n.d.; U.S. Department, 2021). The SSBHD's customers are those within the State who are uninsured, receiving Medicaid, and seeking services for BH challenges or intellectual/ developmental disabilities. In addition, services can often include collaboration with family members. The stakeholders include clients, families, employees, and a range of community constituents and partners in delivering services (National Institutes of Standards and Technology [NIST], 2021; Johnson & Rossow, 2019). The preceding information about the growing opioid epidemic and the need for BH services in communities, along with the SSBHD's organizational profile, regulatory requirements, and customers/stakeholders, set the stage for establishing CCBHCs. This is a positive step toward integrated care and meeting SSBHD's vision. Hence, evaluating SSBHD's strategy to ensure the success of CCBHCs is the focus of this study.

Practice Problem

I evaluated the strategic leadership steps used by the SSBHD to certify and create a future reimbursement rate for the new CCBHCs in the state that meets SAMHSA's grant requirements (SAMHSA, 2021a, n.d.). SSBHD is a state government BH entity; therefore, it has oversight responsibilities for the new CCBHCs, must establish a strategic way to fully certify the CCBHCs, and work with them to create a future reimbursement rate. The establishment of CCBHCs is groundbreaking and still developing (Hu et al.,

2021; Implementation, 2020; NCBHJ, 2017, 2020). Although some researchers have written about other states' CCBHCs implementation, professional research about CCBHCs and organizational practice knowledge on the specifics of how to strategically establish a certification process to grade the readiness of new CCBHCs in SSBHD's region is lacking (Hu et al., 2021; Implementation, 2020; NCBH, 2017, 2020; Office of the Assistant Secretary for Planning and Evaluation [OASPE], 2019).

Strategic planning is essential to gauging, managing, monitoring, and better ensuring the success of a project in government agencies (DiNapoli, 2003). The specific organizational problem that is addressed through this study is evaluating SSBHD's strategic process for creating a certification tool to certify the CCBHCs and establish a new reimbursement rate that meets SAMHSA's grant guidelines. To assess the SSBHD's strategic process, the research questions were:

Research Question 1 (RQ1): What is the SSBHD's strategy for ascertaining if newly established CCBHCs are ready to operate per federal and state requirements?

Research Question 2 (RQ2): What is SSBHD's approach to creating a certification tool to certify new CCBHCs?

Research Question 3 (RQ3): What is needed to establish a specified reimbursement rate for the new CCBHCs?

Research Question 4 (RQ4): How does SSBHD's strategic approach compare to other states' approaches to certifying CCBHCs?

I conducted a case study to address the research questions in this qualitative study. Researchers use case studies for more flexibility in researching because of opportunities for continued learning for the researchers and organizations (Mills et al., 2010).

I used SSBHD's process as a case study design via observation, interviews, and document reviews to reflect the perspective of the behavioral health leaders (BHLs) and the strategies used for creating a certification tool and reimbursement rate (Austin & Sutton, 2014; Mills et al., 2010). I used the following interview questions to answer the research questions:

1. What are the strategic steps leadership uses to establish the certification tool?
2. What tools were reviewed in preparation for this specific certification process?
3. How will a helpful tool be developed?
4. What are the leadership's short-term and long-term goals for certifying the new CCBHCs?
5. How are those goals being tracked and reported on?
6. Who are the key stakeholders chosen by leadership?
7. Who are the people in the workgroups established to develop the tool?
8. Why did leadership choose them?
9. Are there any strategic leadership plans for aligning the tool with federal requirements?

Purpose

In this qualitative study, I examined the strategy used by the SSBHD leadership in creating a certification tool that assesses the readiness of new CCBHCs in its state. This

certification tool can be used to ensure that CCBHCs meet SAMHSA grant requirements for comprehensive whole health care and make them eligible to establish a future reimbursement rate from the Federal 223 SAMHSA grant (SAMHSA, n.d., 2021). The SSBHD is the mandated state health authority in its southern state and has implementation and oversight responsibilities for mental health, addictive disease, and intellectual/developmental disabilities services. The SSBHD is responsible for services provided in five state inpatient psychiatric hospitals and partners with contracted CCBHCs to deliver community-based mental health, addictive diseases, and I/DD services. In addition, the SSBHD hires and partners with various behavioral health professionals (psychiatrists, psychologists, nurses, social workers, behavior specialists, paraprofessionals, etc.) to deliver and assess an array of needed services. The SSBHD's creation of a certification tool for new CCBHCs is the specific focus of this study.

I used the Baldrige Excellence framework to address the practice problem by evaluating SSBHD's leadership strategy for creating a certification tool and defining a reimbursement rate for new CCBHCs (Ford, 2022; NIST, 2021). The research design involved primary interviews with the BHLs and those who were part of the workgroups organized to create the certification tool and a reimbursement rate. Additionally, I reviewed preplanning data, existing programmatic data from the new CCBHCs, and meeting notes to evaluate strategic plans. I obtained those sources of primary and secondary data by coordinating with key BHLs to request access to the needed information. This was a critical expectation in the service order agreement between me and SSBHD. In addition, I used these data sources for background and comparison to

better understand the groundwork laid before certifying the CCBHCs (Walden, 2014). Lastly, I reviewed case study/comparative data from other states that have successfully established CCBHCs, certified them, and created a reimbursement rate to compare strategic approaches (NCBH, 2020; NIST, 2021).

Significance

CCBHCs are the new value and evidence-based ways to provide whole health services to the populations who need these services (Hu et al., 2021; NCBH, 2017, 2020; OASPE, 2019; SAMHSA, 2021a, 2021b). This study is significant because I outlined the SSBHD strategy for developing a certification tool for the new CCBHCs in the State. If the existing CCBHCs are successfully certified, there can be continued grant funding of these programs. In addition, by outlining the strategic process for developing a certification tool, SSBHD will have a standardized operational schematic to certify any future CCBHCs in the state.

SSBHD can use the findings from this study to design the best strategic practices to use when creating any certification tool and to make a standardized manual for developing and measuring the success of programs, like CCBHCs, in the future (Connors et al., 2021). CCBHCs have been successfully implemented in other states. They are the new behavioral health industry's approach to help address the growing opioid epidemic and mental health crises across the country (Hu et al., 2021; NCBH, 2017, 2020; Office of the Assistant Secretary for Planning and Evaluation, 2019). The findings of this study may be used for positive social change because I evaluated SSBHD's strategy and documented the strategic process for creating an evidence-based method for certifying

CCBHCs' approaches to providing integrated healthcare to constituents (Connors et al., 2021). Additionally, this process lays a groundwork for evaluating other organizational strategies endeavoring to implement programs that increase access to BH services in the field.

Summary and Transition

CCBHCs are the new innovative value-based program offering in the BH industry (NCBH, 2017, 2020; SAMHSA, 2021a, 2021b). CCBHCs can be used to address the growing opioid epidemic and BH service needs in a more integrated and community-based way (Brown, 2021; Caton et al., 2020; Hu et al., 2021; Implementation, 2020; Plough, 2019). The SAMHSA has awarded grants to several community providers in the SSBHD's state to create new CCBHCs. The challenge for SSBHD is to strategically create a certification tool and a new reimbursement rate to fully certify the new CCBHCS in its State. In this study, I focused on the strategic steps toward certifying CCBHCs and establishing a future reimbursement rate.

Section 1b includes a more detailed look at SSBHD's organization. In that section, I explain the SSBHD's governance structure, service/treatment offerings, and relationships with the budding CCBHCs. I also address the nuances of SSBHD's organizational profile, including a closer look at its mission, vision, values, and what may be of strategic importance to SSBHD's operations. I also discuss the purpose of this study, define organizational terms, and discuss any laws and regulations that influenced SSBHD's operational endeavors.

Section 1b: Organizational Profile

In this study, I analyzed the strategic process for creating a certification tool and a future reimbursement rate for new CCBHCs in the SSBHD's state. The certification and reimbursement rate needs of the new CCBHCs must meet SAMHSA grant requirements for them to be fully funded in subsequent years (SAMHSA, 2021a, 2021b, n.d.). The SSBHD is a state government-appointed entity with oversight of the new CCBHCs and a role in ensuring that they become fully certified by SAMHSA's standards. Erecting and supporting new CCBHCs in communities that need integrated BH care is the industry's new value-added and evidenced-based model for BH services (Implementation, 2020; Hu et al., 2021; NCBH, 2017, 2020). It is in SSBHD's best interest to support their certification and success. According to Fortune Business Insights (2021), innovativeness (like whole health/integrated care) is key to meeting the growing needs of the BH industry.

Strategic planning for innovation in service offerings is vital for the future of behavioral health care (NIST, 2021; DiNapoli, 2003). In this study, I answered the following questions:

RQ1: What is the SSBHD's strategy for ascertaining if newly established CCBHCs are ready to operate per federal and state requirements?

RQ2: What is SSBHD's approach to creating a certification tool to certify new CCBHCs?

RQ3: What is needed to establish a specified reimbursement rate for the new CCBHCs?

RQ4: How does SSBHD's strategic approach compare to other states' approaches to certifying CCBHCs?

The purpose of this study was to examine SSBHD's leadership strategy in its creation of a certification tool and future reimbursement rate for its new CCBHCs. I used the Baldrige framework to evaluate SSBHD's organizational profile, its situation as it relates to the problem under study, and the key characteristics that drive its operations and relationship with stakeholders (Jones et al., 2018; NIST, 2021).

Organizational Profile and Key Factors

The SSBHD central office is in a growing Southern city in the United States. Established in 2009 by the Governor and General Assembly, SSBHD is the state's health authority. The central office directs the workflow and gives oversight of three main program divisions: BH, I/DD, and Hospital Services. These divisions have employees who work out of six regional offices and five psychiatric hospitals, along with a network of other contracted community providers to serve constituents across the state's 159 counties. This large SSBHD and its network of contracted community providers offer treatment and supportive services to aid citizens dealing with mental health challenges, addictive disease challenges, living with an I/DD, and any combination of those diagnoses. In addition, as related to the problem under study, the SSBHD has partnership responsibilities with contracted providers in the State who were issued the new grants by the SAMHSA to establish CCBHCs (Hu et al., 2021; National Council for Mental Wellbeing, 2020; SAMHSA, 2021a). However, the challenge/gap for SSBHD is how to assess the readiness of these budding CCBHCs' to operate within federal and state

requirements and how to help them establish a reimbursement rate system for future billing (Hu et al., 2021; NCBH, 2020; SAMHSA, 2021b, n.d.).

Service Array and Vision, Mission, Values, and Competencies

The SSBHD's service array includes community access and integration opportunities that help clients focus on their strengths to achieve a life of recovery and independence. Those services are offered in partnership with contracted providers and other community constituents. The SSBHD and its safety net of contracted providers offer BH, I/DD, and inpatient psychiatric hospital services to the uninsured, those on Medicaid, or who have few resources to obtain treatment/care. The implementation of CCBHCs resulted in more integrated care (Brown, 2021; Hu et al., 2021; Implementation, 2020; NCBH, 2020; SAMHSA, 2021b). Table 1 displays SSBHD's vision, mission, values, and competencies.

Table 1

SSBHD's Vision, Mission, Values, and Core Competencies

Vision	Provide easy access to high-quality care that leads to a life of recovery and independence for the people served
Mission	Lead an accountable and effective continuum of care to support constituents with BH challenges and intellectual D.D. in a dynamic healthcare environment
Values	• Person-centered care • Community partnerships • Caring professionals • Employee engagement
Core Competencies	• Collaboration • Community networking • Strategic planning • Grant writing/tracking • Data collection • Quality improvement • Information Technology

According to the NCBH (2014), the core competencies of BH and primary care practitioners are similar. They include interpersonal communication, collaboration and teamwork, screening and assessment, care coordination, intervention, and cultural competence, to name a few. Johnson and Rossow (2019) stated that healthcare management should have core competencies in business, finance, governance, healthcare delivery, technology, information technology, human resources, laws and regulations, leadership, professionalism and ethics, and quality and performance improvement. The SSBHD works with its community providers to establish similar professional

competencies for integrated care to realize its vision, mission, and values. Thus, the idea of CCBHC is in line with SSBHD's vision and mission.

Employees and Positions

The SSBHD has over 7,000 employees across its various services and office locations. SSBHD employs highly skilled professionals from diverse professional backgrounds and expects the same of its contracted providers. The professionals working for SSBHD have backgrounds ranging from business, mental health, medical, and positions in-between that are needed to manage client care within its BH system. In addition, an array of supportive staff is hired, from janitorial workers to human resource specialists. The SSBHD operates a central office, the state office, with three main divisions that direct staff in six field offices and five state psychiatric hospitals. However, the need for BH and I/DD services across its 159 counties is vast. There is difficulty procuring professional/technical staff such as psychiatrists, nurses, behavior specialists, and other direct support staff (Bryant, 2021; Morse & Dell, 2021). To realize its vision of easy access to high-quality care, SSBHD contracts with various local community professionals/agencies to serve citizens living in their local communities.

Most of SSBHD's clinical positions require an advanced/specialized degree, licensure, and experience working with the BH or I/DD populations. Johnson and Rossow (2019) shared that the bureaucratic form of an organization is characterized by staff who are hired based on their technical abilities and qualifications, wherein employees are paid fixed salaries based on their hierarchy in the organization and their levels of responsibilities. Staff in this kind of organizational configuration follow

systematic rules and policies established by officials (Johnson & Rossow, 2019). This bureaucratic organizational structure describes the SSBHD, its staffing profile, and its relationships with its network of contracted providers. From its quality improvement plan, SSBHD state that it is intentional about engaging employees and contractors in collaborative conversations, providing supportive training, and access to information technology (IT) capabilities to help motivate them to carry out its mission and vision. Block (2011) stated that organizations need to have supportive and collaborative relationships with their workforce to enable their mission and vision to succeed.

Organizational Assets

The SSBHD's assets include all required hardware for operations (computers and peripherals), cell phones, multiline phone systems, office furniture/equipment, buildings, and innovative IT infrastructure. The IT infrastructure is monitored regularly to ensure that it secures the information shared and stored about individuals in services and maintains the accessibility and reliability of the many systems used by its employees and its extensive network of community contracted providers. The SSBHD also runs five inpatient psychiatric hospitals with patient-required medical equipment, an electronic medical record system, and living facilities. These inpatient hospitals also include equipment and structures for the forensic population (those legally deemed guilty by reason of insanity or incompetent to stand trial).

Regulatory Requirements

Johnson and Rossow (2019) explain that regulatory oversight, responsibility, and adherence give an organization legitimacy; furthermore, institutions need regulatory

mechanisms to establish accountable routines. The SSBHD's nine-member governing body primarily sets its policies and rules. Additionally, as a state institution, the SSBHD has many regulatory requirements. For example, SSBHD serves those with health needs funded by Medicaid. The SSBHD must comply with the Federal Health Insurance Portability and Accountability Act (HIPAA) which requires that information about patients' health statuses, mental health diagnoses, or substance use be secured and only shared in compliance with the HIPAA regulations (U.S. Department of Health and Human Services (HHS), 2021). Also, the Centers for Medicare and Medicaid Services (CMS) issues regulations for its service operations within the SSBHD's inpatient facilities. The Joint Commission evaluates them on its standards for accreditation and certification of operations (Centers, n.d.; The Joint, n.d.). Furthermore, SSBHD must stay aware of the adherence requirements for the specific staffing, systems, operational, certification requirements, etc., for the SAMHSA grant funding issued to establish CCBHCs in the State (NCBH, 2014; SAMHSA, 2021a, n.d.).

Customers and Stakeholders

The SSBHD's customers are all people within the State with BH challenges or intellectual/developmental disabilities who are uninsured, on Medicaid, or have few resources to obtain needed BH, I/DD, or psychiatric treatment/care. These customers are served in a range of community programs or the SSBHD's inpatient psychiatric hospitals. In addition, customer service extends to the families of those served through the SSBHD's system of care. The SSBHD's stakeholders include its board of directors, employees, clients, the family of clients, the state's legislature, the state's

taxpayers, federal Medicaid partners and grantors, accreditors, and other community partners (local law enforcement, other partner state agencies, contracted providers, local hospitals, etc.).

Organizational Background and Context

In 2021 SAMHSA awarded $250 million to establish 100 CCBHCs (SAMHSA, 2021b). Several community providers within the SSBHD's state were grantees of this funding, partly aimed at addressing the growing BH needs exacerbated by the COVID-19 Pandemic (SAMHSA, 2021a; 2021b). The CCBHCs are tasked with increasing access to quality, integrated, and evidence-based patient-centered services that address the needs for mental health and substance use disorder treatment services in communities (SAMHSA, 2021a, 2021b). However, to further expand and continue to receive reimbursement for services, the CCBHCs must be certified by SAMHSA's standards and work with states to establish a prospective payment system (SAMHSA, 2021a). According to SAMHSA's guidelines for funding (SAMHSA, 2021a), key definitions in the work of establishing CCBHCs that the SSBHD will need to ensure are weaved into their certification process include the following:

1. Agreement – In the context of care coordination, this is an agreement between CCBHCs and other involved entities in the coordination of care. Also known as a Memorandum of Understanding (MOU).
2. Care coordination - "deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the

patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." (SAMHSA, 2021a, p. 3).

3. Engagement – A set of activities to connect clients with services that they need. This includes ensuring that patients and families are well informed of services that could benefit them.

According to Johnson and Rossow (2019), quality/performance improvement is a crucial element of health organizations' management; therefore, they usually establish a team to monitor and guide the work involved in improving operations/services. The SSBHD has a team referred to as the quality council. It comprises an eclectic group of professionals within the organization that meet to review operations, services, and systems to assess how they are performing against the vision and mission of the organization. This quality council meets quarterly to evaluate initiatives, threats in the market, and the advantages of new projects that may improve the system. Understanding the organization's strategic environment and its plan for performance improvement gives insight into how organized they are and how they strategically approach issues through identified projects. This information helps shed light on why/how SSBHD went about evaluating the requirements needed to certify and establish a reimbursement rate for CCBHCs in its State.

This doctoral study benefits the SSBHD because it compiles and assesses the strategic maneuvers of SSBHD's leaders in establishing new projects. Specifically,

establishing a process for certifying and establishing a reimbursement rate for CCBHCs in their State that meets SAMHSA's grant requirements (NCBH, 2014; SAMHSA, 2021b, n.d.). The work in this study can highlight successful and inefficient processes in the SSBHD's strategic plans that can be corrected in the future and start an evaluation process for how a BH organization such as the SSBHD can successfully plan for new programs/projects like CCBHCs. Tracking strategic methods offers insight, accountability, and improvement opportunities, so that future work has evidence-based information to start with (NIST, 2021; Connors et al., 2021; DiNapoli, 2003). This research endeavor employs data from the SSBHD's website, document reviews, preplanning/programmatic data, meeting attendance, meeting notes, SAMHSA grant information, and personal interviews.

Summary and Transition

The SSBHD's mission is to lead an accountable and effective continuum of care to support its service constituents in a dynamic healthcare environment. Its vision is to lead that dynamic healthcare environment in a way that is accessible and of high quality. As the state's BH authority, the SSBHD must contract with community providers to deliver BH services to meet service demands. CCBHCs aim to provide accessible and high-quality integrated health care to address the growing need for BH services (Hu et al., 2021; NCBH, 2020; SAMHSA, 2021a, n.d.). The purpose of CCBHCs is in line with the SSBHD's mission and vision. To help ensure the success of CCBHCs, the SSBHD must strategically plan how to certify them per SAMHSA guidelines and help them establish a reimbursement rate that is in line with SAMHSA's prospective payment system

(SAMHSA, 2021a). This research evaluated the SSBHD's strategic process for working with CCBHCs to help trace successful and inefficient strategies so that improvements can be made in future strategic planning. The information in upcoming Section 2 further analyzes the problem under study by presenting how data was gathered and how other organizations have strategically navigated projects of this kind, and shares more information about the SSBHD's strategy, data, and participants.

Section 2: Background and Approach–Leadership Strategy and Assessment

In this study, I analyzed the SSBHD strategic process for implementing CCBHCs within its state. I examined how the SSBHD endeavored to create a certification tool to certify the new CCBHCs according to the SAMHSA's grant requirements and how it worked in a collaborative effort to establish a future reimbursement rate for the new CCBHCs (SAMHSA, 2021a, n.d.). As a state government agency appointed to oversee BH services within its state, the SSBHD has oversight of the new CCBHCs and plays an essential role in successfully implementing them within the state.

The newly established CCBHCs may mitigate the opioid crisis and the lack of adequate BH care in the most rural areas of the SSBHD's state (Fassbender et al., 2019; Hu et al., 2021; Implementation, 2020; NCBH, 2017; Scanlon & Hollenbeak, 2019). The BH industry hopes that the success of CCBHC services will provide needed evidence-based, value-added, and integrated whole health care in communities struggling with addiction and lack of access (Brown, 2021; Implementation, 2020; Caton et al., 2020; Hu et al., 2021; NCBH, 2017, 2020; Plough, 2019; Implementation, 2020). Providing such integrated care to its communities is in line with the SSBHD's vision to provide easy access to high-quality care and supporting innovative BH initiatives to address the emerging needs of constituents (Fortune, 2021).

The supporting literature evaluates the existing research on the reasons for CCBHC establishment, the challenges with certifying them/establishing a reimbursement rate, and the current success of CCBHCs. I discuss multiple sources of evidence and describe the planning and strategic steps taken by the SSBHD in the establishment of the

CCBHCs. I examined the SSBHD's leadership strategy to evaluate how leaders of the CCBHC project lead their teams and how they identified and implemented the strategies needed to establish the CCBHCs. The population served is discussed to explain who they are, their needs, how the CCBHCs may help them, and how the SSBHD planned to engage them to use the new CCBHC services. A strategy for analyzing this study's findings is also discussed.

Supporting Literature

I did an extensive search using the Walden University Library to find peer-reviewed articles that discussed the strategic steps for establishing CCBHCs. Because CCBHCs are a recent whole health option for the industry, the search results were not numerous. I also searched for research articles that discussed options for addressing the opioid epidemic and found discussions about whole health options listed in those. Walden University Library's Thoreau Multi-Database Search tool and Google Scholar helped to uncover research articles from the following databases:

- Academic Search Complete,
- ProQuest Central,
- ProQuest Health & Medical Collection,
- SocIndex with Full Text, and
- Sage Research Methods

The search terms used included the following descriptors:

- Certified Community Behavioral Health Clinics
- SAMHSA and Opioid Addiction

- Opioid Addiction and Behavioral Health Solutions
- Opioid Addiction and Integrated Care
- Qualitative Study Information

The search fields were specific to peer-reviewed, full text, and articles published within the last 5 to 6 years. Another method used to find related peer-reviewed articles was reviewing the reference sections of the most relevant articles found on the search topics to see what reference materials were listed in those articles. A good number of the articles' reference sections included information from the NCBH, the OASPE, and the SAMHSA's websites, which provided more information on CCBHCs. The following presentation of supportive literature is divided by information found on addressing the opioid epidemic and information about establishing CCBHCs.

Addressing the Opioid Epidemic

Caton et al. (2020) discussed the opioid epidemic and used informant interviews to discuss states' progress after passing the Century Cures Act in 2016. It provided 7.5 billion dollars in grant aid for states to fund evidence-based practice responses to the growing opioid epidemic (Caton et al., 2020). However, there were barriers to sustaining evidence-based practice programs due to financing/reimbursement issues, problematic service integration, and workforce shortages (Caton et al., 2020). However, partnerships and increasing public awareness of opioid prevention programs drove their popularity (Caton et al., 2020). In addition, the early prevention programs highlighted key challenges inherent in time-limited grant-funded BH programs and offered insight into how they can be more successful.

Jones (2018) used descriptive and multivariable analyses as well as BH survey data to assess the availability of addictive disease services in health centers that are federally qualified. Specifically, the use and availability of buprenorphine treatment, an essential resource in treating opioid addiction, was mentioned. Jones (2018) stated that, "Urban health centers, those in the West, and health centers with electronic health records had higher odds of offering on-site substance use disorder treatment." (p.14). However, rural areas did not have the same access to these services nor expressed an interest in expanding their treatment modalities to address the opioid crisis in their areas. This information highlights that rural areas are not fully equipped to provide or may not be adequately informed about the available treatment options and benefits of expanding current services to treat opioid addiction.

The economic costs associated with treating opioid use disorder are high. Leslie et al. (2019) discussed those economic costs using states' Medicaid programs. They used data from 17 states' Medicaid Analytic eXtract files for 1999 and 2013 to understand the changes in healthcare costs used to address opioid use disorder (OUD; Leslie et al., 2019). They compared these costs for patients being treated for OUD with patients with other medical treatment needs not associated with OUD (Leslie et al., 2019). An interesting trend in their study was that patients diagnosed with OUD increased by 378% from 1999 to 2013, and Medicaid costs for treating OUD tripled from $919 million in 1999 to $3 billion in 2013 (Leslie et al., 2019). They concluded that the treatment of OUD causes severe financial burdens on states' Medicaid programs which need to be addressed. This article provides essential information because it verifies that a more

value-based option (like the CCBHC model) is needed to address the growing opioid use crisis in the United States, particularly in rural areas.

Information on Establishing CCBHCs and Their Success

According to Implementation (2020), the Medicaid program leaders decided that a more value-based reimbursement option was needed to address BH needs within the United States and that was one of the catalysts for establishing CCBHCs. Behavioral health clinics that chose to convert to CCBHCs began receiving a fixed daily rate or a monthly rate set by their state to cover the total cost of nine types of required services (Implementation, 2020). They found that to take on this value-based way of providing comprehensive services, the newly established CCBHCs had to hire a range of trained staff, add specialized services (e.g., crisis, psychiatric rehabilitation), expand access to services (e.g., same-day scheduling, serve outside of clinic walls), and work to make key community partnerships (Implementation, 2020). The payment rates varied based on the population needs across the states, but overall, the service cost was lower than estimated and lower than previous Medicaid costs (Implementation, 2020). This information highlights that payment rates can vary based on State-specific factors and that programs seeking to become CCBHCs will need to plan to expand significantly to provide the comprehensive services needed that would yield cost savings (Implementation, 2020).

NCBH (2017) discussed that CCBHCs are new provider types in the Medicaid system and were established to offer comprehensive BH services to those who need them most. These new provider types are expected to meet additional requirements for specialized staffing and oversight while producing empirical data and quality reporting

(NCBH, 2017). The payoff for BH agencies who choose to become CCBHCs is that they will receive a Medicaid reimbursement rate that compensates them for their service costs associated with a more multidimensional system of care. According to NCBH (2017), eight states were selected to initiate pilot CCBHCs programs under Section 223 of the Protecting Access to Medicare Act of 2014. Key statistics are shared like the SAMHSA indicating that only 43.1% of all people living with serious mental illnesses like schizophrenia, bipolar disorders, and major clinical depression receive behavioral health care; the remainder are served in homeless shelters, hospital emergency rooms, and penal institutions, which serve as the largest inpatient psychiatric facilities in the United States. In addition, only one in 10 Americans with an addiction receive treatment in any given year. (NCBH, 2017, p. 1).

The results showed that CCBHCs work because specialized staff (psychiatrists, addiction specialists, other BH staff) are being recruited and services are accessible to more people who need them. Additionally, sites can expand opioid treatment services, offer more innovative approaches to care based on new technologies and service expansions, and increase community partnerships as the services increase in effectiveness and lives are changed (NCBH, 2017). This article expands understanding of CCBHCs and how they change care in BH services and communities (NCBH, 2017).

The NCBH (2020) impact report broke down the establishment and reason for CCBHCs' existence. It mapped the current array of CCBHC programs and their locations and discussed the challenges that CCBHCs were created to address. This report also discussed how CCBHCs make a difference in addressing the suicide crisis, the opioid

epidemic, and filling treatment gaps. Finally, it addressed the needs of active military personnel and veterans, creating jobs, reducing the use of ER departments and hospitals for treating mental health and addiction crises, and improving coordination efforts with law enforcement (NCBH, 2020). For example, CCBHCs are required to provide nine different types of evidence-based practices, and they must consistently measure their quality, have increased access to care, lower wait times, offer medication-assisted treatments (MAT), be accessible 24/7, and receive a reimbursement rate that supports the continued expansion of their services; whereas, traditional BH models do not have these metrics or consistency standards built in (NCBH, 2020). This kind of information lends credence to the need for the current study of CCBHCs because it lays out key differences between services in a CCBHC and traditional BH treatment models (NCBH, 2020).

The OASPE (2019) discussed the experiences of the eight original CCBHCs that were piloted in Minnesota, Missouri, Nevada, New Jersey, New York, Oregon, Oklahoma, and Pennsylvania. Like other scholarly articles, this research presents information about the critical contributions of CCBHCs in the areas of increased staffing, increased availability and access to services, better care coordination, a more comprehensive scope of services, and quality reporting. However, this report describes the payment rate system employed in the states and shares that the rates were based on clinic-specific details (OASPE, 2019). It stated that,

> For example, some CCHBHCs hired new or trained existing staff to provide care consistent with the CCBHC model of care specified in the program criteria. The amount paid through the rate was also affected by the location of the individual

> clinics: urban, rural, or frontier areas. Some rural clinic directors reported the need to incur higher staffing costs under the demonstration to attract qualified providers. (OASPE, 2019, p. 29).

The SSBHD must establish a payment system for the new CCBHCs in its state so that stakeholders of the emerging CCBHCs know that rates will need to be based on community-specific trends and needs as well as staffing nuances (OASPE, 2019). It will take the SSBHD's leadership team time to ascertain a payment rate that fits the mix of services offered by CCBHCs, their staffing, and the needs of the CCBHC community population.

SAMHSA (2021) explained Section 223, an overall planning grant issued to 24 states and inclusive of a demonstration program in which eight states participated (SAMHSA, 2021a). Section 223 is a part of Protecting Access to Medicare Act (PAMA) (PL 113-93). Part of PAMA's goal and funding for Section 223 is to create integration with BH and physical health, promote evidence-based practices, and make quality care more accessible. Out of this planning grant came the idea for CCBHCs and the plan for participating states to be compensated based on a prospective payment system (PPS). This resource is important to this study because it identifies and describes the grant funding that helped establish CCBHCs and discusses the PPS, which is an area SSBHD plans to help the upcoming CCBHCs in the state figure out.

SAMHSA (n.d.) further described the funding stream that allowed the creation of CCBHCs via the 2014 PAMA legislation. It informs that the legislation requires that the following criteria are met for further funding of CCBHCs: staffing, availability,

accessibility of services, care coordination, the scope of services, quality and other reporting, and organizational authority. Specifically, as it relates to organizational authority, Section 223 of PAMA states that clinics participating in the program be nonprofit, part of a local government BH authority, or operated as an Indian Health Service, Indian Tribe, or Tribal organization (SAMHSA, n.d.). It is also required that there be a yearly independent financial audit, that board members be representative of those being served (to include matching the area's demographics), and that states require that CCBHCs be accredited, certified, and/or have licensing requirements (SAMHSA, n.d.). This information specifies additional requirements of CCBHCs for them to meet federal guidelines.

Hu et al. (2021) described the CCBHCs and the expectations for them from the federal grant perspective and how well they are doing in enhancing BH organizations' ability to provide integrated health that is also evidence-based. They found that CCBHCs do increase access to integrated healthcare, supports the BH workforce, and are well-suited to offer addictive disease and mental health (MH) services. Additionally, CCBHCs are hiring social workers to fill the MH provider gap, which allows social workers to make a difference in treating the opioid crisis because they train to see the person in the environment and advocate for whole health (Hu et al., 2021). This article offers a perspective on the kind of BH professionals being hired for positions in CCBHCs and why.

The preceding literature provided background on how CCBHCs can be beneficial to communities needing behavioral health care. A closer look is needed into the

SSBHD's specific area to understand how it may be useful for their state. Following is a discussion of the sources of evidence used in this study to better understand the SSBHD's strategy for making CCBHCs relevant in its community.

Sources of Evidence

The evidence used in this study includes interviews with the BHL and workgroup members who were figuring out the creation of a certification tool and, eventually, a reimbursement rate for the CCBHCs. Steering meetings were attended to gather information about how meetings were conducted, how group members communicated, and with whom and how information was shared with/gathered from the CCBHC leaders. Document reviews were conducted to review preplanning leadership data from the SSBHD and existing programmatic data to understand the SAMHSA grant requirements and how the SSBHD plans to guide the CCBHCs toward expansion. Industry and government website (e.g., SAMHSA, NCBH) reviews were also done to assess the reason for grant funding for CCBHCs and why the model is considered an evidenced-based way to provide whole health to the BH population.

Additionally, case study/comparative data from other states who have successfully established CCBHCs by certifying them and creating a reimbursement rate were reviewed to get information about the strategic steps taken by other states (NIST, 2021; NCBH, 2020; SAMHSA, 2018, 2021, 2022). These sources of evidence gave background data to help better understand the strategic leadership groundwork that was laid before and during the work to establish the CCBHCs in SSBHD's state.

Leadership Strategy and Assessment

Per the SSBHD Board Bylaws, its board is made up of nine members whom the governor appoints to serve three-year terms. From the board's bylaws, the board members are responsible for establishing general policies, making rules to include amendment or repeal of administrative rules and regulations, and appointing and setting the salary of the SSBHD's Commissioner. The nine-member board includes four men and five women, all Caucasian. The board members are professionals from the community with expertise in finances, banking, psychiatry, internal medicine, higher education, provider network experience, law enforcement experience, and addiction specialty from a local healthcare system. Three of the board members are selected to serve as the Chair, Vice-Chair, and secretary in charge of appointing special committees (with the board's vote), presiding over and recording meetings. The board meets every other month to discuss the Commissioner's report, budgeting concerns, programmatic decisions/changes, take public comments on issues (as needed), and discuss legislative decisions/occurrences that affect the Department. In the most recent board meeting, four million dollars were set aside from state funds to transition an existing crisis stabilization unit to a CCBHC model; it was the second most expensive fund appropriation for the upcoming fiscal year.

It is interesting to note that the SSBHD's board shows gender inclusivity but not racial diversity. According to Johnson and Rossow (2019), women comprise approximately 80% of healthcare's workforce; yet they only account for 28% of board members. The SSBHD's female board membership is in the majority and thus surpassing the norm. However, racial diversity on healthcare boards is also essential for societal

representation, service mix, and social responsibility, and SSBHD's board membership is falling short of representing its constituents' mix because the board is made up of what appears to be all Caucasians, even though an FY 2020 SAMHSA's report shows that the demographic characteristics of persons served by the SSBHD include approximately 45% of non-white constituents (Beji et al., 2021; Davis, 2022; Johnson & Rossow, 2019; Muñoz et al., 2019; SAMHSA, n.d.).

In addition to the board's leadership, the SSBHD has a BH Coordinating and a Developmental Disabilities (DD) Advisory council that serves to identify overlapping service funding and policies and advise the SSBHD about matters of care, services, and supports for the people it serves. Additionally, the BHD has a 15-member leadership team that directs the work of many other employees within the different segments of the SSBHD. That leadership team is made up of the Commissioner, Assistant Commissioner, Deputy Commissioner, General Counsel, Chief Medical Officer, Deputy Medical Officer, Chief Financial Officer, Division BH Director, Division DD Director, Division Strategy, Technology, and Performance Director, Chief Information Officer, Hospital Operations Director, Public Affairs Director, and Human Resources and Learning Director.

The SSBHD is a large governmental organization and has a hierarchical, bureaucratic structure. Per Suzuki and Hur (2020), having a hierarchical structure, like SSBHD's, comes with the expectation that formal rules, tenure protection, seniority, and promotion systems inform and influence leadership strategies and the commitment of civil servants. Additionally, this kind of formalized/centralized structure in a large organization is necessary and could lead to greater job performance and agency

effectiveness (Daft, 2021; Suzuki & Hur, 2020). Furthermore, because the SSBHD's structure is centralized with different divisions of responsibility, the CCBHC strategic process is mainly delegated to a director within SSBHD's division of behavioral health. Personal communication with that CCBHC director (March 18, 2022) revealed that the board and the SSBHD leaders approved her position, funded partly by the SAMHSA federal grant dispersed to establish the CCBHCs.

From the CCBHC director's leadership and collaborations with her divisional director, the CCBHC steering team comprises an eclectic group of professionals around the SSBHD and a consulting group that the SSBHD hired to help members understand and organize what is needed to establish CCBHCs in the state. The CCBHC work has three groups: Finance, Certification, and Data collection all working with the four provider agencies selected to transform their operations to the CCBHC model (BHL Interview, CCBHC director, March 18, 2022). The Baldrige framework states that part of evaluating strategic leadership within an organization is to assess how leaders set the vision, communicate, engage stakeholders, and set actionable items (Jones et al., 2018; NIST, 2021). The SSBHD CCBHC leadership team had regular group meetings to discuss regulations and the needs of the new CCBHCs. For example, the finance group met weekly to discuss what is needed to establish a reimbursement rate for the new CCBHCs and often discussed how that funding is impacted by Medicaid and state funding. Meeting notes were taken for all meetings. Additionally, the consultant group had experience helping other states establish CCBHCs, so they worked directly with the

promising CCBHC providers to direct them on what is needed and how to garner the resources they need to comply with SAMHSA grant requirements.

The CCBHC director also gathered all group members monthly to have a joint meeting to discuss the progress within the teams. Additionally, she held meetings with the 15-member leadership team to give them updates on the project and get feedback. Regular and targeted communication occurred with all stakeholders to discuss the project's progress, reassess needs, and celebrate milestones (Jones et al., 2018). The CCBHC project leadership actions exemplified Stogdill's successful leadership traits and skills given that the CCBHC work showed adaptability to situations, alertness to the social environment, ambitious and achievement orientation, cooperation, tolerance, intelligence, creativeness, knowledgeability, organization, and open and consistent communication (Johnson & Rossow, 2019). This information about how the SSBHD governed and led the CCBHC project gave insight into how leaders strategized and collaborated with key partners to move its vision and expectations for CCBHCs forward (NIST, 2021).

Clients/Population Served

According to Kelly et al. (2021), public BH agencies often provide comprehensive services to people with serious mental illnesses. In addition, the BH population served in public agencies is often a mix of different ages and backgrounds and presents various needs (Kelly et al., 2021; Kodet et al., 2019). Another characteristic of public agencies is that they often serve uninsured people who are at or below the federal poverty line and whose services are covered by Medicaid or other grant-funded programs

(Kodet et al., 2019; Winkelman & Chang, 2018). The SSBHD fits this description of public agencies, and its customers are those who require mental health, substance use, and/or intellectual/developmental disabilities services (e.g., autism).

As described on its website and by the BHLs participating in this study, the SSBHD is a large governor-appointed BH state agency, and in partnership with a network of contracted community providers, they offer treatment, support, and recovery services. These services are targeted to engage individuals living in SSBHD's state with often severe and persistent mental health challenges, substance use issues, or striving to live with an I/DD. The needs of the SSBHD client population are often multifaceted because many are experiencing co-occurring issues (a mix of mental health, substance use, and I/DD diagnoses).

According to the SSBHD's website information and interviews with its BHLs, the SSBHD's customers are constituents within its state who are uninsured, receiving Medicaid, or who have limited finances or capacity to garner adequate BH, I/DD, or medical care. The SSBHD's client population engages in services via community-based programs or in the SSBHD's inpatient psychiatric hospitals. Because of the integrated needs of the SSBHD's client population, the CCBHC model is ideal for the state (Implementation, 2020; Hu et al., 2021; NCBH, 2017). The families and supportive networks of clients are often also customers of the SSBHD because they serve integral roles within the lives of the individuals receiving services and are essential to realizing recovery goals.

Workforce and Operations

The BH workforce's ability to engage with its clients is essential for successful service delivery and treatment (Block, 2011; Johnson & Rossow, 2019; Lloyd-Hazlett et al., 2020). According to the National Alliance on Mental Illness (NAMI) (2016), approximately 70% of people who seek mental health care disengage after the initial visits. This means that initial relationship building is crucial. PatientTrak (n.d.) shares that engagement with clients can be improved by sending out appointment reminders, including clients in decisions about their care, exploring technology to engage clients who may not want to come to the office, and assessing if employees are engaged in their work, so they can help motivate clients to engage in care. Because client engagement is essential to treatment success, BH staff must be trained to interact competently and help motivate clients to participate in services (Johnson & Rossow, 2019; Lloyd-Hazlett et al., 2020; NCBH, 2014). Lloyd-Hazlett et al. (2020) and NCBH (2014) agreed that client engagement efforts include client visits, consultation, and collaboration with other professionals in a client's life, facilitating client education, health risk assessments, shared decision making, and the collection of feedback information about engagement outcomes.

According to information from the SSBHD's website, the SSBHD's employees include over 7,000 staff with diverse professional backgrounds. The SSBHD strives to hire and collaborate with contracted community staff who are highly skilled professionals (e.g., doctors, nurses, social workers, counselors, and addiction specialists). The SSBHD's workforce is expected to manage client engagement and care within and

throughout its offered services (counseling, addiction programs, case management, residential supports, etc.). Additionally, the SSBHD's workforce includes an array of supportive staff who assist in client engagement (e.g., peer support services), safety, and recovery efforts. Efforts to engage clients in services happen in community BH fairs, school-based information sharing, community partners collaborations (ERs, churches, etc.), media advertisements, community coalition meetings, and via the state's crisis line (which is a doorway to needed services).

Per information on the SSBHD's website, its FY 2022 Community Quality Improvement Plan shared that it uses a high utilizer management program to understand the factors that cause its clients to disengage from services. Through the individualized client information from that program, leadership and staff develop re-engagement strategies with internal SSBHD employees, contracted providers, and other stakeholders to build and sustain competitive advantage (Jones et al., 2018). The SSBHD actively uses its human resources department to assess ways to better train the workforce on engagement and effectiveness; they use an "Intelligent Automation project" to identify areas for improvement.

Additionally (as shared on its website and by its BHLs), the SSBHD conducts an annual consumer survey to evaluate client satisfaction and perception of services. The survey is usually done face-to-face with clients who are asked to complete a paper survey. Due to the COVID-19 Pandemic, the 2022 survey was coordinated with the help of a local state university to enable online completion. The client survey is anonymous and targeted to adult clients and parents of minors. The survey asks questions about

- Service access,
- Cultural sensitivity,
- Quality and appropriateness (are they given ways to complain about services),
- Treatment outcomes,
- Treatment planning (was the plan directed by the client),
- Service satisfaction,
- Service connectedness (did staff engage and "stick" with me), and
- Social support

The survey information is available in English and Spanish, with options for other languages as needed. The data from the survey is aggregated.

The SSBHD contracted community providers were asked to share the location of the online survey with their clients. The providers were also given flyers with QR codes displayed around service sites or printed and given to clients. This information from client surveys is federally mandated for the CCBHC block grant programs. The SSBHD added CCBHC metric requirements to its consumer survey to facilitate this mandate. Specific websites were created for the four budding CCBHCs so clients in those programs could submit the needed information. In this way, the CCBHCs being established can survey clients on their experience with the integrated services offered. The CCBHCs can then use the results from that quality metric to gauge the success of their program's implementation. The strategies used by the SSBHD to engage clients in services help to create service relationships by bridging the gap between BH and I/DD service needs and successful service delivery.

Analytical Strategy

A qualitative case study design was employed to answer this study's research questions and to analyze the SSBHD's strategic leadership steps for establishing new CCBHCs. According to Range (2021), qualitative

> Case study methodologies examine a bounded system over time in detail, employing multiple sources of data found in that setting. The case may be a program, an event, an activity, or an individual. The researcher chooses the case and its boundary. A case can be selected because of its uniqueness or because of its typicality. (para. 1).

Kekeya (2021) adds that qualitative case studies can be an intensive focus on a single organization, or a single program using in-depth data to understand the details and paint a complete picture. BH organizations typically start new programs out of necessity to address the needs of their clients (Block, 2011; Implementation, 2020; Caton et al., 2020; Johnson & Rossow, 2019). The SSBHD's strategy for establishing needed CCBHCs in its state was chosen as the subject of this case study to highlight what can be learned about the strategic approaches used in large BH organizations and how those strategic steps can be improved and/or replicated in other BH organizations (Kekeya, 2021). The Baldrige Excellence framework was used to evaluate the SSBHD's leadership strategy (Ford, 2022; NIST, 2021).

This study used the SSBHD as a single-case design to understand a BH organization's strategic approach (Austin & Sutton, 2014; Kekeya, 2021; Mills et al., 2010; Range, 2021). Specifically, this single case qualitative study gave the researcher

flexibility to understand and present a particularistic, descriptive, and heuristic presentation of the SSBHD's strategic process for certifying CCBHCs and helping them establish a reimbursement rate fitting to their services (Kekeya, 2021). This approach allowed the researcher to evaluate the everyday actions of BH leaders in their natural environment (particularistic), describe those actions to determine end goals (descriptive) and to make inferences about what those actions mean and how they measure against the Baldrige framework's assessment of strategic leadership (heuristic) (Ford, 2022; Kekeya, 2021; Mills et al., 2010; Range, 2021). This section detailed the participants, how data was collected, and the procedure for evaluating evidence so that the credibility of the information is evident and trustworthy (Kekeya, 2021).

Participants and Data Collection

Participants can include parties within the organization that have direct access to information and involvement in the work under study, and those participants can be selected using purposive sampling (Kekeya, 2021). Data can be gathered via interviews, direct observation, and document analysis (Austin & Sutton, 2014; Kekeya, 2021; Mills et al., 2010). According to Ferrell et al. (2020) and Kukartsev et al. (2022), strategy implementation involves setting deadlines and motivating others to meet targeted goals. Daft (2021) adds that strategy implementation involves establishing key performance indicators (KPIs) to set a standard for goal achievement. The SSBHD under study implemented strategy by creating workgroup coalitions. To better understand the SSBHD’s strategic process for establishing CCBHCs, semistructured primary interviews were conducted using purposive sampling of the SSBHD's CCBHCs project director, the

four coalition leaders who led different workgroups tasked with researching the required areas related to establishing CCBHCs, and a member of the consulting company hired to help the BHD understand and organize the moving parts of creating CCBHCs.

The coalition workgroups were organized into the following teams: finance, quality performance and data outcome, governance, and clinical staffing. Due to the COVID-19 pandemic, most of the SSBHD's staff worked remotely. Each interview was scheduled when conducive to the BHL's and researcher's time and location, the interviews were voice recorded and transcripts generated for information accuracy using the Microsoft TEAMS program; this allowed for transcripts and documents to be shared virtually. In keeping with the deductive method of qualitative coding, the researcher had semistructured interview questions prepared that were in line with the purpose of this study (see Appendix A). Before the interviews, interviewees were emailed a copy of Walden University's IRB informed consent form, so they could read it and reply via email with their consent to be interviewed. The researcher documented the responses to the semistructured questions during the interviews and generated transcripts after interviews were voice recorded.

Each coalition workgroup had its own set of goals to certify CCBHCs and conducted its work via scheduled virtual meetings. The researcher attended virtual coalition meetings which discussed goals, the steps to take toward those goals, barriers, and progress. During attendance in those meetings, the researcher took notes and was also part of the email group to receive minutes taken during those gatherings. The coalition members reported their progress toward their specific goals to the director of the

overall CCBHC project. That shared information included their achievement, delays, or modifications toward those goals. That information was collected by the project's director and shared in quarterly meetings with the SSBHD's top leaders (e.g., the Commissioner).

As the study continued, archival data was used as primary and secondary sources to evaluate the SSBHD's strategic roadmap against Baldrige's strategy category (NIST, 2021). Those data sources included:

- The SSBHD's preplanning documents for the CCBHC project
- Needs assessment survey documents
- The CCBHC grant requirements documents
- Existing programmatic data from the new CCBHCs
- Coalition workgroup meeting notes
- Public notices/communications disseminated to the public about CCBHCs
- Information gathered by the SSBHD about how other states established CCBHCs
- Information about how the CCBHC project consultant is needed and helpful in the CCBHC strategic planning process

Those primary and secondary data sources were collected by coordinating with the CCBHC project director to request access to the information (this was a critical expectation in the service order agreement between the researcher and the SSBHD's CCBHC project director).

Evaluation of the Evidence

For this study to be credible, it must demonstrate trustworthiness in evaluating the data collected. Triangulation demonstrates multiple ways that data is gathered and

establishes trustworthiness (Kekeya, 2021). Kekeya (2021) explains four types of triangulations: data, observer, method, and theory. Data triangulation is when information is gathered from multiple sources over time (Kekeya, 2021). The present study used data triangulation to cross-check the information shared about the SSBHD's strategic approach to certifying CCBHCs. Through the researcher's descriptive coding of semistructured interviews, meeting attendance, and document review of archival informational sources, this study presents credible information about the strategic leadership groundwork used before and during the work toward certifying CCBHCs in the SSBHD's state. The descriptive coding and triangulation method also allowed for a clear comparison of how the SSBHD's strategic leadership approach fairs against the strategic leadership criteria discussed in the Baldrige framework.

Role of Researcher

During qualitative research such as this study, a researcher must be aware of the inter-subjectivity that occurs.

> Inter-subjectivity relates to the personal experiences a qualitative researcher encounters in undertaking research when he/she acts as an instrument and draws knowledge from the participants. (Kekeya, 2021, p. 33).

This inter-subjectivity can impact the research process and outcome. This further explains why data coding and triangulation are essential in the present research to preserve the credibility of how the information is gathered and how it is used to determine outcomes. Part of that process was for the researcher to flatten any perception of power by letting the participants know the reason and purpose of the study, the researcher's intent to

preserve the authenticity of the information, and to maintain confidentiality by masking BHLs names and the organization's name in the study (Kekeya, 2021).

Summary and Transition

Section 2 began with a discussion of the supporting literature that represents why CCBHCs are the behavioral health industry's new value-based option for providing integrated services. The sources of evidence that were used to help answer the research questions were discussed, including how they were collected. Additionally, how the SSBHD leaders govern the organization, lead their staff, their client demographics, services, and how they collect feedback was explained. This section culminates with a specific discussion of how the collected data was organized and analyzed to garner trustworthiness and build credibility for the findings. Upcoming in Section 3, the researcher dives deeper into the SSBHDs workforce, operations, how it measures effectiveness, and how it leverages knowledge and technology to meet its strategic objectives for CCBHCs.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

The problem under study was evaluating the SSBHD strategic leadership steps for certifying and creating a future reimbursement rate for new CCBHCs in its state. According to its website, the SSBHD is a state government organization designated as the BH authority by the state's governor. With oversight responsibilities for all BH services, the SSBHD is accountable for having strategic and collaborative plans in place to help manage and monitor the new CCBHCs to ensure that they are fully certified and have a future reimbursement rate that is in line with the SAMHSA federal grant requirements (DiNapoli, 2003; SAMHSA, 2021a, n.d.).

There is existing research on how other states have certified CCBHCs, but according to its website and its BHLs, a strategic certification process for CCBHCs needs to be fully developed for the SSBHD's state (Implementation, 2020; Hu et al., 2021; NCBH, 2017, 2020).

The following practice-focused questions were used to assess the SSBHD's strategic process:

1. What are the strategic steps leadership uses to establish the certification tool?
2. What tools were reviewed in preparation for this specific certification process?
3. How will a helpful tool be developed?
4. What are the leadership's short-term and long-term goals for certifying the new?
5. How are those goals being tracked and reported on?
6. Who are the key stakeholders chosen by leadership?

7. Who are the people in the workgroups established to develop the tool?
8. Why did leadership choose them?
9. Are there any strategic leadership plans for aligning the tool with federal requirements? (NIST, 2021; Strategies, n.d.)

To better understand the SSBHD's strategic leadership groundwork for certifying/establishing CCBHCs, a descriptive coding, and triangulation qualitative analysis was done to organize the collected sources of evidence into themes related to strategic planning. Table 2 shows the sources of evidence used in this study and how they were obtained.

Table 2

Sources of Evidence

Source of evidence	How the evidence was obtained
The SSBHD's purpose, structure, board, vision, mission, divisions, clients, employees, and the new CCBHC project	The SSBHD's website was reviewed, and semistructured interviews were conducted with the CCBHC BHLs to gather this information
Interviews with the SSBHD's BHLs/workgroup members who collaborated to create a certification tool and a reimbursement rate for the CCBHCs	Semistructured interviews with the BHLs of the CCBHC project
Workgroup meeting notes that displayed how meetings were conducted, communication	A review of the SSBHD's archival CCBHC project documents (shared by the CCBHC

Source of evidence	How the evidence was obtained
activities between members, and how information was gathered and shared between the SSBHD leaders and the new CCBHC providers	project director), virtual CCBHC meeting attendance, and CCBHC meeting minutes shared by the CCBHC project's BHLs
The SSBHD's CCBHC programmatic data documents (e.g., CCBHC needs assessment survey, financial documents, etc. were reviewed to understand preplanning data for the CCBHC project, to understand the SAMHSA grant requirements, and how the SSBHD planned to guide the CCBHCs towards certification and a reimbursement rate	A review of the SSBHD's archival CCBHC project documents (shared by the CCBHC project director) and a review of existing Federal and state website information on CCBHCs
Industry and government website information on CCBHCs were studied to assess the CCBHCs grant funding, purpose, and why CCBHCs are being established as the new evidenced-based model for providing whole health services to the BH population	A review of existing Federal and state website information on CCBHCs (e.g., SAMHSA, NCBH) and a scholarly review of peer-reviewed articles on the CCBHC initiative
A review of comparative data from other states' CCBHCs certifications and reimbursement rate establishment to gather information about their strategic steps	A review of existing Federal and state website information on CCBHCs (e.g., SAMHSA, NCBH) and a scholarly review of peer-reviewed articles on the CCBHC initiative

Analysis of the Organization

Workforce Environment

An organization's ability to manage its workforce's capability and capacity, recruitment, change, accomplishment, and climate (i.e., health, security, benefits, policies) affects its performance (NIST, 2021). Furthermore, having intentional employee development goals is critical in fostering a motivated and committed workforce (Daft, 2021). Because it is an important endeavor for the SSBHD leadership to help establish and certify CCBHCs to meet the service needs of its constituents, how it rallies its staff and partners to engage and invest in the project is essential for success. Based on information from the SSBHD's website, bylaws, 2022 quality improvement plan (QIP), and interviews with its BHLs, it has a robust and capable human resource (HR) and learning office. That HR/learning office manage the recruitment, onboarding, training, discipline, and performance evaluation of all SSBHD's staff. In addition, the HR/learning office work jointly with the IT office to equip staff with the tools/training to perform their work tasks successfully.

Per information from the SSBHD's HR office's webpage, the SSBHD employs over 7,000 people they assess to have high level professional skills (medical doctors, nurses, licensed BH experts/clinicians, and a range of supportive staff) who display integrity and good work ethics. The HR office posts positions on a state sponsored website that lists all available vacancies within the state's various agencies. Per its website, the SSBHD offers a comprehensive benefits package (paid vacation, holidays, health insurance, retirement contributions) and salary ranges based on licensure and

experience. The HR office also authors a gamut of policies to guide employment expectations and benefits, such as employee physical safety, performance, complaints, work hours, leave, professional conduct (e.g., sexual harassment), etc.

As the state's BH authority, the SSBHD is responsible for providing and linking constituents to various BH services. Those service needs (mental health, substance use, intellectual/developmental disabilities) drive recruitment efforts to find the skills, competencies, certifications, and staffing mix needed within the department and in the community through partnerships with contracted providers. The SSBHD's HR office works with the state's licensing board to verify the license of its professional staff. Information in the SSBHD's 2022 QIP mentioned that the HR office has set initiatives to improve its employees' effectiveness, engagement, empowerment, and recognition. Those initiatives include:

- Improving the HR/learning offices' efficiency by finding ways to automate manual processes,
- Increase the efficiency and effectiveness of its workforce scheduler via Kronos (a cloud-based company that helps organizations manage employee scheduling), and
- Increasing market competitiveness by reworking their job classification and career path options to bolster recruitment and retention.

Since the start of the 2020 COVID-19 pandemic, the SSBHD had to find and implement innovative ways to engage staff and ensure the successful continuation of operations. Its 2022 QIP discussed that the SSBHD implemented quality remote

technology. TEAMS and Cisco WebEx were established and expanded by its IT office to facilitate continued employee engagement and successful operations in the transition to remote work; this trend continued and was successful over the last 2 years.

Specifically related to the CCBHC project, part of the SSBHD's responsibility in certifying its CCBHC partners is to ensure that each expanded clinic can serve the comprehensive needs of the population via adequate and appropriate staffing levels (NCBH, 2017, 2020; SAMHSA, 2021a, 2021b). Of the CCBHCs going through the certification process in other states, despite recruitment challenges, 100% of them reported the need to hire new professional staff, such as psychiatrists and addiction specialists, at wages comparable to those professionals working in other areas within their state/region (National Council for Behavioral Health, 2017; National Council for Mental Wellbeing, 2020). Likewise, the SSBHD's BHLs report that the CCBHC partners bolstered their recruitment efforts to meet the demand and certification requirements. Furthermore, per the CCBHC project director's interview, her position was paid from money allotted for her role in the CCBHC federal grant. The SSBHD's HR/learning office and the CCBHC project leaders had strategies and guidelines to build, support, and monitor workforce needs.

Workforce Engagement

When employees are not adequately engaged at work by employers, they may feel lack of control over their work environment, the resources needed to do their job well, and their professional autonomy, leading to burnout and subpar performance (SAMHSA, 2022). However, when employees are engaged in decision making and other meaningful

ways (e.g., interpersonal relationships with bosses and coworkers), they are better equipped to perform the duties that make their organization's mission successful (NAMI, 2016; SAMHSA, 2022). Jacobson (2021) shared that government employers are most successful in engaging employees by allowing unit-level supervisors to create an engaging work environment for their staff. Per website information and discussions with BHLs, the SSBHD strived to engage staff on multiple levels. The SSBHD's HR/learning office established a learning university for staff to access training on all the systems used within the organization that are specific to an employee's position. That site provided basic training on Microsoft Office programs and those used to facilitate remote work (TEAMS, WebEx). The SSBHD fostered a culture of respect and inclusion by requiring all staff to engage with and complete yearly training about critical subjects such as sexual harassment, fraud, waste, and abuse, and the importance of offering services to individuals with disabilities (e.g., deaf/hard of hearing, limited English, and blind communities). Those training included reporting issues to HR with a promise of no retaliation. The SSBHD's IT office required staff to undergo quarterly IT security training to teach staff how to protect the department's and clients' information. The SSBHD's staff had access to regularly scheduled training and symposiums that offer continuing education credits for professional staff. All the SSBHD's staff and their families had access to an employee assistance program that is fully paid for by the department.

Since the SSBHD is a state-sanctioned government agency, there were many levels of leadership within its bureaucratic structure. With many levels of leadership, it is

difficult to engage employees from the top. However, according to the SSBHD's BHLs, engagement is best facilitated within offices and units where collaboration often happens in meetings, team events, and cubicle visits (Jacobs, 2021). At the larger organizational level, the SSBHD's commissioner sponsored and supported using a strengths deployment inventory (SDI) to help teams engage their staff (Corestrengths, n.d.). The SDI is an assessment that employees take to understand their motivational factors better and gauge how they respond to conflict with others. This assessment aims to improve communication among coworkers/work teams via understanding the strengths and needs of each other and taking those into account when collaborating. The SSBHD's Commissioner invested in the SDI program so that all staff could have a tool to help with unit-level and across-office communication, collaboration, and problem-solving. This tool was shared with the SSBHD's partners to facilitate productive collaboration.

Per the SSBHD's provider manuals and interviews with its BHLs, community contracted providers who partner with the SSBHD (such as the CCBHC providers) were expected to also have HR staffing policies supporting high quality BH services. By extension that requirement behooves partnering providers to engage their staff via training and operational practices so that they can meet the SSBHD's contract expectations. Additionally, a key requirement of the CCBHC federal grant certification process is for the SSBHD to ensure that CCBHC staff are engaged in assessment-based training in cultural competency and offering services that are accessible to all clients (NCBH, 2020; SAMHSA, 2021a, 2021b). The SSBHD's approach to engaging its staff and partners showed that they were aware of the importance between employee

engagement, motivation, productivity, and a high performing work environment (Jacobson, 2021; NIST, 2021).

Work Processes

Huang (2022) explained that it is essential that government agencies know how to be creative about funding needed services because they are often short on the capital needed to meet all the service needs of the public. Within the delivery of community behavioral health services, government agencies have the responsibility to define work processes that are:

- Responsive to the needs of constituents,
- Tangible so that employees and customers know and understand the workflow,
- Reliable enough to build accountability and trust,
- Predictable so there can be reasonable dependence on the services provided, and
- Perceptive enough to help foster further trust and fairness in how services are distributed (Padiyar, 2022).

Furthermore, there are hierarchical levels of leadership within a government organization so that work processes can be organized into specialized departments by tasks and ideally with flexibility in the way each department coordinates to achieve a better degree of economies of scale (Johnson & Rossow, 2019).

The preceding describes the SSBHD's work processes because, per information gathered from its website, archival data, and interviews with its BHLs, service needs and staffing were determined by need assessment surveys and legislations that were influenced by population data, input from the community (e.g., hospitals, law

enforcement), stakeholders, regulatory requirements, technology needs, and demand from constituents. Additionally, funding and staffing for needed services were often garnered through legislation, Medicaid, and federal grants. Based on information from the SSBHD's website, archival data, and interviews with BHLs, the SSBHD's key work processes included mechanisms, technologies, and policies for how to provide inpatient psychiatric care to address the intensive needs of constituents who require stabilization and community-based services that address the ongoing needs for mental health, addictive disease, and intellectual/developmental disabilities. Specific to the focus of this study, the SSBHD was responsible for ensuring that CCBHCs met the requirements for certification and reimbursement based on SAMHSA guidelines (SAMHSA, 2015). That certification guide listed the criteria for CCBHC staffing, availability and accessibility of services, care coordination, the scope of services, quality reporting (to include customer feedback via surveys), and organizational authority, governance, and accreditation (SAMHSA, 2015). Successfully certifying CCBHCs opens the door for further federal funding for this program.

Operational Effectiveness

Based on information from the SSBHD's website, archival data, and interviews with BHLs, the SSBHD produced a quality improvement plan (QIP) each fiscal year which included information on the effectiveness of services (based on data from contracted providers, internal effectiveness data, and feedback from customers). Performance evaluations were also completed on employees each year to determine

individual successes and improvements needed. Embedded in its QIP, policies, and staff performance evaluations was information about:

- The efficiency and effectiveness of programs/offices/processes,
- How it addresses cybersecurity,
- Plans for the physical safety of employees and patients, and
- How it evaluates its policies to ensure that they are adequate to cover disasters and emergencies that may disrupt operations on various levels.

Johnson and Rossow (2019) advise that healthcare organizations, like the SSBHD, can assess effectiveness objectively and subjectively. The objective ways include internal data from medical records, standardized assessments/surveys, and administrative databases. Subjective measures include patient/caregiver satisfaction reports via follow-up phone calls and staff's perception of the quality of the work and the overall work environment. The SSBHD appeared to be implementing those measures in their operations assessment.

Knowledge Management

According to website information, archival data, and interviews with BHLs, the SSBHD had several strategies for tracking and evaluating information about daily operations and overall performance. The SSBHD leveraged technology to collect, store and share essential information with employees, leaders, and partners. For example, the SSBHD had a quality improvement (QI) office dedicated to tracking clinical and operational performance to evaluate and develop its fiscal quality improvement plans (QIP). The SSBHD also employed continuity of operations plans (COOPs) that propose

actions that staff can take if the unexpected occurs, quarterly cost allocation surveys that evaluated how employee time was spent and reports on incidents within programs that reveal risk (Kilbourne et al., 2018). Before the end of each fiscal year, the QI office evaluated the SSBHD's programs based on metrics aligned with the SSBHD's vision and mission and develops a QIP.

The QI office used technology and reports to gather information from each program area and contracted community providers. Program areas and contracted providers were required to submit metrics showing how well they met service thresholds/requirements set by the SSBHD's policies and required by the grants that fund their services. That information was used to create systematic approaches to identifying where programs are doing well and where there were opportunities to improve service delivery and solve identified problems. The COOP set objectives for how the SSBHD identified essential functions and how it will work to ensure those functions can continue or resume if disruptions or unexpected events arise. The quarterly cost allocation surveys were sent to each employee to assess the programs they spend most of their time on so that the SSBHD's budget is accountable. Incident reports were evaluated to ascertain the risk experienced by individuals in services and how best to mitigate those risks.

Specifically, for the CCBHC project, the BHLs explained, and archival data reveal that the SSBHD had an eclectic array of staff members (including staff from the QI and technology offices) working with the new CCBHCs to establish metrics, surveys, policies, standards, and financing options that would measure the quality and accessibility of their services as required by the SAMHSA and the SSBHD program

standards. Part of the SSBHD's strategy for ensuring that new CCBHCs get certified was to communicate and share information with the new CCBHCs upfront. This way, CCBHC providers had the skills, knowledge, and data-gathering tools to report on program metrics so services could be evaluated for their effectiveness at critical points throughout their service implementation (Connors et al., 2021; SAMHSA, n.d.).

Summary and Transition

The SSBHD's website, bylaws, 2022 QIP, and interviews with its BHLs revealed an organized HR structure. That HR structure managed the recruitment, onboarding, training, discipline, and performance evaluation of its over 7,000 staff (including medical doctors, nurses, licensed BH experts/clinicians, and a range of supportive staff). Together with the information technology (IT) office, the SSBHD staff was equipped with the training to perform tasks successfully (Daft, 2021; NIST, 2021). In addition, the SSBHD used best practice strategies to engage its staff through policies, technology, learning, and shared decision-making (Jacobson, 2021; NAMI, 2016; SAMHSA, 2022).

As a government organization, the SSBHD used needs assessment surveys, legislative results/initiatives, and other community-based data to determine its service array (Huang, 2022; Johnson & Rossow, 2019; Padiyar, 2022). Those data points helped establish the need for CCBHCs in the SSBHD's state (SAMHSA, 2015). Additionally, the SSBHD used a fiscal QIP, COOPS, cost allocation surveys, and incident reporting to track all program effectiveness and to reveal areas of risk and improvement (Kilbourne et al., 2018). The SSBHD used its already organized structure to establish strategies for

certifying new CCBHCs. Establishing ways to engage staff further to get more qualitative feedback is an area of improvement that the SSBHD can consider.

Section 4: Results, Analysis, Implications, and Preparation of Findings

The problem under study focused on the Southern State Behavioral Health Department's (SSBHD) strategic leadership steps used to certify and create a future reimbursement rate for new Certified Community Behavioral Health Clinics (CCBHCs) in their state. Because the SSBHD is its state's BH authority, it has oversight responsibilities for BH programs and services, like CCBHCs. The SSBHD is a large state BH government agency with multiple service offerings; however, the focus of this study and the upcoming results are specifically on the SSBHD leadership's strategic process for certifying CCBHCs and helping them to create a future reimbursement rate for their services.

CCBHCs are the new industry approach to addressing the opioid epidemic and the growing need for BH care (Hu et al., 2021; Implementation, 2020; NCBHJ, 2017, 2020). Hence, the SSBHD CCBHC leadership team spearheaded the certification process for new CCBHCs to help ensure that they are in line with the Substance Abuse and Mental Health Services Administration's (SAMHSA) grant requirements and SSBHD's state provider requirements (SAMHSA, 2021a, n.d.). This study used the Baldrige Excellence framework to evaluate SSBHD's strategic leadership process (NIST, 2021). In addition, the following practice-focused research questions (RQ) guided this study's evaluation:

RQ1: What is the SSBHD's strategy for ascertaining if newly established CCBHCs are ready to operate per federal and state requirements?

RQ2: What is SSBHD's approach to creating a certification tool to certify new CCBHCs?

RQ3: What is needed to establish a specified reimbursement rate for the new CCBHCs?

RQ4: How does SSBHD's strategic approach compare to other states' approaches to certifying CCBHCs?

Additionally, the semistructured interview questions in Table 4 below and Appendix A were posed to the CCBHC BH project leaders and helped to answer the overall research questions.

A qualitative case-study design was used to evaluate the SSBHD's strategic processes. The sources of evidence used included a scholarly review of academic, professional, and governmental literature to better understand CCBHCs and how they were developed in other states (e.g., SAMHSA, NCBH). Recorded and transcribed semistructured interviews with the BHL/workgroup members, steering meeting attendance, and project document reviews (e.g., meeting notes, preplanning data, finance planning documents) were also critical sources of information. The sources of evidence were coded by description and triangulated to find how the themes converge and diverge. This process aided in answering the four main research questions aimed at revealing and then evaluating SSBHD's strategic process for establishing CCBHCs (Ford, 2022; Kekeya, 2021; Mills et al., 2010; Range, 2021).

The upcoming section discusses the data analysis process, the results, and the implications for the study's findings. Specifically, the following section presents how the SSBHD strategically endeavored to partner with community providers to certify CCBHCs in the state, create a process for establishing a future reimbursement rate, and

how that strategy compares to Baldrige's framework. Furthermore, the potential for positive social change and the strengths and limitations of the study are discussed.

Analysis, Results, and Implications

Data Analysis

After the data were collected, they were reviewed and organized into different buckets of information related to similarities in how the BHLs responded to the semistructured interview questions (Kekeya, 2021). The semistructured interview questions in Table 4 below and Appendix A helped to find the answers to the four research questions. The purpose of the four research questions was to discover the SSBHD's strategic steps. File folders, Microsoft Word, and Microsoft Excel sheets were used to organize the information into corresponding buckets.

The interview recordings were reviewed, and transcript recordings were downloaded so that the researcher could align them with her notes for accuracy and have ready access to the information shared by each of the five BHLs who participated. To contribute to trustworthiness, data triangulation and a thematic analysis of the sources of evidence (shown in Table 2) were used to collate similarities which helped to reveal SSBHD's strategy for certifying CCBHCs and helping them establish a reimbursement rate (Kekeya, 2021). Table 3 below shows the four main research questions and answers gathered from the various sources of evidence listed in Table 2 above. The specific questions asked of the BHLs, and their similar responses are presented below in Table 4.

Table 3

Answers to Research Questions

Research questions	Answers gathered from the sources of evidence
What is the SSBHD's strategy for ascertaining if newly established CCBHCs are ready to operate per federal and state requirements?	Several of the BHLs have reviewed what other states have done to certify CCBHCs. The SSBHD has joined a learning community/collaborative with other states to share ideas about CCBHCs. The SSBHD has hired a consultant group to guide and monitor the certification process/assessment and have conducted a needs assessment survey to ascertain how/where CCBHCs can be helpful to the state. The potential CCBHCs have conducted a staffing and costing survey, must submit attestations that they can do what is required of CCBHCs, and the SSBHD will follow a 3-phase certification process: 1). Begin certification, 2). Implement connections to physical healthcare, adjust policies/procedures to the CCBHC model, hire staff/expand capacity, and 3). Certification.
What is SSBHD's approach to creating a certification tool to certify new CCBHCs?	The SAMHSA State Certification Guide (SAMHSA, 2015) presents the certification requirements. The consulting group helped the SSBHD project leaders and the potential CCBHCs learn what/how to implement the areas needed for certification and track progress toward certification goals.
What is needed to establish a specified reimbursed rate for the new CCBHCs?	SSBHD and its hired consultant help budding CCBHCs collect and evaluate cost data, understand the implications of current funding models (e.g., fee for service and contracts), and create accurate estimates of the number of service days needed. The consulting group worked

Research questions	Answers gathered from the sources of evidence
	with the CCBHC candidates to develop their agency-specific costs via a cost-collection survey.
How does SSBHD's strategic approach compare to other states' approaches to certifying CCBHCs?	The SSBHD's certification approach compares to other states in that needs assessment surveys were completed, and consulting was needed to guide the process. All states' BH organizations had to apply to SAMHSA, be accepted to participate in the CCBHC model, and use the SAMHSA model to certify their CCBHCs to meet requirements to receive continued funding and a specified reimbursement rate. SSBHD's process diverges from other states in the following ways: they want to incorporate services for those who have co-occurring I/DD diagnoses into the service mix of CCBHCs, they have their own standards that they expect providers in the state to meet, and while other states had Medicaid expansion, SSBHD's state does not participate in Medicaid expansion. These factors make the reimbursement rate process more complex.

Table 4

Questions to BHLs/Similar Responses

BHLs specific questions	Similar Responses
What are the strategic steps leadership uses to establish the certification tool?	Per the BHL of the CCBHC Governance Sub Committee, "A big part of our strategy was that the agency brought in a consultant that has done CCBHC work across the country to assist in building a structure for us to evaluate existing providers that might receive those grants". Per the BHL of the Project Quality Outcome and IT, "We are working with an outside consulting group who has a lot of experience in the CCBHC world. They designed a questionnaire that was to be used in order to determine how ready community service boards [community providers] were to undertake the CCBHC process".
What tools were reviewed in preparation for this specific certification process? How will a helpful tool be developed?	Per the Finance Chair of the CCBH project, "We began the project with a broad set of expectations….we set up a construct for communication for partnership both internally and with our external stakeholders. The team leaders were given a number of opportunities to speak with outside experts, with the National Council, with [consulting group/name masked for this study], with other states, and then essentially given the instruction to put together recommendations within our sphere of influence for vetting and approval by the executive leadership team". Per the BHL of the Project Quality Outcome and IT subgroup, "We did have other tools in use such as the risk profile and the quality reviews, which are ongoing evaluations of providers from a variety of different

BHLs specific questions	Similar Responses
	viewpoints. So, we utilized some of those existing tools to help us think about readiness on the part of the community contractors [providers]"
What are the leadership's short-term and long-term goals for certifying the new CCBHCs?	Per the BHL of the CCBHC project, "Near term strategic goal is to implement PPS [perspective payment system] within a FY 2023 timeline…. we still have not talked about how to measure outcomes; those are tactical goals that require incremental implementation so there are a range of possible dates to consider". Per the BHL of the CCBHC Governance Sub Committee, "Those were put together early on. We were asked to put together a document that said these are the things we believe need to happen…so we identified this is what we need in the way of you know, board structure compliance. This is what we think around making sure that network adequacy is in place and that organizations that come into the CCBHC model are able to provide the service array across the expected areas and things like that."
How are those goals being tracked and reported on?	Per the BHL of the CCBHC project, "There's no sophisticated methodology. The Teams site is not as active as it was on project inception; part of that is because committees have not been active recently. I have tried Asana as a tracker to keep up with the moving parts of the project, but using a tracker requires training and updating. I have my own tracking method and I have suggested that a technology navigator be consulted to help leaders know how to use the existing technology for the project." Per the BHL for the clinical access workgroup, "each subgroup has folders for documents related to the

BHLs specific questions	Similar Responses
	work they are doing together. The CCBHC project director helps each one of the workgroups keep track of metrics, progress made…, and initiatives that are in the parking lot waiting to be addressed."
Who are the key stakeholders chosen by leadership?	All the BHLs agreed that stakeholders are the staff serving on the CCBHC project, the consultant, the prospective CCBHC providers, SAMHSA, individuals in services, CCBHC communities, etc.
Who are the people in the workgroups established to develop the tool? Why did leadership choose them?	Per the BHL of the CCBHC project, "they are knowledgeable [SSBHD] staff chosen for their expertise in the areas of finance, budgets, quality performance and data outcome, governance, and clinical access to services." Per the Finance Chair of the CCBH project, "they have experience in areas related to budget, finance, Medicaid, accountability, IT, IDD component for co-occurring diagnoses".
Are there any strategic leadership plans for aligning the tool with federal and state requirements?	Per the BHL for the BH clinical access workgroup, "So one of the approaches to creating [a tool] that is comprehensive is creating some standardization around thought processes and how we arrive at a model that creates equity within certification and has the ability to enhance or support diversity around how the CCBHCs work. From a rural perspective, making sure that we had allowances within that certification tool that support the communities that would ultimately benefit from that CCBHC because, as you know, the state has lots of different community diversity." Per the BHL of the Project Quality Outcome and IT, "obviously when you have a national program like this, you want to

BHLs specific questions	Similar Responses
	ensure that you're all capturing the same data in the same way, if at all possible. If you're not, you want to understand what those differences are so that you can make appropriate comparisons between services and between states…that is a major challenge for us. Our agency has another kind of internal reporting mechanism that we look at once a year for key performance indicators. In order to align that with the CCBHC work, some of the indicators that we were collecting needed to be changed to more closely align with the expectations for CCBHCs."

Note. All respondents had similar answers to the above questions; however, only a couple of responses were used for each question above.

Tables 3 and 4 showed that SSBHD's strategic approach to certifying and helping establish a reimbursement rate for CCBHCs was organized, methodical, and collaborative. The following themes about their strategy emerged from the data: consultation, review of other states' CCBHC process, collaboration, and the divergence in SSBHD's CCBHC certification/reimbursement process. I used the Baldrige framework to evaluate that strategy (Ford, 2022; NIST, 2021).

Theme 1: Consultation

Block (2011) defined a consultant as a person or a group of people hired to influence an organization as they make changes or implement programs; however, consultants are not managers in an organization because they do not have the power to implement changes. Implementing should be reserved for managers with the power, position, and organizational authority to direct changes/plans (Block, 2011). All the

BHLs agreed that the SSBHD hired a consulting firm to help them better understand and guide certifying the CCBHCs. According to the BHLs, the consulting group has been a supportive layer on the project by helping them with planning, recommending, assisting the potential CCBHC staff, and advising on the steps for certification. The researcher also observed these consultant qualities during project meetings that she attended. The consulting group's role and tasks flowed from their experience helping other states implement their CCBHCs and are in line with what Block (2011) describes as the function of consulting.

Theme 2: Review of Other States' CCBHC Process

The SSBHD's CCBHC project BHLs described and their programmatic preplanning documents revealed that one of the initial steps toward starting the CCBHC certification process was evaluating data from previous states who implemented CCBHCs. The hired consultant also helped in this regard because they came with a wealth of knowledge about CCBHCs, and the success and challenges faced by the states who implemented them. Per interview information, the CCBHC implementation process of approximately two to three states with similar demographics as SSBHD's was reviewed for ideas. The research supports that studying how other states have implemented CCBHCs, certified them, and the benefits that CCBHCs bring to communities is a good practice and motivator for other states to try the CCBHC whole health model (Implementation, 2020; NCBH, 2017; NCBH, 2020; OASPE, 2019). For example, the information from the existing CCBHC body of research is available to other states who want the benefits of CCBHCs for their communities. That research presents a

wealth of information about the experiences of the eight states who piloted the CCBHC program model and established reimbursement rates for the CCBHCs in their communities (Implementation, 2020; NCBH, 2017; NCBH, 2020; OASPE, 2019).

Theme 3: Collaboration

Block (2011) and Johnson and Rossow (2019) agree that collaboration is crucial for consulting and for teams working together to implement new programs in BH organizations. Collaboration maximizes the use of resources and talents and establishes a sense of shared responsibility (Block, 2011). The use of multidisciplinary teams in BH organizations yields many advantages, including collaboration and increased coordination, which work together to enhance communication and conflict resolution skills that improve effectiveness (Johnson & Rossow, 2019). Per interview information, BHLs had direct conversations with key CCBHC project leaders from a few states who established CCBHCs. Furthermore, the SSBHD's CCBHC project leader advised that project members and the leaders of the budding CCBHCs in the state, joined a CCBHC learning collaborative with other states to keep abreast of the updates on CCBHCs and stay at the forefront of implementation changes. This continued collaboration with other states helped them learn how best to implement and certify CCBHCs in their state. The SSBHD's CCBHC project group devised a communication plan for sharing information with the CCBHC stakeholders. That plan included sending branded messages about CCBHCs via scripts, email/website messages, signage, and direct messages to individuals and communities served by potential CCBHCs. The plan aimed to facilitate collaboration via "transparency and accountability to customers, clients, and the public."

Theme 4: The Divergence in SSBHD's CCBHC Certification Process

All of the CCBHC project's BHLs and consultant contact who participated in the structured interview explained that SSBHD's CCBHC certification process adds the expectation that CCBHCs in the state also be equipped to offer services to individuals who have co-occurring (co-morbid) mental health (MH) and/or addictive disease (AD) diagnoses and an intellectual/developmental disability (I/DD) (e.g., autism spectrum disorder, cerebral palsy). Per interviews, meeting attendance, website, and programmatic data, a large part of SSBHD's programs are funded to address the needs of the state's I/DD population; many of whom also present with MH and/or AD diagnoses. Therefore, it is SSBHD's/state's expectation that CCBHC providers be equipped to meet the needs of constituents who present with co-occurring diagnoses and is a key element for certification. Consequently, the implementation of services for those with co-occurring diagnoses (specifically including the I/DD population) veers from the service array of CCBHCs in other states, from SAMHSA's requirements, and is a point of divergence from the research literature. Per SAMHSA (2022),

> Although clinics can provide services to the IDD population, these services are not part of the CCBHC certified services and are not to be included in the prospective payment system (PPS). CCBHCs are to provide behavioral health, not IDD, services. Individuals who have co-morbid behavioral health/IDD conditions would be eligible for the behavioral health services that are provided if they meet the eligibility criteria. (para 7).

According to the BHL for the finance group, the SSBHD's state does not participate in Medicaid expansion; therefore, including services for those diagnosed with BH and I/DD presents a funding challenge for the work to create a reimbursement plan with the CCBHCs.

Strategy Effectiveness Based on the Baldrige Framework

The themes above show that the SSBHD's strategic approach to certifying and helping CCBHCs establish a reimbursement rate involved thought and collaborative efforts. However, the Baldrige framework can assess the potential success of SSBHD's strategy, specifically in key processes, customer, workforce, leadership, and strategy implementation areas to reveal how their strategy may converge or diverge from effectiveness (Ford, 2022; NIST, 2021). Following is a review of the potential effectiveness of the SSBHD's strategy in specific CCBHCs service areas.

Client Programs, Services, and New Initiatives Effectiveness

Per the SAMHSA requirements/guidelines, CCBHCs are expected to provide the following nine types of services (NCBH, 2020; SAMHSA, 2015, 2021a, 2021b):

- Crisis Services
- Person-Centered Treatment Planning
- Screening, Assessment, Diagnosis & Risk Assessment
- Outpatient Mental Health & Substance Use Services
- Case Management
- Outpatient Primary Care Screening and Monitoring
- Community-Based Mental Health Care for Veterans

- Peer, Family Support & Counselor Services
- Psychiatric Rehabilitation Services

Additionally, the expectation is that crisis services be accessible 24 hours, practices are evidenced-based, and care is coordinated with local primary care clinics and hospitals, so there is integration between BH and physical health care (NCBH, 2020; SAMHSA, 2015, 2021a, 2021b). Per information from the SSBHD's specific sources of evidence, the SSBHD desires for all prospective CCBHCs to be more comprehensive. However, one of the BHLs explained that the state does not participate in Medicaid expansion. Therefore, working to find the correct reimbursement rate for the prospective payment system (PPS) is challenging because the additional services that SSBHD wants to add to the CCBHC service array (e.g., services for co-occurring IDD diagnoses, BH residential) may have to be paid for separately using state funds and other federal grants. Having different pots of money for reimbursement would result in a two-payment system for CCBHCs, which is not ideal.

The Baldrige framework asks organizations to capture key outcome measures and service performance indicators that point to effectiveness (NIST, 2021). According to SSBHD's sources of evidence, the data on the effectiveness of the new CCBHCs are still in the data-gathering process. As of the writing of this study, the SSBHD has five potential CCBHCs in phase one of implementation (meaning they have recently been awarded SAMHSA planning and implementation grants), four are in phase two (beginning to implement connections to physical healthcare, adjusting policies/procedures to meet the CCBHC model, and hiring staff to expand service

capacity), and only two have submitted attestations stating that they believe they can operate per the CCBHC grant requirements and are closest to having what is needed to submit a reimbursement rate. The sources of evidence also reveal that once a reimbursement rate is established, the SSBHD must work with the state's Medicaid entity to approve the rate as part of a State Plan Amendment, which is then submitted for approval by SAMHSA/Federal Medicaid. When asked if there are evidence-based assessments in place to measure how effective the CCBHCs are on the grant requirements, the BHL for the project stated: "No, not yet, but [SSBHD] plans to collect data annually through core performance monitoring reports (PMR), still being developed. The Dept will start getting quarterly data from CCBHC sites, but for now only basic programmatic data about progress is available. However, it is not thorough quality measures since it is still early in implementation".

The programmatic data that the BHL referenced is a certification assessment tool based on requirements from the SAMHSA certification guide and tracking information from the consulting company, SSBHD hired (SAMHSA, 2015). That assessment tool tracks how well each CCBHC is aligned with the six required sections for continued SAMHSA grant funding. The scores range from 1 (low) to 4 (high) to depict how well each section meets SAMHSA's required standards. Table 5 presents data on the two sections related to assessing new initiatives, programs, services, and effectiveness for the two CCBHCs who submitted attestations: Section 4: Scope of services and Section 5: Quality and other reporting.

The data in Table 5 shows the results on these two sections for the two CCBHCs who have submitted attestations (after two rounds of assessment). The results show that each of the two budding CCBHCs improved on the measures after each round of assessment. Based on the data collected from SSBHD's evidence, improvement can be attributed to the collaborative communication efforts via meetings and expert help from SSBHD's BHLs and the hired consultant. The SSBHD, with the help of its consultant group, surveyed the community providers selected to become CCBHCs. One of the questions asked was, "Based on your knowledge of the CCBHC Certification Criteria, please choose the specific area(s) you feel your organization will have no challenge meeting." Approximately 62% of the respondents replied that they would be fine meeting the requirements for the scope of services. However, there was more perceived challenge related to quality and other reporting measures, which received almost 31% confidence that there would be no challenges. Correspondingly, Section 5: Quality and other reporting had the lowest scores in both rounds on the assessment tool.

Table 5

The Available Scores for Two CCBHCs on Sections Four And Five of The SSBHD's Certification Tool

Section	Description	State Average (high=4, low=1)			
		CCBHC 1 1st round	CCBHC 1 2nd round	CCBHC 2 1st round	CCBHC 2 2nd round
4	Scope of services				
	General service provisions	1.57	3.67	2.29	4.00
	Person-Centered and Family-Centered Care	4.00	4.00	4.00	4.00
	Crisis behavioral health services	4.00	4.00	3.50	4.00
	Behavioral Health Screening, Assessment, and Diagnosis	3.83	3.83	3.67	4.00
	Person-Centered and Family-Centered Treatment Planning	4.00	4.00	4.00	4.00
	Outpatient Mental Health and	4.00	4.00	4.00	4.00

Section	Description	State Average (high=4, low=1)			
	Substance Abuse Services Outpatient Clinical Primary Care Screening and Monitoring	4.00	4.00	3.25	3.50
	Targeted case management services	4.00	4.00	4.00	4.00
	Psychiatric rehabilitation services	4.00	4.00	4.00	4.00
	Peer Supports, Peer Counseling and Family/Caregiver Supports	4.00	4.00	4.00	4.00
	Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	3.50	3.70	4.00	4.00

Section	Description	State Average (high=4, low=1)			
5	Quality and other reporting				
	Date Collection, Reporting, and Tracking	2.40	3.00	2.60	3.25
	Continuous quality improvement (CQI) plan	3.50	3.50	3.00	3.00

Note. The sections and descriptions in Table 5 are from the certification assessment tool SSBHD devised based on requirements from the SAMHSA certification guide and the tracking information suggested by the consulting company they hired (SAMHSA, 2015).

Client-Focused Results

Continuing with SSBHD's programmatic and initial assessment data for the two maturing (attested) CCBHCs, the Baldrige framework was used to assess the perceived effectiveness of SSBHD's strategic plans for ensuring that client-focused results are met according to SAMHSA guidelines (NIST, 2021; SAMHSA, 2015). The data in Table 6 shows the results of the two CCBHCs in Section 2: Availability and accessibility of services and Section 3: Care coordination, which are related to client-focused effectiveness. The results show that each CCBHC maintained the same scores (the initial scores were already high in the 3-4 range) for each round in most subcategories or improved slightly.

Incidentally, one of SSBHD's survey questions to potential CCBHC providers asked, "Based on your knowledge of the CCBHC Certification Criteria, please choose which specific area(s) you feel your organization has the most significant challenge meeting." Approximately 14% of respondents felt their organization would have challenges meeting Section 2: Availability and accessibility of services, and about 7% chose that there would be challenges in Section 3: Care coordination. The data shows that the potential CCBHCs were initially confident in meeting the requirements for these two sections. The two assessment rounds show that they were correct in their initial assessment. Therefore, the potential CCBHCs did not require extensive assistance from SSBHD to meet the requirements in these sections.

The SSBHD's strategic step to survey the potential CCBHC providers and use their devised assessment tool to grade their readiness on SAMHSA criteria on client-focused services is meeting the mark. SSBHD also implemented client surveys for programs and did update those client feedback surveys to be relevant to the CCBHC model; however, data from the CCBHC-specific client surveys were not yet collected and evaluated upon the writing of this study.

Table 6

The Available Scores for Two CCBHCs on Sections Two And Three Of The Certification Tool

Section	Description	State Average (high=4, low=1)

		CCBHC 1 1st round	CCBHC 1 2nd round	CCBHC 2 1st round	CCBHC 2 2nd round
2	Availability and accessibility of services				
	Requirements of access and availability	4.00	4.00	3.90	4.00
	Requirements for timely access to services and initial & comprehensive evaluation for new consumers	3.55	3.64	3.64	3.64
	Access to Crisis Management Services	4.00	4.00	3.50	4.00
	No Refusal of Services Due to Inability to Pay	4.00	4.00	4.00	4.00
	Provision of Services Regardless of Residence	4.00	4.00	4.00	4.00
3	Care coordination				

General Requirements of Care Coordination	4.00	4.00	3.83	4.00
Care Coordination and Other Health Information Systems	4.00	4.00	3.20	3.20
Care coordination agreements	3.46	3.62	3.46	3.46
Treatment Team, Treatment Planning and Care Coordination Activities	3.33	3.33	3.00	3.00

Note: The sections and descriptions in Table 6 are from the certification assessment tool SSBHD devised based on requirements from the SAMHSA certification guide and the tracking information suggested by the consulting company they hired (SAMHSA, 2015).

Workforce-Focused Results

Reviewing SSBHD's BHLs' interview responses, meeting notes, and programmatic data for the two CCBHCs that submitted attestations revealed the early results of their strategy for addressing the workforce related results for CCBHCs. The Baldrige framework was used to assess the potential effectiveness of SSBHD's strategy to ensure the alignment of the CCBHCs' workforce with SAMHSA guidelines (NIST, 2021; SAMHSA, 2015). The data in Table 7 shows the results of the two CCBHCs' early progress toward meeting workforce requirements in Section 1: Staffing. The results show

that each CCBHC improved or maintained its scores in each round of assessment across the staffing requirement measures. Both sites averaged close to or met the high score (4); however, that may not be representative of the other CCBHCs who are waiting in the pipeline to be able to submit their attestations that they can meet the requirements for certification.

The result of SSBHD's survey of potential CCBHCs asked the group to rate "which specific area(s) you feel your organization have the most significant challenge in meeting"? The results show that over 64% of those surveyed thought staffing would be a significant challenge. Additionally, the survey respondents made comments like "Health professional shortages are real, especially the farther south you operate. Staffing shortages impact service accessibility and scope so significantly. Adequate financing is a foundational part of recruiting and retention. The median salary for adult psychiatry is $300K plus CME budget and time off plus sign on bonus, as example". The SSBHD's strategy for assessing the workforce needs of CCBHCs is in line with the Baldrige framework because it has measures in place to assess the skills, staffing levels, credentials, and staff diversity needed to provide the services required by SAMHSA.

Table 7

The Available Scores for Two CCBHCs on Section One of The SSBHD's Certification Tool

Section	Description	State Average (high=4, low=1)

1	Staffing	CCBHC 1 1st round	CCBHC 1 2nd round	CCBHC 2 1st round	CCBHC 2 2nd round
	General staffing requirements	3.36	3.36	3.79	4.00
	Licensure and Credentialling of Providers	3.89	3.56	3.56	4.00
	Cultural Competence and Other Training	3.80	3.80	3.40	3.40
	Linguistic competence	3.67	3.67	3.89	3.89

Note. The sections and descriptions in Table 7 are from the certification assessment tool SSBHD devised based on requirements from the SAMHSA certification guide and the tracking information suggested by the consulting company they hired (SAMHSA, 2015).

Leadership and Governance Results

The Baldrige framework describes an organization's leadership and governance as follows:

- Senior leadership's ability to communicate and engage all of its stakeholders,
- How it addresses accountability to legal, regulatory, and accreditation requirements,
- How it fosters ethical behavior, and
- How it contributes to society's well-being and the needs of its communities (NIST, 2021).

Based on SSBHD's sources of evidence and information from two CCBHCs that submitted attestations, SSBHD has a strategy for assessing the emerging CCBHCs' leadership and governance factors. Table 8 below shows the results of the two attested CCBHCs' leadership and governance evaluations. Section 6: Organizational authority, governance, and accreditation of SSBHD's evaluation tool show that each CCBHC maintained the same high scores in both assessment rounds.

Additionally, SSBHD's leadership survey of potential CCBHC senior leaders (CEOs, CFOs, and COOs) asked them to "choose the specific area(s) you feel your organization will have no challenge meeting"? Over 92% were confident they would not have any challenge meeting the organizational authority, governance, and accreditation requirements for CCBHC certification. Those results from the initial survey of CCBHC leaders proved true for the two CCBHCs evaluated in SSBHD's certification assessment shown in Table 8. The SSBHD's strategy for evaluating CCBHCs' leadership and governance needs appears to adequately address the criteria for leadership and governance presented in the Baldrige framework (NIST, 2021).

Table 8

The Available Scores for Two CCBHCs on Section Six Of The SSBHD's Certification Tool

Section	Description	State Average (high=4, low=1)			
		CCBHC 1 1st round	CCBHC 1 2nd round	CCBHC 2 1st round	CCBHC 2 2nd round
6	Organizational authority, governance, and accreditation General Requirements of	3.33	3.33	4.00	4.00

Organizational Authority and Finances				
Governance	3.25	3.25	3.00	3.00
Accreditation	4.00	4.00	4.00	4.00

Note. The sections and descriptions in Table 8 are from the certification assessment tool SSBHD devised based on requirements from the SAMHSA certification guide and the tracking information suggested by the consulting company they hired (SAMHSA, 2015).

Financial and Marketplace Performance Results

In the SSBHD's strategic planning documents, they proposed that the purpose and expectation for developing a prospective payment system (PPS) model for CCBHCs depended on collecting and evaluating the accuracy of cost data to include costs related to implementing the CCBHC model in the different areas of the state. Additionally, a complete understanding of the different funding methods, including fee for service and existing contract funding, and a well-rounded estimate of the number of service days for each client would be necessary. Therefore, in the SSBHD's planning document, the hired consultant would work with each CCBHC candidate to create their agency-specific cost survey, assess the impact other payment options would have on the PPS, and complete Medicaid cost reports to compare with the proposed PPS costs. The SSBHD would then review the cost survey results to ensure that all anticipated costs for CCBHC implementation were accounted for and collaborate with each potential CCBHC to propose a yearly anticipated PPS rate to submit to other state partners and the federal government for approval.

Securing continued funding for CCBHCs in SSBHD's state is critical to the success of the CCBHC model. Comments from the initial leadership survey of potential

CCBHCs yielded concerns in this area. For example, one comment from that survey stated: "Our organization is strong and highly adaptable; our ability to meet the staffing, availability/accessibility, coordination, scope, reporting requirements is contingent on adequate financing". Table 8 above presents the attested CCBHCs' scores on the general requirements for organizational authority and finances as a subcategory to Section 6: Organizational authority, governance, and accreditation. The Baldrige framework tests an organization's financial viability and the strategy it has in place to predict/assess the market's needs (NIST, 2021). Based on the high scores of the two CCBHCs who attested that they could meet the requirements for the CCBHC model, the SSBHD's strategy for determining a PPS may be solid toward the effort to predict and garner continued funding.

Implications of Findings for Individuals, Organizations, Communities, and/or Systems

The implementation of CCBHCs in SSBHD's state, certifying them, and helping them to create an individualized reimbursement model are steadily progressing. This trend implies that, like other states who have implemented and certified CCBHCs, the model can also be an impactful BH program modality in the SSBHD's state (NCBH, 2017; NCBH, 2020; OASPE, 2019; SAMHSA, n.d.; SAMHSA, 2021b). Overall, the results presented in Tables 5-8 (discussed in the five sections above) culminate to show that two of the budding CCBHCs have steadily improved on the measures after each round of assessment. The strategic interventions implemented by the SSBHD are working in tandem to gear the potential CCBHCs toward certification. The interventions' success

is evidenced by the data in Tables 5 – 8, which show that the two assessed CCBHCs improved or maintained high scores in each subsequent round. Table 9 below continues that line of evidence because it supports the upward improvement trend by showing the comprehensive total for the two CCBHCs in sections one - six of the SSBHD's certification tool. While the other potential CCBHCs are working towards submitting their attestations and data is still being collected about their readiness, the hope is that the SSBHD's strategy continues to prove effective at steering them toward certification.

Table 9

The Total for The Available Scores for Two CCBHCs on Sections One - Six Of The Certification Tool

Section	Description	State Average (high=4, low=1)			
1 - 6		CCBHC 1 1st round	CCBHC 1 2nd round	CCBHC 2 1st round	CCBHC 2 2nd round
	TOTAL	3.61	3.73	3.59	3.77
	Percentage TOTAL	90.25%	93.17%	89.83%	94.36%

Note: The totals in Table 9 are from the certification assessment tool SSBHD devised based on requirements from the SAMHSA certification guide and the tracking information suggested by the consulting company they hired (SAMHSA, 2015).

Implications for Positive Social Change

An essential focus for the CCBHC model is to address the health needs of those living in the most rural counties because the need for behavioral and physical health is high. The early indications of the success of the CCBHCs in the SSBHD's state are good news for SSBHD's most rural communities. SSBHD's state's rural health data (2016-2020) shows that of the state's 159 counties, 120 are in rural areas. These rural areas' demographics include average incomes below 200% of the federal poverty level, most are uninsured and more likely to need/receive Medicaid coverage, and on average, have poorer mental health. The CCBHC model has the potential to provide the services needed in rural counties and put SSBHD's state in a better position to address the opioid crisis and provide service options to meet the growing need for better BH and physical health

care within a value-based system of reimbursement that narrows the health disparity gap in the state.

Strengths and Limitations of the Study

The strength of this study lies in the data gathered from the SSBHD's programmatic documents, archival documents (assessments and surveys), and semistructured interviews with the organization's BHLs managing the project. Additionally, since the beginning of this study's endeavor to evaluate the strategic leadership steps used by the SSBHD to certify and create a future reimbursement rate for the new CCBHCs in the state that meets SAMHSA's grant requirements (SAMHSA, 2021a, n.d.), two of the potential five CCBHC sites submitted attestations signifying that they believe they meet all the requirements necessary to be fully certified by the SSBHD. Per the BHL's interviewed and the hired consultant, this is a good sign because those two CCBHCs are closer than ever to reaching full certification and establishing a reimbursement rate that will meet the continued service needs of their communities.

However, the limitation of the study lies within the unknown of whether the strategic process will yield different results for the three other CCBHCs who are still working towards submitting attestations to indicate their ability to meet the requirements for certification. Secondly, securing a final reimbursement (or PPS) rate for each CCBHC is contingent on approval from the state agency that governs Medicaid in the SSBHD's state and the federal requirements of the Centers for Medicare & Medicaid Services (CMS), which partners with SAMHSA to issue the CCBHC grants (SAMHSA, 2022). There may be other challenges in navigating the requirements for approval from the

SSBHD's state's Medicaid entity and CMS that are not fully understood and presented in this study, especially as it relates to the lack of Medicaid expansion options in the SSBHD's state (Garfield et al., 2021).

Section 5: Recommendations and Conclusions

Using the Baldrige framework as a guide, the above Analysis, Results, and Implications of Findings sections show that the SSBHD CCBHC leadership team has a solid strategic process in place for certifying the growing number of potential CCBHCs and helping them to establish a reimbursement rate (NIST, 2021). Additionally, the SSBHD's steps toward creating a path for how to certify new CCBHCs are aligned with the steps used by other states who have established CCBHCs and in accordance with SAMHSA's requirements (Implementation, 2020; NCBH, 2017; NCBH, 2020; OASPE, 2019).

Since the start of this study, the list of CCBHCs in SSBHD's state has grown to nine candidate agencies. Five are in Phase 1 (beginning/planning/needs assessment), and four are in Phase 2 (implementing/adding physical healthcare/adjusting policy/hiring staff). As of the writing of this study, two of the four sites in Phase 2 have submitted attestations that they believe their operations are in line to meet full certification. Those two sites' scores on the certification assessment are presented in Tables 5 through 9 above. However, none of the sites are in Phase 3 (certification by SSBHD) because work is still underway to develop a sustainable reimbursement rate for the mix of CCBHC services required by SAMSHA and SSBHD's state. The analysis and synthesis of the information/evidence collected throughout this study yield gaps and provide an opportunity for recommendations that stem from the themes found in the data and guidelines from the Baldrige framework. As the SSBHD's work to certify CCBHCs continues, the following are recommendations for SSBHD to consider.

Recommendations

Recommendation 1: Consultation/Project Management

Understanding, establishing, and certifying CCBHCs is a significant project undertaking in states because it requires transformational and integrated changes to produce evidence-based solutions for coordinated and comprehensive behavioral health care (SAMHSA, 2022). Tracking all of the moving parts of the CCBHC project is essential for timely certification. The Project Management Institute defines project management as "the use of specific knowledge, skills, tools, and techniques to deliver something of value to people" (para 1). Knowledge of specific project management software can help project managers organize the different parts of a venture, so that information and the status of its moving parts are efficiently available (Marnewick & Marnewick, 2021). Additionally, in an increasingly remote work environment, project management tools and the skills to use them to direct a project and share information with involved parties are essential to the success of a project (Marnewick & Marnewick, 2021).

The SSBHD has a system to track the moving parts of their CCBHC project; however, it is a mix of spreadsheets and documents housed in different places. Therefore, finding the task status of each work group takes time. In an interview, the director of the CCBHC project was asked how the project's goals are being tracked and reported on. She replied that,

> there's no sophisticated methodology. I have tried Asana as a tracker to keep up with the moving parts of the project, but using a tracker requires training and

> updating. I have my own tracking method, and I have suggested that a technology navigator be consulted to help leaders know how to use the existing technology for the project.

According to the Baldrige framework, clear and reliable work processes are essential to an organization's strategic planning and success (NIST, 2021). Baldrige described work processes as methods organizations use and improve (NIST, 2021). Specifically, the information and knowledge management criteria of the Baldridge framework can be used to evaluate an organization's data and information management processes to determine if the systems are of quality and available to the workforce and collaborators (NIST, 2021). Organizations that have high scores on this Baldrige criteria have innovative systems in place that are user-friendly and can reliably provide timely and relevant information to their workforce and organizational collaborators (NIST, 2021). Therefore, it is recommended that the SSBHD adopt and use an innovative, efficient, and reliable project management system for the CCBHC work.

Monday.com (n.d.) boasts a streamlined project management system that offers quick real-time updates that are efficient, organized, and automated, making collaboration and customization easy. In addition, the monday.com site offers solutions to manage various tasks across teams, including project management, marketing, tasks management, and operations (Haan & Watts, 2023; monday.com). Monday.com is a publicly traded multi-product company providing (free and subscription-based) solutions for companies to manage their work (Monday.com, n.d.). Haan and Watts (2023) recommend Monday.com because:

- They have 24/7 support,
- Their products can be used in many areas of a company,
- They have a robust free plan,
- Their program can be integrated with other apps or used on its own because no coding is involved, and
- The programs can generate reports that help a company make informed decisions.

It is recommended that SSBHD try monday.com's project management program because it may be easier to use and yield a more organized, efficient, accessible, and reliable way to track the moving parts of the CCBHC certification project.

Recommendation 2: Collaboration/Agreements

While assessing the SSBHD's strategy for certifying CCBHCs, it became clear that some budding CCBHC sites were awarded private grants by the SAMHSA the others were sites that the SSBHD sponsored for the CCBHC grant. The sites that applied for the CCBHC grant independently and were awarded planning grants directly from the federal government without the state's input were allowed to do so per the grant application guidelines (Substance Abuse and Mental Health Services Administration, 2022). However, per BHL interviews, the SSBHD is still responsible for certifying these independent CCBHC grantees so they can continue receiving SAMHSA grant funding. This presents an issue for the SSBHD because there is a misalignment between the state's expectations for all CCBHCs and the federal guidelines. Although the SAMHSA has criteria for the agencies who apply independently for the grant, the state's expectation for all CCBHC providers is stricter. Therefore, if a provider in SSBHD's state applies for the

CCBHC grant independently and they are not a provider site that the state would recommend because of its existing low performance in critical areas, the SSBHD may have challenges helping that low-performing site reach certification and a sustainable reimbursement rate for continued grant funding.

Collaboration with states appears to be a part of SAMHSA's 2022 Interim Strategic Plan to address BH needs nationwide because that plan states that SAMHSA is committed to working with states to identify a qualified workforce, evidence-based practices, and equitable services (SAMHSA, 2022). The Brookings Institute supports the idea that there are better overall outcomes for society and the national bottom line when levels of government work together collaboratively to solve problems (Liu & Rezk, 2023). The SAMHSA is a key stakeholder and funding source for the CCBHCs in SSBHD's state. According to the Baldrige framework, understanding the needs of and fostering a collaborative relationship with key stakeholders/collaborators is an essential element for successful organizational relationships (NIST, 2021).

I recommend that the BH organization liaisons with the SAMSHA grant issuing office to develop agreements allowing the state to give feedback to SAMSHA about existing BH providers who apply for the CCBHC grant. In this way, the state can preempt issues with a potential CCBHC provider who may present problems that delay the certification process because their current structure could be more conducive to expansion to become a CCBHC. Because the state BH agency is expected to certify all CCBHCs and they may already know which providers need more organizational leadership and rapport in the community to become successful CCBHCs, they should

have input about which providers are good CCBHC candidates. It is advantageous for SSBHD that one of its former BH directors is employed at SAMHSA. That former SSBHD employee may be a key contact in the effort to ally with the two entities regarding CCBHC grantees, so networking with that former SSBHD employee should be explored. Once an agreement is in place between the SSBHD's state and SAMHSA about CCBHC grantees, the certification process may experience fewer delays, and funding will be disbursed to areas/agencies that will be good stewards of public funding with the ability to produce a good return on federal/state investment.

Recommendation 3: Other States' Approach for Assessing CCBHC Performance

The Baldrige framework provides tools to assess an organization's competitive environment to determine what comparative data it uses to determine needed changes and strategies to address challenges and advantages (NIST, 2021). Additionally, it is vital to determine what performance improvement systems the organization has in place to evaluate important projects and processes (NIST, 2021). Baldrige's process scoring for an organization's competitive environment and its performance improvement system uses approach, deployment, learning, and integration (ADLI) as measures. Table 10 shows Baldrige's ADLI factors (NIST, 2021).

Table 10

Baldrige framework's ADLI Factors

ADLI Factors	Description
Approach	An organization's approach includes its methods for carrying out processes, how appropriate those methods are to the environment, how effective they are, and how repeatable/reliable the approach is based on its information and data.
Deployment	An organization's deployment evaluates the relevancy and importance of the questions in the approach, how consistently the approach is applied, and if the approach is used by all work units.
Learning	This factor evaluates how the approach is refined over different cycles of use and improvement, how best practices are adopted, how innovation is used to improve the approach, and how the refined approaches are shared within the organization.
Integration	This evaluates how aligned the approach is with the organization's needs, if measures and improvement systems are complementary throughout work units, and how harmonized the plans, results, learning, and actions are across units in supporting organizational goals.

High-scoring organizations have an effective approach (A) that is deployed throughout the organization with no impactful gaps (D), is based on reliable facts that foster innovation (L) and is well integrated and aligned with organizational needs and goals (I) (NIST, 2021).

According to SAMHSA's 2018 Report to Congress about the results of the CCBHC demonstration in other states, 21 quality measures are in the certification criteria

for CCBHCs (SAMHSA, 2018). The specific CCBHC sites are required to produce reports on nine of those measures using data from electronic health records (EHRs) or a variety of electronic administrative sources, and the state entity is expected to report on the other 12 measures using data from various sources to include Medicaid claims and encounters (SAMHSA, 2018). However, the report shares that states and CCBHC sites had to invest considerable time, training, and effort to ensure that CCBHCs had adequate data systems in place to meet the reporting requirements so that systems could talk to each other, and the reporting process can be streamlined (SAMHSA, 2018). Reportedly, 97% of the CCBHC sites in the 2018 report had to change their EHR systems, and 33% had to adopt new EHR systems to facilitate reliable reporting (SAMHSA, 2018). Many reporting challenges were related to a lack of familiarity with obtaining the necessary measures and variables (e.g., service codes) (SAMHSA, 2018). The same sentiment was shared in SAMHSA's 2021 Report to Congress, stating,

> Modifying data systems required considerable resources and staff time. State agencies played a critical role in providing technical assistance to help CCBHCs make these changes and, in some states, helped clinics link to external data systems. In contrast, calculating the state-reported measures generally did not require major changes to state data systems. (SAMHSA, 2021, pg. 16)

This shows that the challenges CCBHC sites faced in the 2018 report were still evident in the 2021 report, and they continued to require significant help from states.

Referencing Baldrige's approach, deployment, learning, and integration (ADLI) measures as a tool for assessing SSBHD's competitive environment/comparative data and

its ability to establish a performance improvement system for the proposed CCBHCs alongside the information in the SAMHSA's 2018 and 2021 report on the potential challenges with CCBHC demonstration in other states; it is safe to conclude that the SSBHD still has significant work ahead to fully certify and assess the effectiveness of the CCBHC model in its state. However, the SSBHD leadership team is aware of and planning to navigate the work needed so they, too, can become a CCBHC demonstration state. The ongoing strategic planning and work at hand for CCBHCs is evident in the BHL interviews. For example, BHLs shared that "we still have not talked about how to measure outcomes; those are tactical goals that require incremental implementation, so there is a range of possible dates to consider." Additionally, one of SSBHD's goals is around "CCBHC compliance [and] making sure that network adequacy is in place and that organizations that come into the CCBHC model are able to provide the service array across the expected areas." Furthermore,

> one of the approaches to creating [a tool] that is comprehensive is creating some standardization around thought processes and how we arrive at a model that creates equity within certification and has the ability to enhance or support diversity around how the CCBHCs work. From a rural perspective, making sure that we have allowances within that certification tool that support the communities that would ultimately benefit from that CCBHC because, as you know, the state has lots of different community diversity.

Another BHL stated,

> obviously, when you have a national program like this, you want to ensure that you're all capturing the same data in the same way, if at all possible. If you're not, you want to understand what those differences are so that you can make appropriate comparisons between services and between states…that is a major challenge for us. Our agency has another kind of internal reporting mechanism that we look at once a year for key performance indicators. In order to align that with the CCBHC work, some of the indicators that we were collecting needed to be changed to more closely align with the expectations for CCBHCs.

As the SSBHD continues to work toward certifying and establishing evidence-based ways to assess the work of CCBHCs, it is recommended that SSBHD consult the past SAMHSA CCBHC demonstration reports to congress to get ideas on how other states have approached quality reporting and quality improvement challenges. For example, the 2018 report shares those states worked with CCBHCs to

- Offer direct technical assistance to explain the measures needed to produce metrics,
- Provide them with examples for how to get information and create measures from their EHR data,
- Show them how to complete the reporting template,
- Collaborate with state Medicaid contacts to test the data collection from CCBHC to see if the data was missing or incorrect, and
- Perform various other data tests to problem-solve validation and quality assurance issues ahead of the reporting expectation deadlines (SAMHSA, 2018, 2021).

SAMHSA also advises states to remain flexible but have a standard of care across the state, aligning with the SSBHD's vision for CCBHCs in their state (SAMHSA, 2021). Additionally, the reports share a wealth of information about implementing technical assistance and possible ways to align CCBHC payment rates with costs to encourage competitive and quality care in CCBHC programs. The learning collaborative that the SSBHD and the budding CCBHCs already engage with is an innovative approach mentioned in these reports. The idea was birthed from the experiences of other states in the CCBHC demonstration program and their desire to form a coalition (the learning collaboratives) to help other CCBHCs navigate challenges in the process. Consulting past reports and continued participation in the learning collaboratives presents an opportunity for SSBHD to contribute to that collaboration and spark their own innovative ways to tackle the challenges of certifying CCBHCs in their state.

Recommendation 4: SSBHD's Divergence in Certification/Reimbursement Process

The SAMHSA grant for CCBHCs requires that certified CCBHCs be prepared to offer comprehensive BH care that integrates physical health services, outreach, screening, assessment, treatment, care coordination, and support for ongoing recovery from mental health and substance use disorders (SAMHSA, 2022). However, the grant criteria allow states/ potential CCBHCs to add services relevant to the needs assessment for their specific areas (SAMSHA, 2022). Hence, per the SSBHD data review, the SSBHD has elected to add services for individuals with comorbid diagnoses (e.g., BH and IDD). The data reveals that SSBHD's service mix veers from the service mix offered by other state CCBHCs. This divergence from SAMHSA's prescribed list of services makes

implementing a prospective payment system for the CCBHCs more challenging. Per the data collected for the study, another layer that makes the certification and reimbursement process more unique for the SSBHD is that its state does not participate in Medicaid expansion; therefore, added services not covered by existing Medicaid allowances or CCBHC grant funding require funding from other sources.

Per BHL interviews, the lack of Medicaid expansion benefits is particularly relevant to individuals who need CCBHC services but do not qualify for Medicaid and remain uninsured or underinsured (Garfield et al., 2021). The CCBHC certification expectation is that all who present to a CCBHC must be served, regardless of their ability to pay, so it is pertinent that the SSBHD and the budding CCBHC sites establish a reimbursement methodology that covers services to all who need them (SAMSHA, 2022). Additionally, per the sources of evidence, once the SSBHD works with CCBHC sites to establish a reimbursement rate, the SSBHD must get the prospective payment methodology approved by its state's Medicaid entity and incorporated in the State Plan Amendment before it is submitted to SAMHSA/Federal Medicaid entity for approval.

Although opting to participate in Medicaid expansion has no expiration date, it is a legislative decision involving many factors (Garfield et al., 2021). The Baldrige framework includes societal contributions criteria that score the strategic plans organizations have in place to contribute to society to better ensure equity, well-being, and overall community health (NIST, 2021). Therefore, it is recommended that the SSBHD participate in legislative actions to advocate for expanded Medicaid coverage for the good of the constituents in the state who fall below the poverty line yet earn too much

to qualify for Medicaid but need whole health services. In the meantime, the SSBHD must continue working towards filling the CCBHC reimbursement gaps. Therefore, it is also recommended that the SSBHD review other states with certified CCBHCs that do not participate in Medicaid expansion to get solutions. For example, other states without Medicaid expansion have worked to develop agreements to bridge the gaps in the cost-reporting methodologies of their CCBHCs' prospective payment systems with levels of care capitation that require service providers to submit semi-annual reports showing usage data for those with some Medicaid coverage, while 78% of other states have opted to offer treatment to the uninsured at no cost or on a sliding fee scale (Alguire, n.d.; SAMSHA, 2021; Texas Health and Humans Services, n.d.).

Recommendations for Future Studies

As of the writing of this study, not all of the potential CCBHCs in SSBHD's state had measures on the certification assessment tool, and none of them were fully certified. Therefore, the work to certify them was still underway, and the data on the CCBHC model's effectiveness in SSBHD's state was sparse because many sites were still in the initial phases of CCBHC development. Per an SSBHD BHL's response to whether there is a measure in place for CCBHC effectiveness,

> No, not yet, but [SSBHD] plans to collect data annually through core performance monitoring reports (PMR), still being developed. The Dept will start getting quarterly data from CCBHC sites, but for now, only basic programmatic data about progress is available. However, it is not thorough quality measures since it is still early in implementation.

A recommendation for a future study is evaluating how a behavioral health organization like SSBHD navigates the challenges presented during the certification of CCBHCs. Many CCBHCs nationwide are still in the planning phase, so future research into how state agencies navigate certification challenges and measure the effectiveness of the CCBHC model may yield exciting information and innovative approaches (National Council for Mental Wellbeing, n.d.).

Additionally, since there may be other challenges in navigating the requirements for a CCBHC prospective payment system approval from the SSBHD's state's Medicaid entity and SAMHSA that was not fully understood or presented in this study, future research can study how CCBHCs establish reimbursement rates in a prospective payment system that meets SAMHSA's, Medicaid's, and community service needs. Research into this aspect of CCBHC implementation is particularly interesting for CCBHCs in states that do not participate in Medicaid expansion (Garfield et al., 2021).

Plan to Disseminate Information to SSBHD

The BHLs of the CCBHC implementation project were gracious to allow research into their strategic planning steps for certifying the CCBHCs in their area. The information in this study serves as evidence of their planning efforts. The study will be shared with the CCBHC director, and her advice solicited for how else to disseminate the study’s contents to the other BHLs across the different work teams. An executive summary will be prepared and presented in a conference call with the BHL and committee chair.

Summary

This study started with my interest in sharing an industry solution for how to address the opioid epidemic and the increased need for behavioral health services across the nation (Fassbender et al., 2019; Hu et al., 2021; Implementation, 2020; NCBH, 2017; Scanlon & Hollenbeak, 2019). Additionally, the study touched on how the need for BH services was exacerbated during the COVID-19 pandemic as states nationwide struggled to meet the growing need for BH services that provided value and the potential for evidence-based service solutions (Brown, 2021; Hu et al., 2021). The national government and industry implementation of Certified Community Behavioral Health Clinics (CCBHCs) was an emerging approach that offered the hope of helping communities across the nation provide more integrated whole-health physical and BH services, particularly in the more rural communities with limited access to needed BH services (Hu et al., 2021; Implementation, 2020; NCBH, 2017). Therefore, this study used a single case study to evaluate a large state-operated BH organization's (the SSBHD) strategy for certifying CCBHCs in its state and helping them create a sustainable reimbursement rate. The Baldrige Excellence framework was used to evaluate the SSBHD's leadership strategy (Ford, 2022; NIST, 2021).

This study shows that the SSBHD had a solid strategy for certifying the new CCBHCs and helping them establish a future reimbursement rate. However, implementing their strategy was multifaceted because the certification and the creation of a reimbursement rate involved a vast array of analysis and many layers of organizational change. Different workgroups of subject matter experts were established and assigned

tasks to accomplish the analysis needed to fully determine what the potential CCBHC sites needed for full SAMHSA certification and to create a sustainable reimbursement rate. Two potential CCBHC sites had good initial results on the certification tool. However, as of the writing of this study, all of the sites still needed to be fully certified. They were still finalizing a prospective payment system to explain the reimbursement rate for their unique mix of services. Recommendations are offered for how the SSBHD's strategy can be more efficient, innovative, and sustainable.

References

Alguire, P.C. (n.d.). Understanding capitation. *American College of Physicians*. https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/understanding-capitation

Austin, Z., & Sutton, J. (2014). Qualitative research: Getting started. *The Canadian Journal of Hospital Pharmacy, 67*(6), 436–440. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4275140

Beji, R., Yousfi, O., Loukil, N., & Omri, A. (2021). Board diversity and corporate social responsibility: Empirical evidence from France. *Journal of Business Ethics*, *173*(1), 133–155. https://doi.org/10.1007/s10551-020-04522-4

Block, P. (2011). *Flawless consulting: A guide to getting your expertise used.* (3rd ed.) Pfeiffer.

Brown, T. R. (2021). Treating addiction in the clinic, not the courtroom: Using neuroscience and genetics to abandon the failed war on drugs. *Indian Law Review, 54*(29), 29–77.

Bryant, B. (2021). How behavioral providers can revamp recruitment, retention to ease workforce shortages. *Behavioral Health Business*. https://bhbusiness.com/2021/03/04/how-behavioral-providers-can-revamp-recruitment-retention-to-ease-workforce-shortages/

Caton, L., Yuan, M., Louie, D., Gallo, C., Abram, K., Palinkas, L., Brown, C. H., & McGovern, M. (2020). The prospects for sustaining evidence-based responses to

the US opioid epidemic: State leadership perspectives. *Substance Abuse Treatment, Prevention & Policy, 15*(1). https://doi.org/10.1186/s13011-020-00326-x

Connors, E. H., Douglas, S., Jensen-Doss, A., Landes, S. J., Lewis, C. C., McLeod, B. D., Stanick, C., & Lyon, A. R. (2021). What gets measured gets done: How mental health agencies can leverage measurement-based care for better patient care, clinician supports, and organizational goals. *Administration and Policy in Mental Health and Mental Health Services Research, 48*(2), 250-265. https://doi.org/10.1007/s10488-020-01063-w

Corestrengths. (n.d.). Assessments. https://www.corestrengths.com/products/assessment/

Daft, R. L. (2021). Organizations and organization design. In *Organization theory and design* (13th ed., pp. 2–43). Cengage Learning.

Davis, K. (2022). *Governance and societal responsibilities* [Unpublished manuscript]. Walden University.

DiNapoli, T. P. (2003). Local government management guide: Strategic planning. *Office of the New York State Comptroller*. https://www.osc.state.ny.us/files/local-government/publications/pdf/strategic_planning.pdf

Fassbender, L., Zander, G. B., & Levine, R.L. (2019). Beyond rescue, treatment, and prevention: Understanding the broader impact of the opioid epidemic at the state level. *American Journal of Managed Care, 25*(13 Suppl), S239-S240.

Ferrell, O. C., Hirt, G., & Ferrell, L. (2020). The dynamics of business and economics. In *Business foundations: A changing world* (12th ed., pp. 3–27). McGraw Hill.

Ford, M. W. (2022). Management standards and institutional influence: An exploratory study using the Baldrige criteria. *Quality Management Journal, 29*(1), 18-33. https://doi.org/10.1080/10686967.2021.2006585

Fortune Business Insights. (2021). *U.S behavioral health market size, share & COVID-19 impact analysis, by type (behavioral & mental health, substance abuse, eating disorders, trauma/PTSD, and others), by payor (public health insurance and private health insurance/out-of-pocket), forecast, 2021-2028*. https://www.fortunebusinessinsights.com/u-s-behavioral-health-market-105298

Garfield, R., Orgera, K., & Damico, A. (2022, January 21). *The coverage gap: Uninsured poor adults in states that do not expand Medicaid.* Kaiser Family Foundation (KFF). https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

Haan, K., & Watts, R. (2023, January 22). *Monday.com vs. Asana (2023 comparison)*. Forbes Advisor. https://www.forbes.com/advisor/business/monday-vs-asana/

Huang, W. (2022). Public service provision with a limited budget: Service design, privatization and subsidies. *Computers & Industrial Engineering, 172*(108374), 1–9 . https://doi.org/10.1016/j.cie.2022.108374

Hu, Y., Stanhope, V., Matthew, E. B., & Baslock, D. M. (2021). A brief report on certified community behavioral health clinics demonstration program. Social Work in Mental Health, 19(6), 534-541. doi: 10.1080/15332985.2021.1929663

Implementation and costs of the certified community behavioral health clinic demonstration. (2020). Health Services Research, 55, 100–101. https://doi.org/10.1111/1475-6773.13473

Jacobson, D. (2021). Our role in fostering employee engagement. GovLeaders.org. https://govleaders.org/employee-engagement.htm

Johnson, J. A., & Rossow, C. C. (2019). Health organizations: Theory, behavior, and development (2nd ed.). Jones & Bartlett.

Jones, E. B. (2018). Medication-assisted opioid treatment prescribers in federally qualified health centers: Capacity lags in rural areas. The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association, 34(1), 14–22. https://doi.org/10.1111/jrh.12260

Jones, T. M., Harrison, J. S., & Felps, W. (2018). How applying instrumental stakeholder theory can provide sustainable competitive advantage. Academy of Management Review, 43(3), 371–391. https://doi.org/10.5465/amr.2016.0111

Kekeya, J. (2021). Qualitative case study research design: the commonalities and differences between collective, intrinsic and instrumental case studies. Contemporary PNG Studies, 36, 28–37.

Kelly, E., Pasquarella, F. J., Davis, L., Hunt, A., Lee, S., Fairhurst, S., Giambone, L., Murch, L., Thorning, H., & Brekke, J. S. (2021). Managing substance use for clients with serious mental illnesses: Knowledge, attitude, and training challenges among outpatient behavioral health providers in California, Ohio, and New York.

Journal of Substance Abuse Treatment, 131. https://doi.org/10.1016/j.jsat.2021.108547

Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R. W., Tomoyasu, N., & Pincus, H. A. (2018). Measuring and improving the quality of mental health care: A global perspective. World psychiatry: Official Journal of the World Psychiatric Association (WPA), 17(1), 30–38. https://doi.org/10.1002/wps.20482

Kodet, J., Reese, R. J., Duncan, B. L., & Bohanske, R. T. (2019). Psychotherapy for depressed youth in poverty: Benchmarking outcomes in a public behavioral health setting. Psychotherapy, 56(2), 254–259. https://doi.org/10.1037/pst0000234

Kukartsev, V., Shutkina, E., Moiseeva, K., Korpacheva, L., & Kireev, T. (2022). Methods and Tools for Developing an Organization Development Strategy. 2022 IEEE International IOT, Electronics and Mechatronics Conference (IEMTRONICS), IOT, Electronics and Mechatronics Conference (IEMTRONICS), 2022 IEEE International, 1–8. https://doi.org/10.1109/IEMTRONICS55184.2022.9795707

Leslie, D. L., Ba, D. M., Agbese, E., Xing, X., & Liu, G. (2019). The economic burden of the opioid epidemic on states: The case of Medicaid. The American Journal of Managed Care, 25(13), S243–S249.

Liu, A & Rezk, P. (2023). Why state and local relationships matter to national prosperity: A case for economic collaboration. Brookings. https://www.brookings.edu/essay/why-state-and-local-relationships-matter-to-national-prosperity/#the-moment

Lloyd-Hazlett, J., Knight, C., Ogbeide, S., Trepal, H., & Blessing, N. (2020). Strengthening the Behavioral Health Workforce: Spotlight on PITCH. Professional Counselor, 10(3), 306–317.

Marnewick, C., & Marnewick, A. (2021). Digital intelligence: A must-have for project managers. Project and Leadership Society, 2, 1-12. https://doi.org/10.1016/j.plas.2021.100026

Mills, A. J., Durepos, G., & Wiebe, E. (2010). Encyclopedia of case study research (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412957397

Monday.com. (n.d.). So how did Monday.com come to be? https://monday.com/p/about/

Morse, G. A., & Dell, N. A. (2021). The well-being and perspectives of community-based behavioral health staff during the COVID-19 pandemic. Social Work in Health Care, 60(2), 117-130.

Muñoz, T. M. J., Fernández, I. M. Á., Rivera, L. J. M., & Escrig, O. E. (2019). Can environmental, social, and governance rating agencies favor business models that promote a more sustainable development? Corporate Social Responsibility & Environmental Management, 26(2), 439–452. https://doi.org/10.1002/csr.1695

National Alliance on Mental Illness (NAMI). (2016). Engagement: A new standard for mental health care. [PDF file]. https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care/NAMI_Engagement_Web

National Council for Behavioral Health. (2017). CCBHC demonstration: Early results show expanded access to care, increased scope of services. [PDF file].

https://www.thenationalcouncil.org/wp-content/uploads/2017/11/National-CCBHC-survey-write-up-FINAL-11-28-17.pdf

National Council for Behavioral Health. (2014, January). Core competencies for integrated behavioral health and primary care. [PDF file]. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Integration_Competencies_Final.pdf?daf=375ateTbd56

National Council for Mental Wellbeing. (2020). Hope for the future: CCBHCs expanding mental health and addiction treatment. [PDF file] https://www.nationalcouncildocs.net/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf

National Council for Mental Wellbeing. (n.d.). What is a CCBHC? https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/

National Institutes of Standards and Technology [NIST]. (2021). Baldrige performance excellence program: 2021-2022 Baldrige excellence framework (health care) proven leadership and management practices for high performance. [PDF file]. U.S. Department of Commerce. https://www.nist.gov/baldrige

Office of the Assistant Secretary for Planning and Evaluation. (2019). Certified community behavioral health clinics demonstration program: Report to congress, 2018. https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018

Padiyar, R. D. (2022). Exploring quality of citizen service delivery system in the state of Karnataka, India. Transforming Government: People, Process and Policy, 16(4), 582-594. DOI 10.1108/TG-05-2022-0062.

PatientTrak. (n.d.). 4 patient engagement strategies to support behavioral health patients. https://www.patienttrak.net/news/4-patient-engagement-strategies-to-support-behavioral-health-patients/

Plough, A. L. (2019). The opioid epidemic: The cost of services versus the costs for despair. American Journal of Managed Care, 25(13 Suppl), S237-S238.

Project Management Institute. (n.d.). What is project management? https://www.pmi.org/about/learn-about-pmi/what-is-project-management

Range, L. M. (2021). Case study methodologies. Salem Press Encyclopedia of Health.

Scanlon, D. P., & Hollenbeak, C. S. (2019). Preventing the next crisis: six critical questions about the opioid epidemic that need answers. American Journal of Managed Care, 25(13 Suppl), S232-S236.

Substance Abuse and Mental Health Services Administration. (2020). 2020 mental health national outcome measures. https://www.samhsa.gov/data/

Substance Abuse and Mental Health Services Administration. (2021a). About section 223. https://www.samhsa.gov/section-223/about

Substance Abuse and Mental Health Services Administration. (2022). Addressing burnout in the behavioral health workforce through organizational strategies. https://www.samhsa.gov/resource/ebp/addressing-burnout-behavioral-health-workforce-organizational-strategies

Substance Abuse and Mental Health Services Administration. (2022). Care coordination for certified community behavioral health clinics (CCBHCs). https://www.samhsa.gov/section-223/care-coordination

Substance Abuse and Mental Health Services Administration. (2022). Certified community behavioral health clinics (CCBHCs). https://www.samhsa.gov/certified-community-behavioral-health-clinics

Substance Abuse and Mental Health Services Administration. (2018). Certified community behavioral health clinics demonstration program: Report to Congress, 2018. [PDF file] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//191806/CCBHRptCong.pdf

Substance Abuse and Mental Health Services Administration. (2021). Certified community behavioral health clinics demonstration program: Report to Congress, 2021. [PDF file] https://aspe.hhs.gov/sites/default/files/documents/5a239c68e1111a1a4896001bc47fc6c7/ccbhc-report-congress-2021.pdf

Substance Abuse and Mental Health Services Administration. (2022, September 1). Certified community behavioral health clinic (CCBHC) - planning, development, and implementation grants. https://www.samhsa.gov/grants/grant-announcements/sm-22-002

Substance Abuse and Mental Health Services Administration. (n.d.). Criteria for the

demonstration program to improve community mental health centers and to establish certified community behavioral health clinics. [PDF file] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

Substance Abuse and Mental Health Services Administration. (2022). FY 2023 cooperative agreements for certified community behavioral health clinic planning grants. [PDF file] https://www.samhsa.gov/sites/default/files/grants/pdf/fy-23-ccbhc-planning-grants-nofo.pdf

Substance Abuse and Mental Health Services Administration. (2022). Interim strategic plan. [PDF file] https://www.samhsa.gov/sites/default/files/samhsa-interim-strategic-plan.pdf

Substance Abuse and Mental Health Services Administration. (2021b). SAMHSA awards $250 million to 100 certified community behavioral health centers to improve community substance use disorder and mental health treatment services. https://www.samhsa.gov/newsroom/press-announcements/202107291030

Substance Abuse and Mental Health Services Administration. (2015). State certification guide. [PDF file] https://www.samhsa.gov/sites/default/files/programs_campaigns/state-certification-guide.pdf

Suzuki, K., & Hur, H. (2020). Bureaucratic structures and organizational commitment: Findings from a comparative study of 20 European countries. Public Management Review, 22(6), 877-907. DOI: 10.1080/14719037.2019.1619813

Texas Health and Human Services. (n.d.). Provider finance department: Directed payment program for behavioral health services. https://pfd.hhs.texas.gov/acute-care/directed-payment-program-behavioral-health-services

U.S. Department of Health and Human Services (HHS). (2021). HIPAA for professionals. https://www.hhs.gov/hipaa/for-professionals/index.html

Walden University. (2014). Sources of data for research: A research primer. https://academicguides.waldenu.edu/ld.php?content_id=2927522

Winkelman, T. N. A., & Chang, V. W. (2018). Medicaid Expansion, Mental Health, and Access to Care among Childless Adults with and without Chronic Conditions. Journal of General Internal Medicine, 33(3), 376–383. https://doi.org/10.1007/s11606-017-4217-5

Appendix A: Semistructured Interview Prompts

Overarching Research Questions for CCBHC Director to Guide the Interview

1. What is the BHD's strategy for ascertaining if newly established CCBHCs are ready to operate per federal and state requirements?
2. What is BHD's approach to creating a certification tool to certify new CCBHCs?
3. What is needed to establish a specified reimbursement rate for the new CCBHCs?
4. How does BHD’s strategic approach compare to other states’ approaches to certifying CCBHCs?

Questions Specific for Coalition Workgroup Leaders to Guide Interviews

1. What are the strategic steps leadership uses to establish the certification tool?
2. What tools were reviewed in preparation for this specific certification process?
3. How will a helpful tool be developed?
4. What are the leadership's short-term and long-term goals for certifying the new CCBHCs?
5. How are those goals being tracked and reported on?
6. Who are the key stakeholders chosen by leadership?
7. Who are the people in the workgroups established to develop the tool?
8. Why did leadership choose them?
9. Are there any strategic leadership plans for aligning the tool with federal requirements