Certified Community Behavioral Health Clinics

State of Rhode Island Certification Guide

January 11, 2023

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INTRODUCTION

Overview of Certified Community Behavioral Health Clinics (CCBHC)

The Protecting Access to Medicare Act (PAMA) § 223 laid the groundwork for the establishment of Certified Community Behavioral Health Clinics (CCBHCs). In accordance with that legislation, in 2015 the Substance Abuse and Mental Health Services Administration (SAMHSA) published Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (the Criteria) as part of the Request for Applications (RFA) for Planning Grants. The RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is designated by SAMHSA as both the state mental health authority and the state substance abuse authority and is charged with administration and oversight of federal block grant and discretionary funding. BHDDH is also charged with the certification of select programs and services that are reimbursed by Medicaid including CCBHCs.

BHDDH received a planning grant in 2015 but was not awarded the two-year demonstration grant at the conclusion of the planning period. However, there was a continued appetite to lay the groundwork for implementation of CCBHCs as circumstances allowed.

SAMHSA subsequently awarded CCBHC expansion grants directly to community providers and four of the organizations designated by the Director of BHDDH as a community mental health center (CMHC) have received these awards, creating a critical mass of providers familiar with the CCBHC model.

Then, in 2021, the Executive Office of Health and Human Services/RI Medicaid worked with BHDDH, and the Department of Children, Youth, and Families (DCYF) to produce the Rhode Island Behavioral Health System Review, with our consultants Faulkner Consulting Group and Health Management Associates. As a part of that process, EOHHS requested that the consultants propose implementation plans, to meet the gaps in Rhode Island's behavioral health system that the report uncovered. The results were implementation plans for both CCBHCs and Mobile Crisis.

Over the next year, the CCBHC Interagency Team (EOHHS/RI Medicaid, BHDDH, and DCYF) worked with input from a group of community providers and advocates to build a CCBHC proposal. And in the State Fiscal Year 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS to submit a State Plan Amendment to CMS to establish CCBHCs in Rhode Island, according to the federal model. It also directed BHDDH to define the criteria to certify the clinics and, working in concert with EOHHS, to determined how many CCBHCs can be certified in FY 2024 and the costs for each one.

The CCBHC Interagency Team will continue to work together to create the CCBHC program, including certification, oversight, and evaluation. Together, we are pleased to share this State Certification Guide that will direct BHDDH's review of potential CCBHCs – leading to the creation of a transformational change in our behavioral health system for all Rhode Islanders.

Purpose of CCBHC State Certification Guide

This CCBHC Certification Guide is a tool used by the state of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to certify a set of providers to deliver services as a CCHBC in eight designated service or catchment areas depicted on the map on page 8. The tool is an adaptation of a template provided by the US Substance Abuse Mental Health Services Administrations and provides an overview of key criteria and program requirements established under The Protecting Access to Medicare Act (PAMA) § 223 to assess the qualifications of prospective CCBHCs. CCBHCs are required to reach standards in six different program areas:

1. Staffing
2. Availability and accessibility of services
3. Care coordination
4. Scope of services
5. Quality and other reporting
6. Organizational authority, governance, and accreditation

Those standards must be achieved across nine services:

1. Crisis Response
2. Screening, Evaluation and Diagnosis
3. Person-Centered and Family-Centered Treatment Planning
4. Outpatient Mental Health and Substance Use Disorder Services
5. Primary Care Screening and Monitoring
6. Peer and Family Support
7. Psychiatric Rehabilitation
8. Targeted Case Management
9. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

The following service enhancements will also be required:

- Screening for Hepatitis A, B and C and HIV
- Assertive Community Treatment (ACT)

The CCBHC will be required to provide these services in a manner that is appropriate for the population of their service area, for people with illnesses of every severity including people with serious emotional disturbance (SED), serious mental illness (SMI) and significant substance use disorders (SUD), and to all Rhode Islanders regardless their age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, correctional system involvement, housing status, or ability to pay.

CCBHCs are to specifically address the behavioral health and related needs of the following targeted populations: Adults with severe mental illnesses, children and youth with severe emotional disorders, and individuals with severe substance use disorder. These populations are referred to as “populations of focus” and are established by the federal government. Subsequent guidance will be made available on integration between the CCBHCs and the Family Care Community Partnerships

CCBHCs should also be able to demonstrate capacity to promote equity by identifying and addressing barriers to effective behavioral healthcare services that may be associated with access issues and health disparities identified by the state among the following populations or groups: Black, Indigenous, People of Color (BIPOC), people with co-occurring Behavioral Health/Intellectual or Developmental Disabilities, older adults, transition-age youth, and people who are LGBTQ+, justice involved, homeless, or from under-resourced communities. The state refers to the people in these groups as our "priority consumer population."

Any CCBHC will be authorized to provide ACT services either directly or through a Designated Collaborating Organization (DCO) contractual relationship. As with all other services, the CCBHC is ultimately clinically responsible for all care provided by a DCO. Additionally, CCBHCs will be required to adopt a minimum set of evidence-based practices.

The State is seeking to align all Mobile Crisis services as seamlessly as possible to ensure that we have one system of care; additional guidance is forthcoming as to how the existing children’s mobile crisis services will align with CCBHC mobile crisis services, and how CCBHCs will integrate with 988.

This guide describes requirements associated with each criteria, or standard, identified by SAMHSA in depth and how compliance with the standard can be demonstrated by the applicant. RI adapted the format and approach used by the state of Missouri to certify their CCBHCs. The criteria or standards are presented in a table with three columns. The first is the SAMHSA standard, verbatim, as it was published in the Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinic, and as such references to appendices do not apply to the RI CCBHC Certification Standards, but rather the original SAMHSA application. The middle, or second, column provides explanation or interpretation. The third describes how the applicant demonstrates compliance with the criteria or standard.

There are addenda that provide important information including detailed interpretation/explanation of a given standard; required services for high acuity populations,

DCOs, required staffing patterns for specific services, required tools/processes for screening assessment and diagnosis for high acuity populations, and required training and evidence-based practices. **The addenda are considered a core component of the certification standards and applicants will be accountable for demonstrating compliance with standards contained in the body of this guide based upon additional details provided in the appendices**. In addition to this guide, there is an application form that must be submitted by the applicant for the initial certification as well as for recertification. The application is designed to minimize burden on the applicant and provides a set of response categories for each standard that reflect the range of ways the standard can be met.

Eligibility to Apply to be Certified as a CCBHC

To be eligible to apply for certification as a CCBHC, the applicant must meet the following requirements:

1. Be licensed in RI as a behavioral healthcare organization (BHO) and within the scope of its license provides CCBHC required services or have a pending application for BHO licensure or request to add service(s) in process at the time of request for certification as a CCBHC. In addition, CCBHCs complying with children's behavioral health organizational licensure requirements, as applicable, when available.
2. Be a qualified Medicaid provider.
3. Be accredited by a nationally recognized accreditation body (The Joint Commission, Commission on Accreditation of Rehabilitation Facilities or Council on Accreditation) with standards specific to delivery of behavioral healthcare services for mental illness and substance use disorder or have a pending application submitted at the time of request for certification as a CCBHC.
4. Have a minimum 3 years of demonstrated experience providing evidence-based practices for people experiencing serious and persistent mental illness (SPMI), serious mental illness (SMI), and/or serious emotional disturbance (SED) or individuals with complex or severe substance use disorders, or a track record of providing person-centered, recovery oriented and trauma informed care.
5. Demonstrated experience and ability to directly provide the following two services for outpatient behavioral health care.
    a. Screening, assessment, and diagnosis, including risk assessment.
    b. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
6. Demonstrated experience and ability to directly provide (not only through a DCO arrangement) the following four services for outpatient behavioral health care.
    a. Crisis behavioral health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
    b. Screening, assessment, and diagnosis, including risk assessment.
    c. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
    d. Outpatient mental health and substance use services.

Catchment or Service Areas

CCBHCs shall be selected to serve eight (8) designated service areas as provided under Rhode Island General Laws section 40.1-8.5-1 et seq. that are currently the eight (8) service areas designated by BHDDH to the private nonprofit CMHCs. The terms catchment and service areas are used synonymously throughout this document.

1. 1. CCBHCs will be designated and certified by service area in accordance with Rhode Island General Laws section 40.1-8.5-1 et seq. Organizations with sites in multiple service areas will need to apply for each individual service area.
2. Applicants will need to meet all the CCBHC standards in each area for which they are applying.
3. Applicants must submit a separate application for each service area for which they are applying.
4. If a behavioral health provider organization providing services in a specific service area chooses NOT to apply to be certified as a CCBHC in that service area, they may either Contract with another CCBHC applicant serving the designated service area as a DCO, and therefore be included in the application of the partner CCBHC, OR Continue to be paid Fee-for-Service in accordance with existing contracts/agreements for services provided in that service area BHDDH intends to certify one CCBHC per service area unless the data indicate to BHDDH that there is an unmet need for additional services for either youth or adults in that area.
7. CCBHCs should have the ability to provide all required CCBHC services throughout the entire service area that the organization is applying to serve.
8. CCBHCs shall enter into DCO arrangements sufficient to meet the behavioral prevention and treatment and cultural competency and outreach needs in their designated service area. Other collaborative arrangements shall also be necessary, including for 988 services. CCBHCs shall be required to accept and maintain involuntary patients under Mental Health Court ordered Civil Court Outpatient Certifications within their service areas or have a DCO arrangement with a

behavioral health provider that can meet the specific level of care requirements for involuntary patients under court order outpatient treatment. This shall include having sufficiently qualified and available physicians and clinical staff to, when necessary, attend Mental Health Court for certifications, recertifications and reviews pursuant to Rhode Island General Laws section 40.1-5-1 et seq. CCBHCs shall also accept inpatient psychiatric hospital discharges with or without court ordered outpatient treatment, individuals with co-occurring intellectual and/or developmental disabilities, and all medically managed (ASAM 4.0) and medically monitored (ASAM 3.7) detoxification service discharges. Individuals seeking services will be free to select a CCBHC (and related DCO) of their choice and are not restricted to the one designated for their community of residence service area.

BHDDH's goal is to ensure that CCBHCs are ready to meet the needs of all of Rhode Islanders across the life course supported by needs assessment and ongoing evaluation data.

How will CCBHCs be Certified for SFY 2024?

BHDDH licensed behavioral health organizations who wish to be certified by BHDDH as CCBHCs will complete an application for certification. Through this application process they will demonstrate compliance with the six program areas detailed in the Protecting Access to Medicare Act (PAMA) of 2014 (PL 113-93). PAMA details 115 separate required standards.

Many components of these standards are already incorporated into BHDDH licensure requirements, and in the accreditation requirements of the Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). **See Addenda 2 for descriptions of the relevant accreditation bodies' program/service specific standards, endorsements or certifications.** As such, compliance with each standard may be demonstrated in one or a combination of the following ways:

1. Current RI Behavioral Health Organization (BHO) licensure [1]
2. Accreditation by CARF, TJC, or COA for relevant behavioral health programs or services.
3. Production of relevant documents for review and/or attestation related to complying with the standard.

In their CCBHC application, providers will demonstrate accreditation through the provision of the relevant documentation. For those criteria for which the provider cannot demonstrate full compliance with a given standard because of their licensure and/or accreditation, they will need to provide documentation, attestation, or other demonstration of compliance.

BHDDH anticipates putting forth a CCBHC application in early Spring 2023. The application will include criteria for certification and scoring and evaluation criteria. Upon receipt of the application, BHDDH will conduct a desk audit of the documentation provided and may request additional or clarifying information. If BHDDH deems the documentation to be complete, BHDDH will conduct an on-site audit. An on-site audit substantiates information provided at the time of application and uses additional vehicles to assess clinical quality such as case record reviews and interviews with staff, supervisors and consumers and evidence of fidelity to required evidence-based practices

Following the on-site audit, applicants will be determined as having achieved one of three designations:

1. **"Certified**" as meeting all the standards of a qualified CCBHC, eligible to participate in the CCBHC PPS program for a two-year period.
2. **"Contingent Certification"** as sufficiently meeting standards to participate in the CCBHC PPS program, with commitments to continue to address identified gaps within

[1] See Rules and Regulations for the Licensing of Organizations and Facilities Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals - Rhode Island Department of State (ri.gov); Rules and Regulations for Behavioral Healthcare Organizations - Rhode Island Department of State (ri.gov).

the six-month period of the Contingent Certification. At the end of the six-month Contingent Certification, providers will (dependent on their progress) be determined either Certified, Not Certified, or as receiving one additional six-month Contingent Certification period. At the end of the second six-month Contingent Certification period, providers will (dependent on their progress) be determined as either Certified or Not Certified.

3. **"Not Certified"** and required to make specified enhancements prior to participating in the CCBHC program.

Interim Review Period for Certified Entities and Recertification

There will be an interim review of CCBHC adherence to standards after initial certification. Technical assistance will be provided to improve compliance with standards in the event a CCBHC encounters implementation challenges.

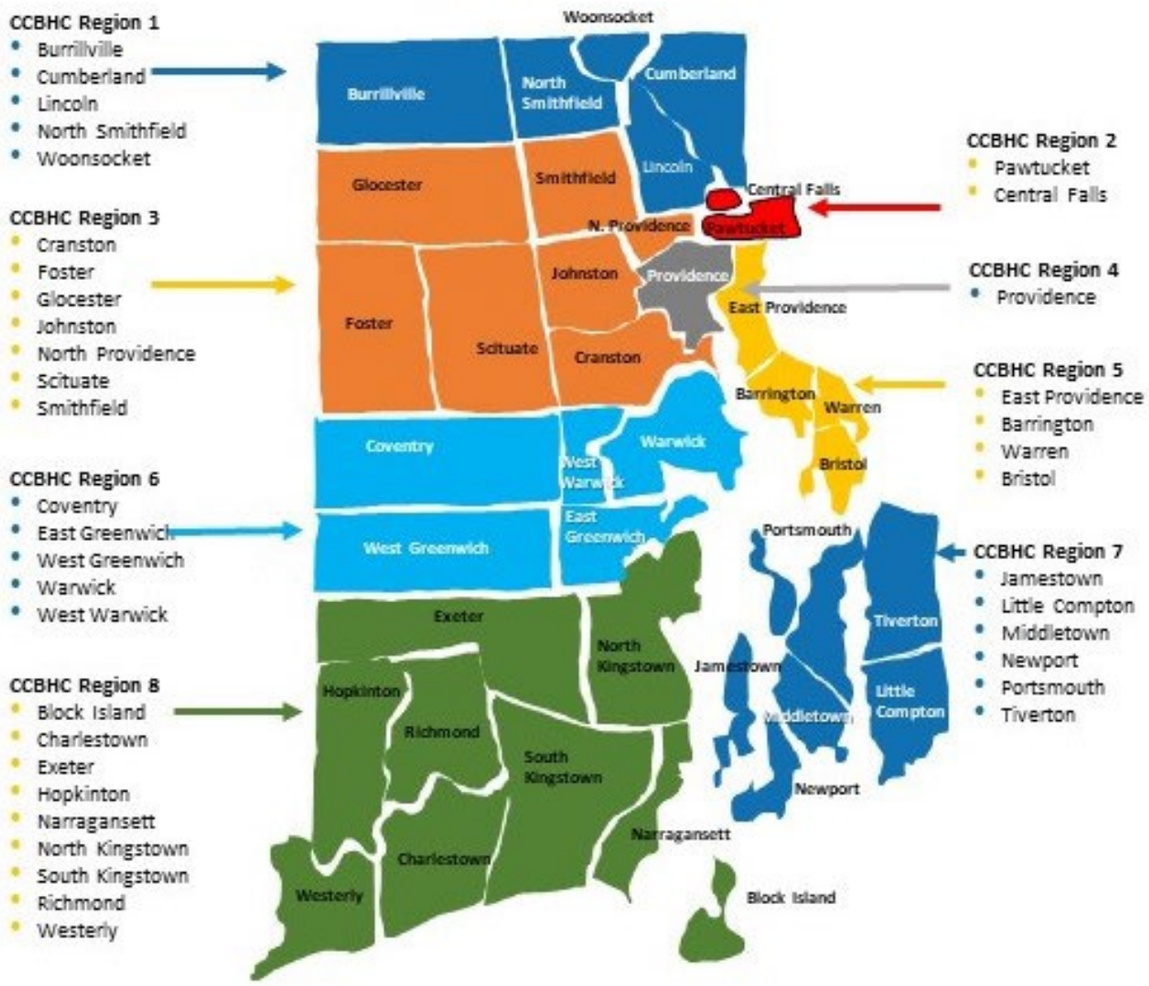
- Any entity who has Contingent Certification status will be required to demonstrate progress against specified deficiencies in accordance with an agreed upon project plan for the CCBHC to continue to be eligible to participate in the PPS payment model.

- Eventually, CCBHCs who have demonstrated that all the requirements have been fully met will be designated as "Certified."

- Certified entities would be subject to recertification every two years. Recertification will occur at the same time as licensing renewal, which is also required every two years.

- Agencies with a Contingent Certification status will be reviewed 6 months after their initial contingent certification and will be determined either Certified, Not Certified, or as receiving one additional six-month Contingent Certification period. At the end of the second six-month Contingent Certification period, providers will (dependent on their progress) be determined as either Certified or Not Certified.

State of Rhode Island CCBHC Regions



Section 1 - STAFFING

General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
1.a.1. As part of the process leading to certification**, the state will prepare an assessment of the needs of the target consumer population** and a staffing plan for prospective CCBHCs. The needs assessment will include cultural, linguistic and treatment needs. The needs assessment is performed prior to certification of the CCBHCs to inform staffing and services**. After certification, the CCBHC will update the needs assessment and the staffing plan, including both consumer and family/caregiver input. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years.**	The CCBHC will need to demonstrate that they have done a population-level assessment of the incidence and prevalence of different behavioral health conditions in their service area to design a program model that meets the needs of the community(ies) served by the CCBHC. *CCBHCs have a state approved needs assessment that addresses cultural, linguistic, treatment and staffing needs and resources of the area to be served, as well as transportation, income, culture and other barriers, and work-force shortages. Consumers and family members and relevant communities (e.g., ethnic, tribal) were consulted in a meaningful way to complete the needs assessment. There is recognition of the CCBHC's obligation to update the assessment at least every 3 years* TJC accreditation can be used to demonstrate partial compliance with this standard because it is not specific to the type of needs assessment or data needed to create the staffing pattern specific to the CCBHC. It is also not specific to the age of needs assessment. **TJC**: LD.03.06.03, EP 1-6,	1. The organization will provide a summary of needs assessment information including the following descriptions: A. The unique socio-demographic factors of their service area, how these factors are reflected in service delivery, and the organization's efforts to reduce health disparities experienced by relevant cultural and linguistic minorities. B. How behavioral health needs of SAMHSA's priority population will be addressed: SPMI, SED, and severe SUD, C. How needs of priority consumer population including Black, Indigenous, People of Color (BIPOC), people with co-occurring BH/IDD, older adults, transition-age youth, and people who are LGBTQ+, justice involved, homeless, or from under-resourced communities will be addressed. D. How health disparities identified by the needs assessment will be addressed in the policies and practices of the organization. 2. Please describe how many individuals did the organization proposed to serve for year 1 (as compared to the previous year) the cost report across the PPS categories. 3. A copy of the organizational chart (can be used to demonstrate compliance with 1.a.2). 4. A copy of the proposed staffing pattern (can be used to demonstrate compliance with 1.a.2). and identify including Qualified Mental Health Professionals (QMHPs) and identify their availability. 5. <u>For applicant without a completed community needs assessment</u> Provide an attestation that needs assessment or update will be completed within 1 year of certification.

Section 1 - STAFFING

General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
		For applicant with a current needs assessment: Provide an attestation that the organization commits to meeting standard 1.a..1 requiring a needs assessment be conducted every three years. *Please note that the organizational chart and proposed CCBHC staffing pattern only need be submitted once and may be used to satisfy demonstration of compliance to any standard for which it applies as part of the application process.*
1.a.2 The staff (both clinical and non-clinical) is appropriate for serving the consumer population in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer. **Note:** See criteria 4.K relating to required staffing of services for veterans.	***The CCBHC's behavioral health services and staffing are appropriate to meeting the needs of the following populations:*** 1. *Adults with severe, persistent mental illness and serious mental illness* 2. *Children and adolescents with serious emotional disorders* 3. *Children, adolescents, and adults with severe substance abuse disorders* 4. *Members of the Armed Forces and Veterans* 5. *General outpatient populations.* CARF, COA and TJC accreditation can be used to demonstrate partial compliance with this standard but lack specific detail needed to address all required services of a CCBHC. **CARF**: 1.I.1. 1.I.3. a & 1.I.9 a.-d. **COA**: HR 2 & MHSU 13 **TJC**: LD.03.06.01, EP 2,3	1. A copy of the organizational chart (fulfilled by 1.a.1). 2. A copy of the proposed staffing pattern (fulfilled by 1.a.1). 3. Accreditation issued by any of the following accreditation bodies related to the provision of behavioral health services: Commission on Accreditation of Rehabilitation Facilities/Behavioral Health Standards (CARF/BH), and/or Council on Accreditation/Services for Mental Health and/or Substance UseDisorders (MHSU), and/or The Joint Commission/Behavioral Health Care and Human Services Accreditation (TJC/BH). *Please note that the evidence of accreditation, endorsement or certification such as correspondence only need be submitted once and may be used to satisfy demonstration to any standard for which it applies or evidence of having applied for accreditation and pending status as part of the application process.*

Section 1 - STAFFING

General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	Licensure as BHO also provides partial demonstration of compliance with this CCBHC standard but the underlying regulation does provide the level of detail needed for each CCBHC required service. RI regulations describing adequate staffing to deliver services: 212-RICR- 10-10-1.4.3; 212-RICR-10-10-1.6.A.	
1.a.3 The Chief Executive Officer (CEO) of the CCBHC maintains a fully staffed management team as appropriate for the size and needs of the clinic as determined by the current needs assessment and staffing plan. The management team will include, at a minimum, a CEO or Executive Director/Project Director, and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO/Executive Director/Project Director and the Medical Director) may be held by the same person. The Medical Director will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated.	CARF, COA and TJC accreditation standards address the need to maintain a fully staffed management team appropriate to the services provided but don't provide information specific to what is required for the CCBHC. **CARF**: 1.A.1.a &b; 1.I.10. a-g; and 2.A.14. **COA:** GOV 8.01 & MHSU 7.01 **TJC**: LD.03.06.01, EP4 & 5. **Approval to fill medical director position with personnel other than a psychiatrist must be approved by BHDDH**. BHDDH will provide training for CCBHC management teams and new Medical Directors on the roles and responsibilities of a Medical Director through its training contracts. **See Addendum 1 for a sample job description for the CCBHC Medical Director.**	1. The organization has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 2. The current job description reflecting duties and responsibilities listed in application (See Addendum 1) including specific functions, and name, and credentials of the Medical Director, *Please note that the job descriptions related to CCBHC or DCO provided services only need be submitted once and may be used to satisfy demonstration for any standard for which it applies as part of the application process.*

Section 1 - STAFFING

General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
1.a.4 The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.	Successful awardees will be required to comply with state insurance requirements as part of contracting. CARF, COA and TJC accreditation standards address maintenance of proper insurance for staffing and scope of services and provide partial demonstration of compliance. None specifically address what is needed to satisfy the requirements of the RI Department of Administration (DOA). **CARF:** 1.G.2.a-c. **COA:** RPM 4.01 **TJC**: LD04.01.01, EP2 & LD.04.01.15, EP 1 Licensure as a BHO also provides partial demonstration of compliance but contracts issued for CCBHC will be reviewed by DOA and successful applicants will need to adhere to those requirements which are not specifically addressed in regulation. RI related regulations requiring malpractice and other insurance: 212-RICR-10-00-1,1.17.1.B.4.,a-d.	1. The organization is currently licensed as a Behavioral Health Organization by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 3. Attestation that the CCBHC will maintain relevant and required insurance during certification and notify BHDDH of any material changes. *Please note that BHDDH will be responsible for verifying licensure as a BHO and the scope of services authorized under it for any organization that applies to operate as a CCBHC and for any DCO proposed to deliver clinical services*

Licensure and Credentialing of Providers

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
1.b.1 All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC, are legally authorized	CCBHC's will need to be appropriately licensed by BHDDH to provide clinical services and also accredited by Joint Commission, CARF, or COA. (If not presently accredited, then	1. The organization or DCO is licensed as a behavioral health organization (BHO) by BHDDH for any clinical service proposed. 2. The organization has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH.

Licensure and Credentialing of Providers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
in accordance with federal, state and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers have and maintain all necessary state-required licenses, certifications, or other credentialing documentation, with providers working toward licensure, and appropriate supervision in accordance with applicable state law. **Note:** CCBHCs are not precluded by anything in this criterion from utilizing providers working towards licensure, provided they are working under the requisite supervision.	application to one of the accrediting bodies needs to be submitted prior to applying for CCBHC certification.) DCO staff must also be appropriately licensed, certified, registered and credentialed as required for the specific service they provide. DCO organizations do not have to accredited but must be licensed as a BHO to provide clinical services. A CCBHC can partner with a DCO that is licensed or certified to provide a Medicaid reimbursable service. There is no required process for state approval of the DCO itself, rather the DCO service delivery would be approved as part of the CCBHC application and certification process. **See Addendum 2 for Accreditation Bodies and Standards, Relevant Endorsements and Certifications for Behavioral Healthcare Services** **See Addendum 3 for Requirements for Designated Collaborating Organization (DCO) Providers** CARF and TJC accreditation address the requirement of having appropriate licensure, certification or accreditation as required by law and provide partial demonstration of compliance as they are not specific to requirements for the State of Rhode Island. CARF: 1.E.1.a., b., e., k.; 1.I.10.a-g. COA: RPM 1; RPM 10.01; RPM 10.02; RPM 10.03; RPM 10.04 TJC: HRM.01,01.03; EP 1-3; HRM 01.02.01, EP1 & 2; LD.04.01.01, EP2	3. Copy of accreditation document including any relevant endorsements or certifications or evidence of current applicancy. 4. Attestation that the organization's staff members, or contractors, who provide direct service possess appropriate licenses, certification or credentialling for the CCBHC and the DCO as required. .

Licensure and Credentialing of Providers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	Each applicant will have to demonstrate that the scope of services/programs covered by their license and their experience implementing those services and programs meet the standards. Licensure provides partial demonstration of compliance as additional review of services authorized under the license and applicant experience with providing the service will be required to establish full compliance with the standard. RI regulations related to licensure be required of organizations providing behavioral healthcare services for adults, children and families: 212-RICR 10-10.1.3.3. A & B and 212-RICR-10-10 1.4.1.A.	
1.b.2 The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state's initial needs assessment, and includes clinical and peer staff. In accordance with the staffing plan, the CCBHC maintains a core staff comprised of employed and,as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers' individual treatment plans and as required by program requirements 3 and 4 of these criteria. States specify which staff disciplines they will require as part of certification but must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders. The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists. Providers must include individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with	CARF and COA accreditation address the need for licensure, accreditation and certification as required by the state, but it is not specific to either RI's requirements or the specific certifications issued by BHDDH for services provided by a CCBHC and can only be used to demonstrate partial compliance and as such other documentation is needed to provide full compliance. CARF: 1.I.1.; 1.I.3.a; 1.I.7.a(1) and (2); 1.I.10a-g; 1.I.9.a-d; 2.A.14.; 2.A.22.a-g; 2.A.29.; 2.B.10.; and 2.E.5.c, COA: RPM 1; MHSU 6.05**;** MHSU 7.01**;** MHSU 13.01-13.08. TJC: HRM.01.01.03, EP 6; HRM.01.06.03.EP1 & 2. RI regulations related to proper staffing to deliver the services of a CCBHC are not specific enough to fully satisfy compliance with the standard. 212-RICR-10-10-1.4.3; 212-RICR-10-10-1.6 **See Addendum 4 – Required Staffing**	1. A staffing plan for each service delivered by the CCBHC, or by a DCO as allowed, detailing the positions and required credentials for each position and whether the position(s) are currently filled or vacant. 2. The organization will provide policy or procedure number, title, issuance or revision date or page numbers related to accessing needed specialized behavioral health services from other providers when current clinicians do not have the requisite expertise. *Please note that the applicant has the option of providing their full set of policies and procedures with their application and identifying the policy or procedure applicable to the specific CCBHC standard by policy or procedure number, title, issuance or revision date or page numbers associated with the relevant policy.*

Licensure and Credentialing of Providers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
serious emotional disturbance (SED) and adults with serious mental illness (SMI) and those with substance use disorders. Examples of staff the state might require include a combination of the following: (1) psychiatrists (including child, adolescent, and geriatric psychiatrists), (2) nurses trained to work with consumers across the lifespan, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) staff trained to provide family support, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff, as necessary given program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers. **Note:** Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part- time or as needed; (2) in CCBHC organizations comprised of multiple clinics, providers may be shared among clinics; and (3) CCBHCs may utilize telehealth/telemedicine and on-line services to alleviate shortages.		

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
1.c.1 The CCBHC has a training plan for all employed and contract staff, and for providers at DCOs who have contact with CCBHC consumers or their families, which satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training which may be required by the	All staff have annual training on cultural competency and trauma related issues/topics. Additional focused training on these topics must be provided to direct service staff.	1. The organization has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/ BH. 2. Policy or procedure numbers, titles, issuance or revision dates or page numbers for the following policies: 3. Staff on-boarding and initial trainings relevant to cultural competency.

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
state. Training must address cultural competence; person- centered and family-centered, recovery- oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration. This training, as well as training on the clinic's continuity of operations plan, occurs at orientation and thereafter at reasonable intervals as may be required by the state or accrediting agencies. At orientation and annually thereafter, the CCBHC provides training about: (1) risk assessment, suicide prevention and suicide response; (2) the roles of families and peers; and (3) such other trainings as may be required by the state or accrediting agency on an annual basis. Cultural competency training addresses diversity within the organization's service population and, to the extent active-duty military or veterans are being served, must include information related to military culture. Examples of cultural competency training and materials include, but are not limited to, those available through the website of the US Department of Health & Human Services (DHHS), the SAMHSA website through the website of the DHHS, Office of Minority Health, or through the website of the DHHS, Health Resources and Services Administration. **Note:** See criteria 4.K relating to cultural competency requirements in services for veterans. If necessary, trainings may be provided on-line.	The organization provides training or technical assistance to clinical and other staff that builds capacity to identify and address barriers to implementing effective behavioral healthcare services associated with access issues and health disparities identified by the state for our priority consumer populations, which are: Black, Indigenous, People of Color (BIPOC), people with co-occurring BH/IDD, older adults, transition-age youth, and people who are LGBTQ+, justice involved, homeless, or from under-resourced communities. DCOs are required to meet the same quality standards as CCBHCs, and CCBHCs have clinical, as well as fiscal, responsibility for the services provided by a DCO. Therefore, DCO staff who have contact with CCBHC consumers or their families should be subject to the same expectations regarding required training. However, CCBHCs should assure themselves that DCO staff are subject to appropriate training requirements. CARF, COA and TJC accreditation program standards provides evidence of partial compliance with this standard because CCBHC standard has specific requirements identified and those are not specifically addressed. **CARF**: 1.A.5.a.(1)-(3); b. (1)-(9); c-e; 1.I.5. a-e; 2.A.16.a-b and c (1)-(4); 2.A.22.a.-g; 2.A.31.a -b; 2.A.32.a-d; 2.B.4.e(1)(2) & 2.B.9.a-c. **COA:** HR 5; TS 1; TS 1.01; TS 2; TS 2.01-TS 2.09; MHSU 13; MHSU 13.04& MHSU 13.05	4. That require the CCBHC and all DCO provided services are trauma informed/responsive, person-centered, recovery based and culturally appropriate 5. Copy of the on-boarding and annual training plans for CCBHC and DCO staff. 6. A list of trainings implemented by the CCBHC including materials related to training on: ADA compliance, abuse and neglect reporting, disaster planning and infection control, the role of peers and military culture 7. Copy of the orientation training for new staff, including a list of topics included. 8. A copy of the plan for addressing the cultural and linguistic treatment needs of the population to be served and a plan to comply with the federal Culturally and Linguistically Appropriate Services (CLAS) standards 9. Contractual agreements with all DCOs that include a provision requiring that DCO staff having contact with CCBHC consumers, or their families are subject to the same training requirements as CCBHC staff.

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	TJC: CTS.02.02.05 EP 1; HRM 01.03.01 EP1 –3; HRM 01.05.01 EP 1, 4,15-16 & NPSG.15.01.01 EP5 Licensure as BHO provides partial demonstration of compliance. RI regulations related to training requirements associated with the delivery of behavioral health services that apply to BHOs do not address all of the specific requirements of the CCBHC standard: 212-RICR-10-00-1.20.3 B. 1.;.212-RICR-10-00-1.20.3 B. 3.; 212-RICR-10-10-1.4.2. D,E&F; 212-RICR-10-10-1.4.3; and 212-RICR-10-10-1.6.A.	
1.c.2 The CCBHC assess the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided during the previous 12 months.	CARF, COA and TJC accreditation address this issue but are not specific enough to demonstrate full compliance with the CCBHC standard or RI required trainings. These accreditations can be used to demonstrate partial compliance with the standard. **CARF**: 1.I.5.b; 1.I.7.a-f.; 2.A.21.a-f; 2.A.22.a.-g.; & 2.A.26.a-c. **COA:** HR 6.01; HR 6.02 & HR 7.01. **TJC**: HRM 01.05.01 EP 1; HRM 01.06.01 EP 1-8. RI regulations related to assessing workforce competencies including training specific to cultural competency and can be used to demonstrate partial compliance with the standard. Additional information on policies are needed to prove full compliance with the standard. 212-RICR-10-00-1.20.3 B. 1.; 212-RICR-10-00-1. 20.3 B. 3; 212-RICR-10-10-1.4.2.D, E& F.	1. The organization has one or more of following accreditations: CARF/BH and/or, COA/MHSU and/or TJC/BH. 2. CCBHC and/or DCO policy or procedure titles, numbers, dates of issuance or revision dates, and/or page numbers for assessing skills and competence of staff providing CCBHC required, age-appropriate services.

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
1.c.3 The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed.	CARF, COA and TJC accreditation program standards provide partial demonstration of compliance as they are not specific to CCBHC requirements at 1.c.1. **CARF**: 1.I.7.a-f.; 2.A.22.a.-g.; & 2.A.26.a-c. **COA:** HR 7.01 **TJC**: HRM 01.05.01 EP 1; HRM 01.06.01 EP 3 & 5 BHO licensure can also be used to demonstrate partial compliance with this CCBHC standards as they are not specific enough to meet the CCBHC requirements at 1.c.1. RI regulations related to maintaining personnel records that document training and demonstration of competency needed to deliver required services of a CCBHC: 212-RICR-10-00-1.20.3 B. 1.; 212-RICR-10-00-1. 20.3 B. 3	1. The organization has one or more of following accreditations: CARF/BH and/or, COA/MHSU and/or TJC/BH. 2. CCBHC and/or DCO policy or procedures titles, numbers, dates of issuance or revision dates, and/or page numbers concerning related to demonstration of cultural competency and training requirement completion in personnel records
1.c.4 Individuals providing staff training are qualified as evidenced by their education, training and experience.	CARF, COA and TJC accreditation address this issue and can be used for partial demonstration of compliance because there are specific requirements for training based on the CCBHC model that are not specifically addressed. CARF: 1.I.10.a-g COA: TS 2 TJC: HRM.01.01.01 EP1; HRM.01.06.01 EP2.	1. The organization has one or more of following accreditation CARF/BH and/or COA/MHSU and/or TJC/BH. 2. Organizations must submit a description of their training plans, including a list of topics included and the qualifications of trainers, as part of their CCBHC application. 3. List of policy or procedure numbers, titles, dates of issuance or revision, and/or page numbers related to qualifications of individuals providing staff training based on their education, training and experience.

Linguistic Competence and Confidentiality of Consumer Information		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
1.d.1 If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services.	CARF, COA and TJC accreditation address the issue of providing services for consumers in a language and manner understandable to them but are not sufficiently specific to demonstrate full compliance with the standard. **CARF**: 2.A.23.b. **COA:** CR 1.06 **TJC**: CTS 06.02.03, EP 9; RI 01.01.03, EP 2.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. List of policy or procedure numbers, titles, dates of issuance or revision, and/or page numbers that reflect compliance with the requirement to provides meaningful access to individuals experiencing Limited English Proficiency (LEP) or with language-based disabilities
1.d.2 Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.	COA accreditation does have the level of detail necessary to provide demonstration of compliance with the standard, necessitating additional documentation to meet the standard.: **COA**: CR 1.06 & MHSU 2 **TJC**: RI 01.01.03, EP 2	1. The organization is accredited by COA as a MHSU and/or TJC/BH. 2. The applicant must provide a detailed description of how interpretation and translation services are to be provided to consumers by the CCBHC and by the DCO for those services delivered by a DCO.
1.d.3 Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).	CARF COA and TJC accreditation address ADA compliance but additional documentation is needed to determine if the services available are appropriate for the populations identified in the CCBHC needs assessment.: **CARF**: 1.L.1.a-b. COA: CR 1.09 & CR 4.06. **TJC**: RI 01.01.03, EP3	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. List of policy or procedure numbers, titles, dates of issuance or revision, and/or page numbers that reflect to compliance requirements related to ADA for any service provided by a DCO not licensed by BHDDH as a BHO including but not limited to including auxiliary aids and services
1.d.4 Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats (for consumers with disabilities). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the needs assessment prepared prior to certification, and as updated.	The organization collects information on commonly spoken languages other than English in their service area and assesses appropriate literacy levels for any materials provided (including English). TJC accreditation addresses this issue but are subject to the same limitations notes above at 1.d.3. Additional information is required to demonstrate full compliance.: **TJC**: RI 01.01.03, EP 1-3.	1. The organization is accredited by TJC/BH. 2. List of policy or procedure numbers, titles, dates of issuance or revision, and/or page numbers that reflect compliance with this requirement related to the provision of written materials that account for different literacy levels and in languages other than English and/or additional formats.

Linguistic Competence and Confidentiality of Consumer Information		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
1.d.5 The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends, so long as the consumer consents or does not object. If a consumer is amenable and has the capacity to make health care decisions, health care providers may communicate with a consumer's family and friends.	CARF, COA and TJC accreditation address compliance with HIPAA and 42 CFR Part 2 but additional information in the way of policies and procedures is necessary to for full compliance due to the DCO relationships that will be required for the CCBHCs. **CARF**: 1.A.3.j.(1) and (2) 1.E.1. a-c.j; 1.E.3.a.-f.; 1.K.1. a-b. 2.A.24.h.-j. & 2.G.1.a-c **COA**: CR 2; CR 2.01-. CR 2.04 & S 2.02-2.03 **TJC**: IM 02.01.01, EP 1,3-4 & RI 01.02.01, EP 8. RI regulations related to training and policies on confidentiality and privacy rights including Health Insurance Portability and Accountability Act (HIPAA) and any applicable federal or state statutes: 212-RICR-10-10-1. 5.2. While these apply to licensed providers, CCBHC standards allow for DCO relationships and additional documentation in the form of policies and procedures is necessary to demonstrate full compliance with the standard.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. DCO agreements include language requiring compliance with applicable federal and state statutes and regulations related to confidentiality and privacy.

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES

General Requirements of Access and Availability

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
2.a.1 The CCBHC provides a safe, functional, clean, and welcoming environment, for consumers and staff, conducive to the provision of services identified in program requirement 4.	CARF, COA and TJC accreditation address environment of care and can be used to demonstrate full compliance with the standard. **CARF**: 1.H.1.	1. The CCBHC and/or DCOs are licensed as BHOs by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH.

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES

General Requirements of Access and Availability

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	COA: ASE 1& ASE 1.01-ASE 1.06. **TJC**: EC 02.01.01, EP 1, 3, 5, & 8; EC 02.06.01, EP 1, 4, 8, 9, 13, 19, 20, 24, 26; RI.01.006.05 EP1, EP9 RI regulations related to the accessibility of services and environment of care can be used to demonstrate full compliance with the standard. 212-RICR-10-00-1.22.A; RICR-10-10-1.4.4	
2.a.2 The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.	CARF, COA and TJC accreditation address this issue but is not specific to the outpatient clinical needs of a CCBHC and can only be used ot demonstrate partial compliance with the standard. Additional information on operating hour is necessary. **CARF**: 3.O.3.a.-c. **COA**: MHSU 5 & MHSU 6.01. **TJC**: CTS 01.01.01, EP 27.	1. The organization has one or more of following accreditations: CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization lists the location of services/programs that will be available, the times that they will be available including evening and weekend hours for the CCBHC service area. (This can also be used to satisfy 2.a.3.)
2.a.3 The CCBHC provides services at locations that ensure accessibility and meet the needs of the consumer population to be served	CARF, COA and TJC accreditation address this issue – see comments above at 2.a.2. **CARF**: 3.O.3. a.-c. **COA:** ASE 2.02. **TJC**: LD 04.01.11, EP 3. RI regulations related to accessibility of services for the population served: 212-RICR-10-00-1.22.A	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization lists the location of services/programs that will be available, the times that they will be available including evening and weekend hours for the CCBHC service area
2.a.4 To the extent possible within the state Medicaid program or other funding or programs, the CCBHC provides transportation or transportation vouchers for consumers.	The state Medicaid program contracts with transportation providers to deliver transportation to medically necessary services. CCBHCs are expected to assist individuals in accessing Medicaid funded transportation to medically necessary services as needed.	The organization provides the policy or procedure title, number, date of issuance or revision, and/or page numbers related to providing or arranging the provision of transportation for individuals needing to access clinical services.

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES

General Requirements of Access and Availability

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
2.a.5 To the extent possible within the state Medicaid program and as allowed by state law, CCBHCs utilize mobile in-home, telehealth/ telemedicine, and on-line treatment services to ensure consumers have access to all required services.	CCBHCs provide in-home services and support as appropriate. CCBHCs are expected to utilize telehealth/telemedicine as appropriate to improve efficient access to care and treatment. There is a presumption that there are CCBHC services that are to be provided in the community including mobile crisis; case management; care coordination; telehealth; outreach and engagement activities, and Individual Placement and Support services. CARF, COA and TJC accreditation address this issue but are not specific the applicable state Medicaid program and can only be used to demonstrate partial compliance with the standard. CARF 2.A.21.a-e COA: ICHH 1.06 & MHSU 6.05. TJC: LD.04.03.01 EP32. RI regulations related use of mobile in-home, telehealth/telemedicine and online services needed by consumers but are not specific to the CCBHC services and DCO relationships and can only be used to demonstrate partial compliance: 212-RICR-10-10-1.6.11B.3	1. The organization provides a description of the organization's use of mobile in-home, telehealth/telemedicine, and on-line treatment services. 2. Provide a copy of the policies or procedures related to services that are provided outside of the clinic including but not limited to ~~mob~~le crisis; case management; care coordination; telehealth; outreach and engagement activities, and provision of Individual Placement and Supports
2.a.6 The CCBHC engages in outreach and engagement activities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs.	1. The CCBHC must have staff dedicated to outreach and engagement who do not carry a caseload. 2. CCBHC must conduct activities to engage those individuals who are difficult to find and engage with an emphasis on special populations lists that is determined by BHDDH. This	1. The organization provides policies and/or procedures related to outreach and engagement activities to assist clients and families to access care and to address behavioral health conditions and needs. 2. The organization provides a description of special populations prioritized for outreach and engagement based on the needs

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES

General Requirements of Access and Availability

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	list would include individuals who are homeless; at risk individuals in communities of color; populations/communities disproportionately impacted by health disparities and inequities; recently incarcerated individuals with behavioral health conditions. 3. The CCBHC must have policies and procedures do describe how outreach and engagement activities will occur to assist clients and families to access care and to address behavioral health conditions and needs CARF, COA and TJC accreditation address this issue but not specific to the CCBHC and the specific outreach and engagement strategies necessary for high acuity populations and can only be used for demonstration of partial compliance. **CARF**: 2.A.10.a-e; 2.A.17.a-e; 2.A.18 & 2.A.19.a-b. **COA:** ICHH 4; ICHH 4.05; MHSU 6.05; MHSU 9: MHSU 9.04 & MHSU 10.01. **TJC**: LD.04.03.01 EP 35. RI regulation related to outreach and engagement of consumers are not specific enough, as described above and can only be used to demonstrate partial compliance: 212-RICR-10-10- 1.6.9. A.13; 212-RICR-10-10- 1.6.11.B.3.; 212-RICR-10-10-1.6.10.	assessment (see standard 1.a.1; information provided to demonstrate compliance with a.1.a may be used to satisfy this standard).
2.a.7 Services are subject to all state standards for the provision of both voluntary and court-ordered services	CARF, COA and TJC accreditation address this issue but are note specific to RI statutes and can only provide evidence of partial compliance. Additional documentation is necessary. **CARF**: 1.E.1.a.-j. **COA**: RPM 1.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. Indicate whether the organization currently has facility status with BHDDH or provide an attestation indicating that the organization has a pending application for facility status to provide court order

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES		
General Requirements of Access and Availability		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	TJC: LD 04.01.01, EP 2 & 3. RI regulation requires that facility status is required for court ordered outpatient treatment services. RI Regulation related to Qualified Mental Health Professionals: Qualified Mental Health Professional: 212-RICR-10-10-1.3.1 (A)(47) OTHER RELEVANT STATUTES AND REGS: Mental Health Law: R.I. Gen. Laws §40.1-5-1 et seq.*;* § 40.1-5-7(a). Emergency certification; Community Mental Health Services: R.I. Gen. Laws §40.1-8.5-1 et seq.	outpatient services, if the organization does not have facility status at the time of application. 3. The organization attests that it has trained staff with appropriate credentials to provide individuals who are ordered by the court to obtain substance use treatment subsequent to a Driving Under the Influence or Refusal charge. .
2.a.8 CCBHCs have in place a continuity of operations/disaster plan.	CARF, COA and TJC accreditation address this issue and can be used to demonstrate full compliance with this standard, by itself or in combination with BHO licensure. **CARF**: 1.H.5.a-c & 1.J.3.c. **COA**: ASE 7 & ASE 7.01-ASE 7.04 **TJC**: EM 02.01.01, EP 2, 4, 5, & 6. RI regulation related to the requirement of continuity of operations/disaster plans and licensure can be used to demonstrate full compliance with this standard by itself or in combination with licensure. 212-RICR-10-00-1.25.4; 212-RICR-10-10-1.6.14.A.11.c.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization is licensed by BHDDH as a BHO. If he DCO is not licensed by BHDDH as BHO, a copy of their policies (policy number and any revision dates) continuity of operations/disaster plan and infection control policies and procedures should be provided at the time of application.

Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
.**2.b.1** All new consumers requesting or being referred for behavioral health will, at the time of first contact, receive a preliminary screening and risk assessment to determine acuity of needs. That screening may occur telephonically. The preliminary screening will be followed by: (1) an initial evaluation, and (2) a comprehensive person-centered and family –centered diagnostic and treatment planning evaluation, with the components of each specified in program requirement 4. Each evaluation builds upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards: • If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. • If the screening identifies an urgent need, clinical services are provided and the initial evaluation completed within one business day of the time the request is made. • If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. • For those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed. Subject to more stringent state, federal or applicable accreditation standards, all new consumers will receive a more comprehensive person-centered and family-	1. This criterion describes a three-step process for assessing consumer needs. Subsequent criteria and reporting requirements further define these steps and indicate specific documentation requirements related to these screening and evaluation steps. 2. CCBHCs will determine whether the need for services is an emergency/crisis need, urgent, or routine, as well as the types of services required. 3. CCBHCs will monitor the number (#) and percentage (%) of individuals with: a. Urgent needs (e.g emergency/crisis) who began receiving required clinical services within 1 business day b. Routine needs who began receiving required clinical services within 10 business days 4. CCBHCs will complete a comprehensive screening on the same day the consumer presents to the clinic. a. CCBHCs will monitor the number of days from first request for services to completion of the comprehensive evaluation. 5. In part the intent of this criterion seems to be that when a crisis has been resolved without a face-to-face encounter then next contact with the individual involved should be face-to-face and the individual's need for services and level of risk assessed. Accreditation body program standards address timely access to services but do not meet the time requirements established for the CCBHC and only provide partial compliance with the standard. COA: MHSU 2' MHSU 2.01- MHSU 2.03; MHSU 3;	1. The organization attests that it will be capable of: A. Assessing and reporting the number (#) and percentage (%) of individuals requesting service who were determined to need urgent and routine care. B. Assessing and reporting the number and percentage of individuals with urgent needs who began receiving required clinical services within 1 business day, and the number and percentage of individuals with routine needs who began receiving required services within 10 business days. C. Reporting the mean number of days before comprehensive diagnostic and planning evaluations are completed. 2. The organization attests that following the resolution of a crisis, if the individual continues in treatment, the next contact with individual involved should be face-to-face, and the individual's need for services and level of risk reassessed. 3. The organization will provide documentation of the policies and practices that demonstrate ability to meet this provision.

Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
centered diagnostic and treatment evaluation to be completed within 60 days of the first request for services. This requirement that the comprehensive evaluation be completed within 60 calendar days does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment during the 60-day period. **Note**: Requirements for these screening and evaluations are specified in criteria 4 D.	MHSU 3.02- MHSU 3.08; CRI 6; CRI 6.01; CRI 6.02; MHSU 3.06 & MHSU 4.01. TJC: CTS.01.01.01. EP1, EP3-4; CTS .02.01.01. EP3; CTS 02.01.03. EP 10; LD.04.01.01 EP 2 RI regulation related to screening, an initial evaluation, comprehensive person-centered and family –centered diagnostic and treatment planning can be used for partial compliance due to different between state regulation related to the frequency of treatment plan review, which is longer than what is required of a CCBHC. Licensure can only be used for partial demonstration of compliance with the standard.: 212-RICR-10-10-1.6.1; 212-RICR-10-10-1.6.2; 212-RICR-10-10-1.6.7	
2.b2. The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 90 calendar days unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent.	1. The comprehensive evaluation is updated with the cooperation of the consumer when changes in the consumer's status, responses to treatment or goal achievement have occurred, and at least every 90 days 2. While engaging an individual PCP in updating the individual's comprehensive assessment is desirable, informing the individual's PCP of any changes in the comprehensive evaluation, including updates to the BHDDH approved functional assessment, and inviting feedback from the PCP, constitutes compliance with this requirement.	1. The organization attests that each individual's comprehensive evaluation is updated with the cooperation of the consumer when changes in the consumer's status, responses to treatment, or goal achievement have occurred, and at least every 90 days for individuals with moderate or more serious impairment as determined by an approved functional assessment (e.g. DLA 20 for adults and CANs for children/adolescents and ASAM for individuals with substance use disorder). 2. The organization attests that staff promote collaborative treatment planning by providing PCPs with all relevant assessment, evaluation and treatment plan information; seeking all relevant treatment and test results from PCPs; and inviting PCPs to participate in treatment planning.

Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2b 3 Outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs must be provided within 10 business days of the requested date for service, unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent. If an established consumer presents with an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. If an established consumer presents with an urgent need, clinical services are provided within one business day of the time the request is made.	1. CCBHCs will determine whether the need for service is an emergency urgent or routine, as well as the types of services required. 2. CCBHCs monitor the number (#) and percentage (%) of individuals with a. Urgent needs (emergency/crisis) who began receiving required clinical services within 1 business day, and b. Routine needs for began receiving required clinical services within 10 business days.	Demonstration of compliance for 2.b.1 can be used to demonstrate compliance for this standard or criteria.

Access To Crisis Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2.c.1 In accordance with the requirements of program requirement 4, the CCBHC provides crisis management services that are available and accessible 24-hours a day and delivered within three hours.	CCBHC Requirement: The CCBHC monitors, and is capable of reporting, the length of time from crisis contact to face-to-face interventions and takes steps to improve performance as necessary.	The organization attests that it is capable of monitoring and reporting length of time from crisis contact to face-to-face intervention as part of its CCBHC application
2.c.2 The methods for providing a continuum of crisis prevention, response, and post-intervention services are clearly described in the policies and procedures of the CCBHC and are available to the public.	CARF, COA and TJC accreditation address providing a continuum of crisis prevention, response and post-intervention but does not specifically address it in the context of a CCBHC or its' services and only provides partial demonstration of compliance. **CARF**: 2.A.20 & 2.B.8. d(1) (d) (vii). **COA:** CRI 1.01; CRI 6.03; MHSU 1; MHSU 1.01; MHSU 1.02; MHSU 4.02; MHSU 4.03; MHSU 4.05 &. MHSU 12. **TJC**: CTS.04.02.33 EP 1-6; NPSG.15.01.01 EP5.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization attests that policies and procedures clearly describes methods for providing a continuum of crisis prevention, response, and post-intervention services in manner accessible to the public. AND 3. Provides a link to the website where the information is posted.

Access To Crisis Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	RI regulation addressing crisis response can be used for partial demonstration of compliance: 212-RICR-10-10-1.6.7	
2.c.3 Individuals who are served by the CCBHC are educated about crisis management services and Psychiatric Advanced Directives and how to access crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1).	CARF, COA and TJC accreditation address the issue of crisis management and advanced directives but not with the specificity in standard 2.c.3 and only meet partial compliance with the standard. **CARF**: 2.B.8. d (1) (d); 2.B.8. d (3) & 2.C.4.a-d. **COA:** MHSU 2.01 & MHSU 4.05. **TJC**: CTS 01.04.01. EP 1&3; CTS 06.01.01, EP2-3; RI.01.01.03 EP1. RI regulation relevant to crisis management planning is not as specific as needed for this standard and only provides evidence of partial compliance. 212-RICR-10-10-1.6.7.A.3.b & c	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization provides CCBHC or DCO policies and procedures, number and titles, issuance or revision date related to accessing crisis management services and related topics covered at the time of initial evaluation.
2.c.4 In accordance with the requirements of program requirement 3, CCBHCs maintain a working relationship with local Emergency Departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.	CCBHCs policies and procedures specify the roles and responsibilities of CCBHC staff in serving CCBHC consumers who present in collaborating Emergency Departments. COA accreditation addresses relationships with EDs but not within the context of the CCBHC and the role of its staff and cannot be used to demonstrate compliance.: COA: CRI 5; CRI 5.01; CRI 5.02; ICHH 2.05; ICHH 4.05; MHSU 6.05; MHSU 9; MHSU 9.02 & MHSU 9.03.	The organization provide a list of the collaborating EDs and a brief description of the collaboration when an existing CCBHC consumer presents with a behavioral health crisis as part of their CCBHC application and relevant policies related to compliance with the criteria.

Access To Crisis Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2.c.5 Protocols, including protocols for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis. **Note:** See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.	COA and TJC accreditation address this issue, but the protocols would need to be specific to law enforcement within the communities served by the CCBHC and as such, cannot be used to demonstrate compliance with this standard. COA: CRI 5.01; CRI 5.02; CRI 6.01; ICHH 2.05 & MHSU 4.05. TJC: CTS.04.02.33 EP5.	The organization provides policy or procedure numbers or titles, dates of issuance or revision related to protocols, including protocols for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis.
2.c.6 Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family. **Note:** See criterion 3.a.4 where precautionary crisis planning is addressed	CARF, COA and TJC accreditation address crisis planning and can be used as partial demonstration of compliance if combined with relevant policies and procedures of the CCBHC. **CARF**: 2.C.4.a-d. COA: CRI 6.01; ICHH 2.05 & MHSU 4.05.**TJC**: CTS.04.02.33 EP6. RI regulation also addresses crisis planning and can be used in combination with accreditation and policies to demonstrate compliance: 212-RICR-10-10-1.6.10.A.1.m.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. Policy/procedure titles and numbers, date of issuance or revision or page numbers on how the CCBHC, in conjunction with the consumer, creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations. **Or** 3. An attestation that the policies or procedures comply with the standard.

No Refusal of Services Due to Inability to Pay		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2.d.1 The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).		Provide an attestation that (1) no one will be denied behavioral health care services, including but not limited to crisis management services, because of an inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).
2.d.2 The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such that the fee schedule will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to consumers and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities	The organization employs a standard means test and implements a sliding fee scale.	The organization provides a copy of the organization's sliding fee schedule is provided including how the information is made accessible for CCBHC consumers including for those with LEP or disabilities and any related policies and procedures related to applying the sliding fee scale.
2.d.3 The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.	The organization employs a standard means test. DCO is required to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO agreement and in compliance with CCBHC standards on access and regardless of place of residence and ability to pay.	The organization provides a copy of the fee schedule and any related policies and procedures related to applying the fee scale in compliance with the no cost-sharing requirement for Medicaid consumers.
2.d.4 The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.	The organization employs a standard means test. DCO is required to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO agreement and in compliance with CCBHC standards on access and regardless of place of residence and ability to pay.	The organization provides a copy of the sliding fee schedule and any policies and procedures related to applying the sliding fee scale.

Provision of Services Regardless of Residence		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2.e.1 The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence or homelessness or lack of a permanent address.	The organization's policies provide that no individual will be denied services due to place of residence or homelessness	The organization attests that it will not deny services to individuals who do not have a current permanent address.
2.e.2 CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.		The organization attests that it is prepared to address the needs of consumers who do not live within the CCBHC service ~~area~~. and will develop protocols by the time of certification.

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
3.a.1 Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high- quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. **Note:** See criteria 4.K relating to care coordination requirements for veterans.	CCBHCs will need to enter into collaboration and/or care coordination partnerships with key organizations/entities that provide services to the residents of their service area, including but not limited to: 9-8-8; the Veterans Administration and Veterans' serving organizations, law enforcement; Emergency Medical Services, local educational authorities; inpatient services; ambulatory and medical detoxification, stepdown or residential programs; Department of Corrections (probation and parole as well); community groups serving individuals and families from divers cultural, ethnic and racial background, District Court, Federally Qualified Health Centers and Accountable Entities, regional substance misuse prevention coalitions, and Health Equity Zones. CARF, COA and TJC accreditation address care coordination but due to the unique characteristics of the communities and the providers within the CCBHC is not specific enough for compliance with the standard.in **CARF**: 2.A.24.a-j; for Health Home 3.I.1.a-e; 3.I.3.a-b; 3.I.5.a-e & 3.I.7.a-c. **COA:** ICHH 3.01; ICHH 3.02; MHSU 4.02; MHSU 9; MHSU 9.02; MHSU 9.03 & MHSU 9.04. **TJC: CTS.04.02.35 EP2.**	1. The organization provides a copy of its policies, procedures and protocols related to care coordination.
3.a.2 The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy	CARF, COA and TJC accreditation address this issue and can be used to demonstrate full compliance with the standard by itself or in combination with licensure as a BHO.	1. The organization is licensed as a BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH.

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends. Health care providers may always listen to a consumer's family and friends. If a consumer consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a consumer's family and friends. Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care. Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships. If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.	**CARF**: 1.A.3.j(1)(2); 1.E.1.a-c, j: 1.E.3.a-f; 1.K.1.a-c; 2.A.24.g,i; 2.G.1.a-c & 2.G.4.b,t,u. **COA:** CR 2; CR 2.01; CR 2.02 - CR 2.05; RPM 6; RPM 7.02; RPM 7.03:RPM 8; RPM 8.01& RPM 8.03 **TJC**: IM 02.01.01, EP 1,3 & 4; IM 02.01.03, EP 1,2,5,6 & 7; RI 01.02.01, EP 4; RI.01.02.01 EP 1,2 & 8. RI regulation addressing compliance with federal and state confidentiality and privacy rights including those of minors address this issue and can be used to demonstrate full compliance with the standard by itself or in combination with accreditation: 212-RICR-10-10-1.5.2	3. The organization complies with all federal and state laws and regulations, for adults and/or minors that pertain to confidentiality, health care privacy and security including, but not limited to, HIPAA and 42 CFR Part 2.
3.a.3 Consistent with requirements of privacy, confidentiality, and consumer preference and need, the CCBHC assists consumers and families of children and youth, referred to external providers or resources, in obtaining an appointment and confirms the appointment was kept.		The organization's policies and procedures include a requirement that when an individual is referred to external providers or resources, staff confirm that the appointment was kept.
3.a.4 Care coordination activities are carried out in keeping with the consumer's preferences and needs for care and, to the extent possible and in accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer. So as to ascertain in advance	CARF, COA and TJC accreditation address consumer preference and family engagement and development of a crisis plan. However, organizational policies and procedures are still required to demonstrate full compliance. **CARF**: 2.B.13.a-e; 2.C.1.a-e; 2.C.4.a-d.	1. The organization has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 2. The organization provides policy or procedure titles, numbers, issuance or revision dates and/or page numbers related to: A. Crisis planning policies and protocols.

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
the consumer's preferences in the event of psychiatric or substance use crisis, CCBHCs develop a crisis plan with each consumer. Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan.	**COA: I**CHH 2.05; ICHH 3; ICHH 3.01; MHSU 4& MHSU 4.05 ,20,22 & RI 01.02.01 EP 1, 6, 7. **TJC**: CTS 01.04.01, EP1, EP 3 CTS 03.01.03 EP 1,4,6; RI 01.02.01, EP 1,2 & 8, RI regulation relevant to care coordination activities and advanced directives in combination with organization polices may be used to demonstrate full compliance with the standard.: 212-RICR-10-10- 1.6.9. A.13; 212-RICR-10-10-1.6.11.B.3.; 212-RICR-10-10-1.6.10	B. Care coordination policies and protocols.
3.a.5 Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and, upon appropriate consent to release of information, to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.	CARF, COA and TJC accreditation address but not at the level of detail needed for implementation of CCBHC, making provision of relevant policies and procedures necessary to demonstrate full compliance. **CARF**: 2.E.3.a-i & 2.E.7.a-g. **COA:** ICHH 4.07; ICHH 4.08; MHSU 7.01& MHSU 9. **TJC**: MM.01.01.01 EP 2; & NPSG 03.06.01, EP 1-5.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization provides policy/procedure titles and numbers, issuance or revision dates and/or page numbers related to obtaining consent and release of information needed for care coordination with other providers not affiliated with the CCBHC and the process for medication reconciliation
3.a.6 Nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose their provider with the CCBHC or its DCOs.	CARF, COA and TJC accreditation address freedom of choice but not specific to CCBHCs and DCOs and provide only partial compliance with the standard. **CARF** 1.K.1.e.(1) &(4) **COA:** CR 1 & CR 1.07. **TJC: CTS.06.01.17 EP 1.** CCBHC/DCO agreements provide for consumer freedom of choice.	1. The organization provides an attestation indicating that the CCBHC/DCO agreements include a provision regarding the consumer's freedom to choose their provider with the CCBHC or the DCO.

Care Coordination and Other Health Information Systems		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.b.1 The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by program requirement 5.	CCBHC's have the timely sharing of client information that supports multiple providers being able to access and document care plans progress including demographic and care information.	The organization attests that their information systems comply with these requirements as part of the application process.
3.b.2 The CCBHC uses its existing or newly established health IT system to conduct activities such as population health management, quality improvement, reducing disparities, and for research and outreach.	. .	The organization provides information on its' HIT system and its' capability to conduct activities such as population health management, quality improvement, reducing disparities, and for research and outreach AND attestation that it is in compliance with this standard.
3.b.3 If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 3.b.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security. CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's Health IT Certification Program.		The organization attests that their information systems comply with these requirements.

Care Coordination and Other Health Information Systems		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consumer consent, to comply with privacy and confidentiality requirements, including but not limited to those of HIPAA (Pub. L. No. 104- 191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	CARF, COA and TJC accreditation address obtaining consent from consumers and may be used, in combination with copies of consent forms or agreements to demonstrate compliance with this standard. **CARF** 1.E.1.a-j; 1.K.1.a-e; 2.G.1.a-c. **COA:** ICHH 1.03. **TJC** IM 02.01.01, EP 1,3&4; IM 02.01.03, EP1,2, 5,6 & 7.	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization provides copies of consent forms utilized for HIT from the organization and any DCOs and/or copies of agreements with DCO reflecting compliance with these criteria. 3. The organization attests that it will work with its DCO(s) to ensure that that the DCO(s) complies(y) with all federal and state laws and regulations for adults and/or minors that pertain to confidentiality, health care privacy and security including, but not limited to, HIPAA and 42 CFR Part 2.
3.b.5 Whether a CCBHC has an existing health IT system, or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care.		The organization provides a description of how their existing HIT system provides for care coordination between the CCBHC and any DCO and will provide a plan for improvements to EHRs within their HIT to improve transitions of care.

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.c.1 The CCBHC has an agreement establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For consumers who are served by other primary care providers, including but not limited	The intent of this criterion seems to be, in part, that all CCBHC consumers have access to health services and that the CCBHC coordinates care with each individuals PCP. <u>CCBHC Requirements:</u>	1. The organization provides agreements regarding care coordination from FQHCs serving CCBHC consumers; or identify that no FQHC/ Rural Health Clinics exist in the proposed service area. A. Explain the circumstances under which agreements were sought but have not been forthcoming.

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. **Note:** If an agreement cannot be established with a FQHC or, as applicable, an RHC (e.g., a provider does not exist in their service area), or cannot be established within the time frame of the demonstration project, justification is provided to the certifying body and contingency plans are established with other providers offering similar services (e.g., primary care, preventive services, other medical care services). **Note:** CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.	1. CCBHC's inquire whether the consumer has a Primary Care Provider (PCP), assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual's PCP. 2. Although FQHCs will often be, or be available to become, the PCP for CCBHC consumers, it is not necessary for all CCBHC consumers to have FQHC PCPs. Written agreements can be helpful in clarifying roles and responsibilities, and preventing gaps in coordination, and are, therefore, often desirable; but developing collaborative working relationships with PCPs is essential to care coordination. CCBHCs should, at least, seek informal care coordination agreements with FQHCs as appropriate. Prior to certification, CCBHCs should seek informal agreements (e.g., letters of support, agreement or commitment) regarding care coordination from FQHCs serving CCBHC consumers.	B. For any other primary care providers please provide care coordination protocols.
3.c.2 The CCBHC has an agreement establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to provide those services for CCBHC consumers. The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non- CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs,	Written agreements can be helpful in clarifying roles and responsibilities, and preventing gaps in coordination, and are, therefore, often desirable; but developing collaborative working relationships with PCPs is essential to care coordination. CCBHCs should, at least, seek informal agreements regarding care coordination with these programs <u>CCBHC Requirements</u>:	1. The organization provides copies of formal agreements with programs that provide inpatient psychiatric treatment, ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to promote care coordination. 2. The organization provides policies and procedures require that it makes, and documents, reasonable attempts to track admissions and discharges of non-Medicaid consumers to a variety of settings, and to provide appropriate transitions to safe community settings.

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
inpatient psychiatric, detoxification, and residential settings to a safe community setting. This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services. **Note:** For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided, and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.	The CCBHC establishes collaborative working relationships, and prior to certification seeks informal agreements, to promote care coordination with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs. CCBHCs have the ability, and are required, to track Medicaid hospital and emergency room admissions and discharges, and to transition individuals to a safe community setting, including active follow up after discharge, and as appropriate, a plan for suicide prevention and safety and provision of peer services. CCBHCs should make, and document, reasonable attempts to track admissions and discharges of other consumers and other settings and to provide appropriate transition to safe community settings. COA accreditation addresses this issue but is not specific enough to be used to demonstrate compliance with this standard. **COA:** ICHH 4.05. & ICHH 3.02.	

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.c.3 The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Services and supports to collaborate with which are identified by statute include: • Schools • Child welfare agencies • Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts) • Indian Health Service youth regional treatment centers • State licensed and nationally accredited child placing agencies for therapeutic foster care service; and • Other social and human services. The CCBHC has, to the extent necessary given the population served and the needs of individual consumers, an agreement with such other community or regional services, supports, and providers as may be necessary, such as the following: • Specialty providers of medications for treatment of opioid and alcohol dependence • Suicide/crisis hotlines and warmlines • Indian Health Service or other tribal programs • Homeless shelters • Housing agencies • Employment services systems • Services for older adults, such as Aging and Disability Resource Centers; and Other social and human services	CCBHC Requirements: The CCBHC establishes collaborative working relationships, and prior to certification seeks informal agreements, to promote care coordination with a variety of community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts), youth residential treatment centers, state licensed and nationally accredited child placing agencies for therapeutic foster care, and other social and human services. The CCBHC establishes collaborative working relationships, and prior to certification seeks informal agreements, with such other community or regional services, supports, and providers as may be necessary given the population served and the needs of individual consumers.	1. The organization provides a list of the community and regional services, supports and providers with which it has established agreements to promote care coordination. 2. The organization provides copies of formal or informal agreements (letters of support, etc.) regarding care coordination from key community and regional services, supports and providers; or explains the circumstances under which informal agreements were sought but have not been forthcoming. 3. The organization provides policies or procedures related to staff development of collaborative working relationships with community and regional services, supports, and providers, as may be necessary to meet the need of individual consumers. 4. The organization provides copies of MOU/MOA with the Veteran's Administration and other veteran serving organizations (3.c.4)

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
(e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs). **Note:** For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.		
3.c.4 The CCBHC has an agreement establishing care coordination expectations with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should explore care coordination agreements with facilities of each type. **Note:** For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.		1. The organization lists the community and regional services, supports and providers with which it has established collaborative relationships to promote care coordination. 2. The organization provides copies of formal or informal agreements (letters of support, etc.) regarding care coordination from key community and regional services, supports and providers; or explains the circumstances under which informal agreements were sought but have not been forthcoming. 3. The organization provides policy or procedure number, title, issuance or revision date and/or page numbers related to collaborative working relationships with Department of Veteran's Affairs and other veteran serving organization community and regional services, supports, and providers, as may be necessary to meet the need of individual consumers. 4. The organization provides copies of MOU/MOA with the Veteran's Administration and other veteran serving organizations.

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.c.5 The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. The agreement is such that the CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge. For all CCBHC consumers being discharged from such facilities who presented to the facilities as a potential suicide risk, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.**Note:** For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination	Written agreements can be helpful in clarifying roles and responsibilities, and preventing gaps in coordination, and are, therefore, often desirable; but developing collaborative working relationships with PCPs is essential to care coordination. CCBHCs should, at least, seek informal agreements regarding care coordination with these programs. CCBHC Requirement: The CCBHC establishes collaborative working relationships, and prior to certification seeks informal agreements, to promote care coordination with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC.	1. The organization lists inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities, ambulatory detoxification and providers of peer-based recovery support services/Recovery Community Centers with which it has established collaborative relationships to promote care coordination. 2. The organization provides copies of formal or informal agreements (letters of support, etc.) regarding care coordination with such programs; or explains the circumstances under which informal agreements were sought but have not been forthcoming. 3. The organization provides policy or procedure number, title, issuance or revision date or page numbers relating to efforts to make and document, reasonable attempts to follow up within 24 hours following hospital discharge.

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
whether the contingency plans are sufficient or require further efforts.		

Treatment Team, Treatment Planning and Care Coordination Activities		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.d.1 The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The HIPAA Privacy Rule does not cut off all communication between health care professionals and the families and friends of consumers. As long as the consumer consents, health care professionals covered by HIPAA may provide information to a consumer's family, friends, or anyone else identified by a consumer as involved in their care.	CARF, COA and TJC accreditation address engagement of the consumer's family in treatment planning and care coordination activities. They can be used to demonstrate partial compliance with this standard. **CARF** 1.E.1.a-c, j; 1.E.3.a-f; 1.K.1.a, b, d (1)(2),e; 2.B.11.a-d; 2.C.1.a(1)(2) & 2.G.1.a-c. **COA:** CR 2; ICHH 3; ICHH 4.02; MHSU 4; MHSU 4.08 & RPM 1. **TJC**: CTS 02.03.01, EP 1-4, CTS 03.01.01, EP 2 & 4; CTS 03.01.03, EP 1-6, 17-22, CTS 03.01.05, EP 1. RI regulation relevant to inclusion of people of the consumer's choosing in treatment planning and care coordination and as above, can be used to demonstrate partial compliance with the standard.: 212-RICR-10-10-1.6.3**;** 212-RICR-10-10- 1.6.11.B.3.; 212-RICR-10-10-1.6.10	1. The organization is licensed by as a BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides policy or procedure number, title, issuance or revision date or page numbers that reflect compliance with this standard.

3.d.2 As appropriate for the individual's needs, the CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native. **Note:** See criteria 4.K relating to required treatment planning services for veterans.	CARF, COA and TJC accreditation address care coordination delivered by a treatment team, but additional information is required to determine adequacy for the CCBHC consumer base. **CARF**: 2.A.23.a – e & 2.A.24.a-j. **COA:** ICHH 3.02 & ICHH 4.02; **TJC** CTS 03.01.01, EP 2 & 16. RI regulation relevant to care coordination responsibilities and activities: and similarly need additional information to demonstrate compliance with the standard. 212-RICR-10-10-1.6.3**.**	1. The organization is licensed as BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides a list of policy numbers, titles and issuance or revision dates that reflect compliance with this requirement.
3.d.3 The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan. **Note:** See program requirement 4 related to scope of service and person- centered and family-centered treatment planning.		The organization's contractual agreements with all DCOs provide that the CCBHC coordinates care and services by the DCO in accordance with the current treatment plan.

Section 4 - SCOPE OF SERVICES

General Service Provisions

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
4.a.1 CCBHCs are responsible for the provision of all care specified in PAMA, including, as more explicitly provided and more clearly defined below in criteria 4.B through 4.K, crisis services; screening, assessment and diagnosis; person-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the US Armed Forces and veterans. As provided in criteria 4.B through 4.K, many of these services may be provided either directly by the CCBHC or through formal relationships with other providers that are DCOs. **Whether directly supplied by the CCBHC or by a DCO, the CCBHC is ultimately clinically responsible for all care provided.** The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers. Despite this flexibility, it is expected CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs, as this will enhance the ability of the CCBHC to coordinate services. **Note:** See CMS PPS guidance regarding payment.	CCBHC Requirement: With the exception of 24-hour crisis line and mobile response team services which may be provided through a DCO contract with an accredited provider, CCBHCs must directly provide each of the nine services required by PAMA: 1. Crisis mental health services 2. Screening, assessment, and diagnosis including risk assessment 3. Patient-centered treatment, including risk assessment and crisis planning 4. Outpatient mental health and substance use services 5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk 6. Targeted case management 7. Psychiatric rehabilitation services 8. Peer support and counselor services and family supports 9. Intensive, community-based mental health care for members of the armed forces and veterans	1. The organization describes its' capacity to directly provide each of the required services as part of its CCBHC application; with the exception of mobile response team dispatch which is to be provided through a DCO contract with the state's sanctioned and contracted provider as well as the 24 hour crisis line, 2. The organization provides a list of all required services and describes those which are offered directly through the CCBHC, and which are provided by a DCO, as allowed by PAMA. 3. The organization provides a list of all MOU's or other agreements that pertain to referral arrangements for treatment, detailing expectations, conditions and time frame. 4. The organization's contracts with DCOs include all of the elements required to comply with the SAMHSA certification criteria. Within the scope of the DCO agreement with the CCBHC, DCO's will need to accept all referrals from the CCBHC evaluation including all payers and free care.

Section 4 - SCOPE OF SERVICES		
General Service Provisions		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	The following service enhancements will also be required: • Screening for Hepatitis A, B and C and HIV • Assertive Community Treatment (ACT) CCBHCs will necessarily contract with Designated Collaborating Organizations (DCOs) to provide some services and supports. This criterion indicates that CMS will hold CCBHCs responsible for assuring that the contracted DCO services and supports comply with all of the SAMHSA certification criteria, as well as other CMS requirements. CARF and COA accreditation address these issues but due to the unique relationships and provider networks in RI will not be accepted as demonstration of compliance. **CARF**: 1.E.1.a-l & 2.A.1.a-d. **COA:** ICHH 2; ICHH 2.02**;** ICHH 2.05**;** ICHH 3**;** ICHH 3.02**;** ICHH 4.05; ICHH 4.10; MHSU 3.07 & MHSU 4.02 TJC: CTS.04.02.35 EP5; LD.04.03.09 EP 1-8 & 10.	
4.a.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the consumer's freedom to choose providers within the CCBHC		The organization attests that consistent with consumer freedom of choice, the consumer may choose their provider within the CCBHC or the DCO.

Section 4 - SCOPE OF SERVICES		
General Service Provisions		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.		
4.a.3 With regard to either CCBHC or DCO services, consumers will have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities.		The organization attests that regarding either CCBHC or DCO services, consumers will have access to CCBHC's existing grievance procedures.
4.a.4 DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.		The organization attests that DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.
4.a.5 The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.		The organization attests that the entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

Person-Centered and Family-Centered Care		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.b.1 The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act, reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-	CARF, COA and TJC accreditation address this issue can only be used to demonstrate partial compliance. **CARF** 1. E.1.a. -I. & 2.A.10.a-e. **COA:** RPM 1; ICHH 1.01& MHSU 1/ **TJC** CTS 03.01.01, EP 2&4, CTS 03.01.03, EP 1-6, CTS 03.01.05, EP 1, & RI 01.02.01, EP1,3, 4,8, & 20	1. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The organization's contracts with DCOs include all the elements required to comply with the SAMHSA certification criteria.

Person-Centered and Family-Centered Care		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
direction of services received. Services for children and youth are family-centered, youth- guided, and developmentally appropriate. **Note:** See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.K relating specifically to requirements for services for veterans.	RI regulation relevant alignment of services to person and family centered plan and the consumer's needs and preferences address this issue but due to the use of DCOs, who are not specifically required to be licensed, can only be used to demonstrate partial compliance. : 212-RICR-10-10-1.6.3	
4.b.2 Person-centered and family-centered care includes care which recognizes the cultural and other needs of the individual. This includes but is not limited to services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.	CARF, COA and TCJ accreditation address this issue and can be used in combination with licensure to demonstrate full compliance, however additional documentation is needed to establish compliance by DCO's if they are not accredited. . **CARF:** 1.A.5.a-e; 2.A.23. a-c; 2.A.26.b.(7); 2.B.12.a-c; 2.B.12. a-c & 2.B.13.a-m. **COA:** ICHH 1.01 & MHSU 1. **TJC** CTS.03.01.03 EP 32 & RI 01.01.01, EP 4 & 6.	1. The organization is licensed as a BHO by BHDDH. **2.** The organization has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 3. The organization's contracts with DCOs include providers with demonstrated experience with the prominent cultural groups including those who have identified through the needs assessment process. 4. The organization attests that it, and any DCOs with whom agreements exists, provides person-centered and family-centered care that recognizes the cultural and other needs of the individuals and includes but is not limited to consumers who are American Indian or Alaska Native (AI/AN), whose preferences may include traditional medicine or approaches

Crisis Behavioral Health Services

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
4.c.1 Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state- sanctioned alternative acting as a DCO, available services must include the following: 1. 24-hour mobile crisis teams, • Emergency crisis intervention services, and • Crisis stabilization. PAMA requires provision of these three crisis behavioral health services. As part of the certification process, the states will clearly define each term as they are using it, but services provided must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification. States may elect to require the employment of peers on crisis teams. CCBHCs will have an established protocol specifying the role of law enforcement during the provision of crisis services. ~~Note~~**:** See program requirement 2 related to crisis prevention, response and post-intervention services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital or ED following a psychiatric crisis.	*The revised ASAM criteria list five levels of Withdrawal Management for Adults. It is a SAMHSA requirement that the CCBHC will have the first four available and accessible to the person experiencing a crisis at the time of the crisis.* Definitions: • "24-hour mobile crisis teams" are teams that provide mobile crisis response off-site from the CCBHC. • "Emergency services" means "crisis response services provided on-site at a CCBHC." • "Crisis stabilization" means "resolution of a crisis whether off-site by a mobile crisis response team or on-site at a CCBHC". **See Addendum 7 – Scope of Services** CCBHC Requirements: *The CCBHC provides* • *Directly, or through contract with a DCO, a 24-hour staffed hotline* • *Directly, or through contract with a DCO, 24-hour mobile crisis teams* • *Qualified Mental Health Professionals (QMHPs) to provide clinic-based and mobile crisis intervention services* *Children's mobile crisis services will need to meet DCYF emergency services certification requirements.*	1. The organization provides the following policies and procedures documenting inclusion of all elements of crisis services: A. Emergency crisis intervention; crisis stabilization; suicide crisis response (Zero Suicide model); services capable of addressing crises related to SUD, harm reduction materials to reduce the risks of overdose and all needs related to intoxication including ambulatory and medical detox. B. ~~Prov~~ision of 24-hour crisis line and 24-hour mobile crisis response teams, and emergency services by a QMHP, either directly provide by them or by contracts with a DCO. C. Roles and responsibilities of Community Mental Health Liaisons and local law enforcement. 2. The organization provides a list of which Crisis Behavioral Health Services it provides and those delivered by a DCO. 3. Copies of DCO agreements, as allowed, for crisis behavioral health services. 4. The organization provides an attestation that A. The organization directly provides ASAM Level1-WM services, including the medical staff trained to provide buprenorphine and other medications to assist with withdrawal B. The organization provides Level 2-WM services. C. The organization has referral relationship to access ASAM Level 3.2 (Social Setting Detox) services. D. The organization has a referral relationship to access ASAM Level 3.7 (Modified Medical Detox) services.

Crisis Behavioral Health Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	CCBHC crisis response policies and procedures specify the role of Community Mental Health Liaisons and local law enforcement. CARF and TJC accreditation address the written procedures for crisis intervention but are not specific enough for the range of Crisis Intervention services required and BHDDH is relying on other forms of documentation to demonstrate compliance.: Endorsements can be used to demonstrate program/service specific compliance. CARF 2.A.20.a-d.; Section 3.E. Crisis Intervention Program Standards COA: ICHH 2.05; ICHH 4.10; MHSU 6.04 & MHSU 6.05. TJC: CTS.04.05.35 EP 1, 2, 5 & 8.	Applicable endorsements that may be used to provide demonstration of compliance with components of this standard: • CARF: Call Center; Crisis Intervention; Detoxification/Withdrawal Management (Ambulatory) • COA: Crisis Response

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.d.1 The CCBHC directly provides screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neurological testing, developmental testing, and assessment, eating disorders), the CCBHC provides or refers them through formal relationships with other providers, or where	CARF, and TJC accreditation address the issue regarding referral to specialized services but need to be coupled with. licensure to demonstrate compliance with the standard. Policies are also requested to demonstrate full compliance. **CARF:** 2.B.4.a-e; 2.B.5; 2.B.6.a-b; 2.B.10. ; 2.B.11.a-d; 2.B.12. a-l &2; .B.13.a-u. **COA:** ICHH 2.06; MHSU 3.05 & MHSU 3.07. **TJC**: CTS,02.01.03 EP1 &3; CTS.02.02.01 EP 1-6; CTS .04.01.01, EP 5&6.	1. The organization is licensed as a BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides the policy or protocol pr the number or title, date of issuance or revision related to screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions, and process for referral where necessary for screening, assessment, or diagnosis.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
necessary and appropriate, through use of telehealth/telemedicine services. **Note:** See program requirement 3 regarding coordination of services and treatment planning.	RI regulation relevant to screening, assessment, and diagnosis for BH and referrals for other services outside the scope of BH: 212-RICR-10-10-1.6.1 (screening); 212-RICR-10-10-1.6.2 (assessment and diagnosis); 212-RICR-10-10-1.6.3 (treatment planning). **See Addendum 6 - Scope of Services for service descriptions.**	
4.d.2 Screening, assessment, and diagnosis are conducted in a time frame responsive to the individual consumer's needs and are of sufficient scope to assess the need for all services required to be provided by CCBHCs.	CARF, COA and TCJ accreditation address the issue of timeliness and responsiveness to consumer needs. However, they do not specifically cover the full scope of services provided by CCBHC or cover them in sufficient depth and can used be used to demonstrate partial compliance. To that end, additional documentation is required to demonstrate full compliance with the standard. **CARF:** 2.B.12.a-i. **COA:** ICHH 2.02. **TJC**: CTS 01.03.01EP 1& 2, CTS 02.01.03, EP 1-3, & CTS 04.01.01, EP 8. RI regulation relevant to timeliness screening, assessment, and diagnosis: 212-RICR-10-10-1.6.2. Licensure and adherence to the regulation can be used to demonstrate partial compliance. As noted above, additional documentation is required to demonstrate full compliance.	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides policy or procedure numbers, titles and issuance or revision dates that reflect compliance with this requirement
4.d.3 The initial evaluation (including information gathered as part of the preliminary screening and risk assessment), as required in program requirement 2, includes, at a minimum, (1) preliminary diagnoses; (2) the source of referral; (3) the reason for seeking	CARF, COA and TJC accreditation address many of these requirements but do not provide the specific time frames that are necessary to demonstrate full compliance and can only provide partial demonstration of compliance with the	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations: CARF/BH and/or COA/MHSU and/or TJC/BH 3. The organization attests that during initial evaluations a determination is made regarding whether the individual

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow- up as required); and (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services. As needed, releases of information are obtained.	standard. Additional documentation is necessary to demonstrate full compliance. **CARF**: 2.B.4.a-e: 2.B.13.a-u.& 2.G.1.a-c. **COA:** ICHH 2.02; ICHH 2.03; ICHH 2.03; MHSU 3; MHSU 3.04; MHSU 3.05 & MHSU 3.06. **TJC**: CTS 01.01.01, EP 1, 3 &4, CTS 01.03.01, EP 1&2, CTS 02.01.01, EP 1&2, CTS 02.01.03, EP 1-3, CTS 02.01.05, EP 2-6, CTS 02.02.01, EP 1-5, CTS 02.02.05, EP2-3, CTS.02.03.13 EP1; NPSG 03.06.01, EP 1-5 & NPSG .15.01.01 EP2 & 3. 1. An initial evaluation and care plan to be completed within 10 days of fist contact to meet presenting needs or other immediate or urgent needs 2. A full mental health assessment to be conducted within 30 days RI regulation relevant to the biopsychosocial assessment: 212-RICR-10-10-1.1.6.2, which addresses the component of assessment and indicates that it serves as the initial treatment plan for up to 30 days unless other requirements are designated for a specific program; assessment is be reviewed and updated. As is true above, the CCBHC standard requires adherence to specific timeframe	presently is, or ever has been a member of the U.S. Armed Forces; and this information is regularly reported to BHOLD and included in the individual's electronic health record. :
4.d.4 As required in program requirement 2, a comprehensive person- centered and family-centered diagnostic and treatment planning evaluation is completed within 60 days by licensed behavioral health professionals who, in conjunction with the consumer, are members of the treatment team, performing within their state's scope of practice. Information gathered as part of the preliminary screening and initial evaluation may be considered a part	.	1. The organization provides a list of policy or procedure numbers, titles and issuance or revision dates that reflect A. The Comprehensive Care Plan will be developed within 60 days. B. The Comprehensive Care Plan (which is person centered and recovery oriented) is reviewed within 3 months to determine if any changes are needed and

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
of the comprehensive evaluation. This requirement that the comprehensive evaluation be completed within 60 calendar days does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment during the intervening 60-day period.		C. The Comprehensive Care Plan is updated every 6 months. 2. The organization attests that it monitors and can report the length of time from preliminary screening to completion of a comprehensive assessment.
4.d.5 Although a comprehensive diagnostic and treatment planning evaluation is required for all CCBHC consumers, the extent of the evaluation will depend on the individual consumer and on existing state, federal, or applicable accreditation standards. As part of certification, states will establish the requirements for these evaluations; factors states should consider requiring include: (1) reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the consumer's presentation to the CCBHC; (2) a psychosocial evaluation including housing, vocational and educational status, family/caregiver and social support, legal issues, and insurance status; (3) behavioral health history (including trauma history and previous therapeutic interventions and hospitalizations); (3) a diagnostic assessment, including current mental status, mental health (including depression screening) and substance use disorders (including tobacco, alcohol, and other drugs); (4) assessment of imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate risks including threats from another person); (5) basic competency/cognitive impairment screening (including the consumer's ability to understand and participate in their own care); (6) a drug profile including the consumer's prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information on drug allergies; (7) a description of attitudes and behaviors, including	Use of a comprehensive diagnostic and treatment evaluation is addressed under the following accreditation body program standards and can be used in combination with licensure to demonstrate full compliance with the standard if coupled with an attestation to ensure that all elements related to the standard are met. CARF: 2.B.13. a-u, & 2.G.1.a-c or by COA: ICHH 2; ICHH 2.02 - ICHH 2.06: MHSU 2.02: MHSU 3.04; MHSU 3.05; MHSU 3.06 & MHSU 3.07. or by TJC: LD.04.04.01 EP2. RI regulation related to assessment and treatment planning: 212-RICR-10-10-1.1.6.2& 1.6.3 can be used in combination with accreditation and an attestation to demonstrate full compliance with the standard.	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization attests that all twelve (12) elements of the requirements of evaluation associated with standard/criteria 4.d.5 are met.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
cultural and environmental factors, that may affect the consumer's treatment plan; (8) the consumer's strengths, goals, and other factors to be considered in recovery planning; (9) pregnancy and parenting status; (10) assessment of need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services, LEP or linguistic services); (11) assessment of the social service needs of the consumer, with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate; and (12) depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk pursuant to criteria 4.G, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by criteria 4.G. All remaining necessary releases of information are obtained by this point.		
4.d.6 Screening and assessment by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated behavioral health screening or assessment and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.5 or Appendix A.	The SAMHSA Certification Criteria require that CCBHCs collect and record the following measures as part of the screening and assessment process: 1. BMI 2. Blood Pressure 3. Tobacco Use 4. Alcohol Use 5. Depression Screening for Adolescents (>12 yrs.) 6. Depression Screening using PHQ-9 for adults (>18 yrs.) 7. Complete metabolic screening for a. Adolescents on antipsychotic medication	1. The organization provides policy or procedure number, title, issuance or revision date and/or page numbers for the following screening requirements: A. Screens all adolescents (13 to 18 years of age) for depression. B. Screens all adults (19 years of age and older) for depression using the PHQ9 C. Assess all adults and adolescents who present a suicide risk for major depression.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	b. Adults with schizophrenia or bipolar disorder and diabetes who are on anti-psychotic medications 8. Assess adults and adolescents with suicide risk for major depression 9. A1c levels for adults with SMI and diabetes 10. LDL levels for individuals a. with schizophrenia or bipolar disorder who are on antipsychotic medications b. with schizophrenia and cardiovascular disease RI Enhancements: 1. Screening for Hepatitis A, B and C and HIV for populations at risk as defined by the US Preventive Services Task Force.	2. BHDDH to establish standards for primary care screening for ALL individuals served (or as explicitly limited to designated populations) such as: BMI screening and follow up; weight assessment and counseling for nutrition and physical activity for children and youth; tobacco use screening and cessation intervention; unhealthy alcohol and use of SBIRT; diabetes screening; dental care screening; vision care screening; and viral infections including Hep and HIV. 3. Attestation indicating that the organization uses primary care screening for all individuals served as described in "Explanation/Interpretation for criteria/standard 4.d.6 if not covered in organization policies and procedures from the organization.
4.d.7 The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques.	CCBHC Requirement: CCBHCs shall use age-appropriate functional assessment and screening tools. **See Addendum 5 for information on the diagnostic and functional assessments associated with the identification of high acuity populations.**	The organization provides a description of the specific functional assessments and screening tools it employs and how brief motivational interviewing techniques are utilized.
4.d.8 The CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.	COA and TJC accreditation address the use of culturally and linguistically appropriate tools and approaches to accommodate differently abled individuals and can be used to demonstrate full compliance when combined with licensure and provision of related policies. **COA:** CR 4; CR 4.03; CR 4.03; ICHH 2.04 & MHSU 3. **TJC**: RI 01.01.01, EP 6, RI 01.01.03 EP 1-3	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides a list of the screening tools used and the policy numbers, titles and issuance or revision dates that reflect compliance with this requirement.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	RI regulation regarding provision of culturally and linguistically appropriate services support use licensure to demonstrate full compliance when combined with and provision of related policies.: 212-RICR 10-00-212-1.17.1.A.1; RICR-10-10-1.1.4.2.D, E & F; 212-RICR-10-10-1.4.3; 212-RICR-10-10-1.6.2	
4.d.9 If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the consumer is provided or referred for a full assessment and treatment, if applicable.	CARF, COA and TCJ accreditation address the need for brief interventions when problematic use of substances is indicated and can be used to demonstrate full compliance when coupled with licensure and provision of policies. **CARF**: 2.B.6.(a) & (b) **COA**: ICHH 2.05**;** ICHH 2.06 **&** MHSU 2.02. **TJC**: CTS.01.03.01 EP2; CST 02.02.01, EP 3; CTS 02.03.07, EP 1,2 & 7; CTS.02.02.01 EP 1; CTS.04.01.01. EP 1 & 5. RI regulation relevant to referral for services and further assessment 212-RICR-10-10-1.6.2	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides a list of policy numbers, titles and issuance or revision dates that reflect compliance with this requirement.

Person-Centered and Family-Centered Treatment Planning		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**

4.e.1 The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. Person-centered and family- centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including consumer involvement and self-direction. **Note:** See program requirement 3 related to coordination of care and treatment planning.	CARF, COA and TJC accreditation address this issue. **CARF:** 2.C.4.a-d **COA:** ICHH 2.05**:** ICHH 3; MHSU 4; MHSU 4.0 **&** MHSU 4.05 TJC: CTS.03.01.03 EP 28. RI regulation regarding consumer and family involvement in treatment planning: 212-RICR-10-10-1.6.3	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides a list of policies or procedures or their titles, numbers and revision dates that demonstrate it has the capacity to directly provide person-centered and family-centered treatment planning, including but not limited to risk assessment and crisis planning, as part of its CCBHC application.
4.e.2 An individualized plan integrating prevention, medical and behavioral health needs and service delivery is developed by the CCBHC in collaboration with and endorsed by the consumer, the adult consumer's family to the extent the consumer so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan. **Note:** States may wish to access additional resources related to person- centered treatment planning found in the CMS Medicaid Home and Community Based Services regulations at 42 C.F.R. Part 441, Subpart M, or in the CMS Medicare Conditions of Participation for Community Mental Health Centers regulations at 42 C.F.R. Part 485.	CARF, COA and TJC accreditation address the issue of full engagement of the consumer, family members if the consumer so chooses and can be used when combined with BHO licensure and provision of applicable policy procedure information to demonstrate full compliance with the standard **CARF**: 2.C.1. a-e. **COA:** ICHH 3.01; ICHH 3.02 ;MHSU 4.01 & MHSU 4.02 **TJC:** CTS.03.01.03 EP 30. RI regulation addressing engagement of consumer, and family involvement and consumer preferences in treatment planning: 212-RICR-10-10-1.6.3.	1. The organization is licensed as a BHO by BHDDH/ 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides a list of policy or procedure numbers, titles and issuance or revision dates that document compliance with this standard. Additional endorsements to demonstrate compliance: • CARF Children and Adolescents and • Intensive Family Based Services.
4.e.3 The CCBHC uses consumer assessments to inform the treatment plan and services provided.	CARF, COA and TJC accreditation address this issue and can be used to demonstrate partial compliance with the standard. Licensure is also required. BHDDH is also requiring providing of information related to organizational policies to demonstrate full compliance with the standard. **CARF:** 2.B.14.a-c & 2.C.1.a-b. **COA:** ICHH 3.02 & MHSU 4.02. **TJC**: CTS .02.02.01 EP 1; CTS 03.01.01, EP 1.	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides copy of organizational policies and procedures including policy numbers, titles and issuance or revision dates related to use of consumer assessment in treatment planning and service provision.

4.e.4 Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the consumer's words or ideas and, when appropriate, those of the consumer's family/caregiver.	CARF, COA and TJC accreditation address this issue and can be used when combined with BHO licensure and provision of applicable policy procedure information to demonstrate full compliance with the standard. . **CARF**: 2.C.2. a- b. **COA**: ICHH 3.02; MHSU 4.01; MHSU 4.02 & RPM 7.06; MHSU 4.04; MHSU 4.06 & MHSU 4.07. **TJC**: CTS 03.01.01, EP 1-6. RI regulation addressing the use of strength based and consumer driven treatment planning: 212-RICR-10-10-1.6.3	1. The organization is licensed as BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. **3.** The organization provides copy of organizational policies and procedures including policy numbers, titles and issuance or revision dates related to inclusion of consumer needs, strengths, abilities, preferences, and goals in words of the consumer in treatment planning and service provision. Additional endorsements to demonstrate compliance: • CARF Children and Adolescents and • Intensive Family Based Services.
4.e.5 The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.	CARF, COA and TJC accreditation address this issue and can be used when combined with BHO licensure and provision of applicable policy procedure information to demonstrate full compliance with the standard. . **CARF**: 2.C.3. a-b. & 2.C.1. a. (1) (2)(3). **COA**: ICHH 3.02; ICHH 3.0; ICHH 3.04; MHSU 4.02; MHSU 4.04 & MHSU 4.06 -MHSU 4.08 **TJC**: CTS 03.01.01, EP 2 & 4; CTS.30.01.09 EP 1-4. RI regulation addressing shared decision making and monitoring progress towards goals in treatment planning: 212-RICR-10-10-1.6.2; 212-RICR-10-10-1.6.3	1. The organization is licensed as BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides organizational policies and procedures or policy numbers, titles and issuance or revision dates and/or page numbers related to this standard. Additional endorsements to demonstrate compliance: • CARF Children and Adolescents and • Intensive Family Based Services.

4.e.6 Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders).	COA and TJC accreditation address this issue and can be used when combined with BHO licensure and provision of applicable policy procedure information to demonstrate full compliance with the standard . **COA:** ICHH 2.06; ICHH 4; ICHH 4.02; ICHH 4.05; MHSU 3.05; MHSU 3.06 & MHSU 3.07. **TJC**: CTS.03.01.11 EP1-3; CTS.02.02.05 EP 1-6; CTS 03.01.07 EP 12. RI regulation addressing shared decision making and monitoring progress towards goals in treatment planning: 212-RICR-10-10-1.6.2; 212-RICR-10-10-1.6.3	1. The organization is licensed as BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides organizational policies and procedures or policy numbers, titles and issuance or revision dates and/or pages related to use of referral partners that provide treatment for clinical presentations and diagnoses outside the CCBHCs area of expertise (ex. eating disorders)
4.e.7 The treatment plan documents the consumer's advance wishes related to treatment and crisis management and, if the consumer does not wish to share their preferences, that decision is documented.	CARF, COA and TJC accreditation address this issue and can be used when combined with BHO licensure and provision of applicable policy procedure information to demonstrate full compliance with the standard. . **CARF**: 2.C.4. a.-d.; 1.K.1. a.- e. & 2.G.4.p. **COA**: ICHH 3.02; MHSU 4.07; RPM 7 & RPM 7.02. **TJC**: CTS 01.04.01, EP 1 & 3, RC 02.01.01, EP 4. RI regulation relevant to advanced directives related ot treatment and crisis management: 212-RICR-10-10-1.6.2; 212-RICR-10-10-1.6.3	1. The organization is licensed as BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides policies and procedures or policy numbers, titles and issuance or revision dates and or page numbers related to this standard.
4.e.8 Consistent with the criteria in 4.e.1 through 4.e.7, states should specify other aspects of consumer, person-centered and family-centered treatment planning they will require based upon the needs of the population served. Treatment planning components that states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports;		The organization provides policies and procedures or policy numbers, titles and issuance or revision dates and/or page numbers related to this standard.

recovery planning; safety planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, accommodations to ensure cultural and linguistically competent services).		

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.f.1 The CCBHC directly provides outpatient mental, and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area. **Note:** See also program requirement 3 regarding coordination of services and treatment planning.	CARF, COA and TJC accreditation address assuring that the organization makes needed services that it does not provide available through referral or other formal arrangement. Accreditation, including endorsements, combined with licensure provide partial evidence of compliance but additional documentation is required to demonstrate full compliance. In the case of a DCO without accreditation, licensure and provision of policies can be used to demonstrate full compliance. **CARF**: 2.A.5. **COA:** MHSU 6.02; ICHH 4.05; MHSU 6.02; MHSU 6.03 & MHSU 6.0. **TJC**: CTS .02.02.05 EP 2; CTS 04.01.01, EP 1,5 & 6; LD 04.04.09, EP 2. RI relevant regulations: 212-RICR-10-10-1.6.7A. & B.; 212-RICR-10-10-1.6.9; 212-RICR-10-10-1.1.6.12	1. The organization or the DCO is licensed as a BHO by BHDDH. 2. The organization or proposed DCO has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. Additional endorsements that could be used to demonstrate compliance: • CARF Intensive Family-Based Services (IFB) • CARF Intensive Outpatient Treatment (IOP) • CARF Outpatient Treatment (OT) • CARF Children and Adolescents (CA) 3. The organization documents that it directly provides outpatient mental health and substance use disorder services or identifies the DCO responsible for the service. 4. A list of organizations with whom there are referral arrangements. 5. A list of the organization's policies and procedure titles, numbers, dates of issuance or revision that require that it provides or makes available through formal arrangement traditional practices/treatments as appropriate for consumers served in the CCBHC area.
4.f.2 Based upon the findings of the needs assessment as required in program requirement 1, states must establish a minimum set of evidence- based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies[1]; recovery supports; first episode early intervention for psychosis; Multi- Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive	***CCBHC Requirement:*** *The CCBHC shall have staff trained to provide the following evidence-based, best, and promising practices. However, the cost report should include any other EBPs offered to address the needs across the lifespan identified during the course of the community needs assessment.: DCYF will review and approve any children's services EBPs (other than Teen ACT and DBT) that a CCBHC wants to implement.*	The organization's application includes: A. A description of its' ability to implement the required EBPs and such elements as relevant training and staff development and quality improvement initiatives. B. The organization describes how fidelity to required EBPs is assessed, or that it is committed to participating in training and technical assistance regarding the adoption of the required evidence based clinical practices and programs.

<table>
<tr><th colspan="3">Outpatient Mental Health and Substance Use Services</th></tr>
<tr><th>SAMHSA Criteria</th><th>Explanation/Interpretation</th><th>Documenting Compliance</th></tr>
<tr>
<td>Community Treatment (F-ACT); evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care). This list is not intended to be all inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.</td>
<td>Required Evidence Based Clinical Practices or Programs - All Populations (Adults and Children)
1. Motivational Interviewing/Motivational Enhancement Therapy
2. Cognitive Behavioral Therapy (CBT) Age/population appropriate
3. Coordinated Specialty Care (CSC) 16-25
4. Dialectical Behavioral Therapy (DBT)
5. Family Psychoeducation (FPE)/ Family to Family
6. Integrated Dual Diagnosis Treatment (IDDT)
7. Medication Treatment, Evaluation and Management (MedTEAM)
8. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
9. Trauma informed care (population and age appropriate)
10. Zero Suicide

Adult Required EBPs
11. Assertive Community Treatment (ACT)
12. Permanent Supportive Housing/Housing First (National Model)
13. Individual Placement and Support (IPS)
14. Medication Assisted Treatment (MAT)
a. For Opioid Use Disorder (2 out of 3 medication types)
b. For Alcohol Use Disorder
c. Nicotine Replacement Therapy
15. 12-Step Facilitation Therapy/Matrix Model

Children’s’ Required EBPs</td>
<td>C. A list of current Evidence Based Practices implemented for children and adults for all required services.
D. A plan and timetable for complying with required EBP training, coaching and fidelity; or an that one will be created and submitted before certification.
E. The organization provides a training calendar for EBPs
F. Organization describes how it will provide ongoing coaching in each of the EBP’s.
G. Provide a list of staff positions and credentials who are currently trained, who will be required to be trained upon certification and those will need to be trained later, with projected timelines for completion of training for all relevant staff.
H. Organization provides a list of other EBP’s that are utilized and the names of individuals who are trained in those clinical practices.
a. The names of employed or contracted physicians who have waivers from SAMHSA to prescribe buprenorphine for the treatment of opioid use disorder.
I. Description of how the organization employs a trauma informed/trauma responsive care approach.</td>
</tr>
</table>

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	16. Teen ACT **See Addendum 6** for detailed information concerning the required EBPs, type and percentage of staff who are required to be trained and by when.	
4.f.3 Treatments are provided that are appropriate for the consumer's phase of life and development, specifically considering what is appropriate for children, adolescents, transition age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. Specifically, when treating children and adolescents, CCHBCs provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver driven with respect to children and adolescents. When treating older adults, the individual consumer's desires, and functioning are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served.	CARF, COA and TJC accreditation addresses use of developmentally: appropriate treatment and can be used in combination with licensure and provision of related policies and procedures to demonstrate compliance with the standard. In the case of a DCO without accreditation, licensure and provision of policies can be used to demonstrate full compliance. **CARF** 2.B.13: 2.A.5; 1.I.7.; 1.I.10. & **For Children**: 5.C.1.; 5.I.1. & **For Older Adults**: 5.I.1. **COA:** MHSU 13.03 & MHSU 13.05; **TJC** CTS02.02.01, EP 2-6; CTS.02.03.03 EP 1-2; CTS.02.03.05 EP 1-8; CTS.04.01.03 EP 1-7; CTS 04.02.01 EP 1-5; HRM.01.06.05 EP 1-3; HRM.01.06.09 EP 1-7. RI regulation addressing developmentally appropriate treatment by professionals with specific, relevant training: 212-RICR-10-10-1.6.3	1. The organization is licensed as BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides policies and procedures including number, title and issuance/revision date related to staff training and the use of developmentally appropriate, evidence based clinical practices and programs.

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.f.4 Children and adolescents are treated using a family/caregiver- driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.	CARF, COA and TCJ accreditation address this issue and can be used in combination with licensure and provision of policy to demonstrate full compliance with the standard. In the case of a DCO without accreditation, licensure and provision of policies can be used to demonstrate full compliance. **CARF:** 5.C.1; 5.C.2. & 5.C.3. **COA:** MHSU 6.02; MHSU 6.03 & MHSU 10.01, **TJC** CTS 02.03.01, EP 1-4: CTS 02.03.03, EP 1-2; CTS 04.02.11, EP 1-2; CTS 04.02.15, EP 1-3; CTS 04.02.19. EP 1-9; CTS 04.02.21, EP 1-4.	1. The organization is licensed as BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. Additional endorsements that could be used to demonstrate compliance: • CARF Intensive Family-Based Services (IFB) • CARF Children and Adolescents (CA) 3. The organization provides policies and procedures, or those of a DCO if services are provided by the DCO, including number, title and issuance/revision date related to the treatment approaches used for children and adolescents.

Outpatient Clinic Primary Care Screening and Monitoring		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.g.1 The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs. The CCBHC ensures children receive age-appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age screening and preventive interventions. Prevention is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services. **Note:** See also program requirement 3 regarding coordination of services and treatment planning.	CCBHC Requirement: The SAMHSA Certification Criteria require that CCBHCs collect and record the following measures as part of the screening and assessment process: 1. BMI 2. Blood Pressure 3. Tobacco Use 4. Alcohol Use 5. Depression Screening for Adolescents (>12 yrs.) 6. PHQ-9 for adults (>18 yrs.) 7. Complete metabolic screening for a. Adolescents on antipsychotic medication b. Adults with schizophrenia or bipolar disorder and diabetes who are on anti-psychotic medications 8. Assess adults and adolescents with suicide risk for major depression 9. A1c levels for adults with SMI and diabetes 10. LDL levels for individuals a. with schizophrenia or bipolar disorder who are on antipsychotic medications b. with schizophrenia and cardiovascular disease RI Enhancements: 1. Screening for Hepatitis A, B and C and HIV for populations at risk as defined by the US Preventive Services Task Force.	1. The organization is licensed as BHO by BHDDH. **And/or** 2. The has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. Additional endorsements or certifications that may be used to demonstrate compliance: • CARF Health Home (HH) Endorsement • COA Integrated Care Health Home • TJC Behavioral Health Home Certification OR 3. The organization attests that it is responsible for outpatient primary care screening and monitoring of key health indicators and health risk as described in 4.g.1 "Explanation/Interpretation."

Outpatient Clinic Primary Care Screening and Monitoring		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	CARF, COA and TCJ accreditation address this issue and can be used to demonstrate partial compliance. Licensure as a BHO is not required for the service. Accreditation is not required for a DCO if a DCO is proposed for this service. BHDDH is requiring the submission of staffing pattern and attestation if a DCO is proposed without BHO licensure or accreditation. **CARF:** For Outpatient Behavioral Health Settings related to screening and monitoring of key health indicators 2.B.13.; for Health Home programs: 3.I.5. **COA:** ICHH 2.02; ICHH 2.04; ICHH 2.06; ICHH 4; MHSU 2.01 & MHSU 7.01. **TJC**: CTS.02.01.08 EP 1, 3 & 4; CTS;02.01.06 EP 1,3, 4-5; CTS.02.02.07 EP 1 & 2; CTS.04.02.19 Ep 1-9; CTS.04.02.21 EP 1-4. RI regulation relevant to this issue: 212-RICR-10-10-1.6.3; 212-RICR-10-10-1.6.10; 212-RICR-10-10-1.6.11. A.2 &3.	

Targeted Case Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.h.1 The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states should specify the scope of other targeted		The organization will provide a description of how it will provide case management services based upon their need to all CCBHC individuals who receive services and the process used to identify consumers eligible for Targeted Case Management. Applicable endorsements from accreditation bodies that can be used to demonstrate compliance: • CARF Case Management (CM) • COA Case Management

case management services that will be required, and the specific populations for which they are intended.		

Psychiatric Rehabilitation Services

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
4.i.1 The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services. States should specify which evidence- based and other psychiatric rehabilitation services they will require based upon the needs of the population served. Psychiatric rehabilitation services that might be considered include medication education; self- management; training in personal care skills; individual and family/caregiver psychoeducation; community integration services; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education. States also may wish to require the provision of supported services such as housing, employment, and education, the latter in collaboration with local school systems. **Note:** See program requirement 3 regarding coordination of services and treatment planning.	CCBHC Requirement: CCBHCs must be provide Psychiatric Rehabilitation services, as appropriate, to children, adolescents and adults including: 1. Community Psychiatric Supportive Treatment Services 2. PSR Assessments/Treatment Planning /Care Coordination 3. Community Psychosocial Rehabilitation Services 4. Independent Living Services (activities of daily living) 5. Social and Interpersonal Relationships and supported Leisure Time Activities (structuring of time) 6. Vocational Rehabilitation: 7. Supportive Educational Services (including English as a Second Language Support) 8. IPS Services	1. The organization is licensed as BHO by BHDDH and provides psychiatric rehabilitation services to children, adolescents, and adults within the scope of its' license. 2. COA accreditation/endorsement specific to Psychiatric Rehabilitation Services (PSR). 3. The organization provides a policy and procedures including title, number issuance or revision date related to provision of psychiatric rehabilitation services.

Peer Supports, Peer Counseling, and Family/Caregiver Supports		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.j.1 The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. States should specify the scope of peer and family services they will require based upon the needs of the population served. Peer services that might be considered include peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services. Potential family/caregiver support services that might be considered include family/caregiver psychoeducation, parent training, and family-to-family/caregiver support services. **Note:** See program requirement 3 regarding coordination of services and treatment planning.	The CCBHC employs certified peer recovery specialists with a credential issued by the RI Certification Board and/or has a DCO contract, or a referral relationship, with a Recovery Community Center to provide recovery supports services RI BHDDH certifies providers of Peer Based Recovery Support Services on behalf of RI Medicaid. The RI Certification Board credentials peers and has a Certified Peer Recovery Specialist credential which is required for Medicaid reimbursement under the state waiver. Non-certified providers and non-credentialed peers may provide outreach and engagement services.	1. The organization/entity is certified by BHDDH on behalf of Medicaid to provide Peer Based Recovery Support Services (PRBSS) as demonstrated by the letter from the Department issuing its' certification. 2. Provide job descriptions, names and credentials for Certified Peer Recovery Specialists and family/youth support partners employed by the organization. **or** 3. A plan, including the description of how peer supervision will be addressed, to become a certified provider for any CCBHC or DCO proposed that is not current certified to provide PBRSS.

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.k.1 The CCBHC is responsible for intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically, in criteria 4.K, are designed to assist CCBHCs in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook. **Note:** See program requirement 3 regarding coordination of services and treatment planning.	COA accreditation covers the quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook: CR 1.05; MHSU 1.01; MHSU 5.04 & MHSU 6.02. – these are more generic screening, assessment, treatment planning items. Military status is a standard part of the screening and assessment process. The VA is less than an hour from most locations in RI.	The organization is required to attest that it will follow all SAMHSA criteria related to provision of intensive, community based mental health care for members of the Armed Forces and Veterans.as described in 4.k.1.
4.K.2. All individuals inquiring about services are asked whether they have ever served in the U.S. military. .	CCBHC Requirement: CCBHCs must ask all individuals inquiring about services if they have ever served in the U.S. military. **See specific protocol for how consumers who affirm current or past military service will be helped at Addendum 7.** Due to the specific requirements associated with serving ADSM and veteran, accreditation is not being used to demonstrate compliance with any of the standards related to Intensive, Community-Based Mental Health Care for	Documentation of compliance related to 4.d.3 may be used to demonstrate compliance with this standard.

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	Members of the Armed Forces and Veterans. Relevant accreditation information is provided for reference.	
4.k.3 In keeping with the general criteria governing CCBHCs, CCBHCs ensure there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.		The organization attests to the following: 1. The organization identifies and appoints a person/person to work on outreach and engagement with the ADSM, Veterans and veteran serving organizations. 2. The organization is capable of measuring and reporting activity including but not limited to care coordination, referrals, meetings with VA staff and other veteran serving organizations.
4.k.4. Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the medical record. The Principal Behavioral Health Provider is identified on a consumer tracking database for those veterans who need case management. See Addendum 6 for requirements fulfilled by the Principal Behavioral Health Provider:		1. The organization is licensed as a BHO by BHDDH. 2. The organization provides policies and procedures titles, numbers, issuance, or revision dates related to: A. Adherence with policies related to care coordination with the Principal Behavioral Health Provider and any other providers B. Care coordination for active-duty services members and veterans.
4.k.5 In keeping with the general criteria governing CCBHCs, behavioral health services are recovery oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health		1. The organization is licensed as a BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides and attestation that care for veterans must conform to that definition and to those principles to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
and wellness, live a self- directed life, and strive to reach their full potential." Care for veterans must conform to that definition and to those principles to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.		
4.k.6 In keeping with the general criteria governing CCBHCs, all behavioral health care is provided with cultural competence. 1. Any staff who is not a veteran has training about military and veterans' culture to be able to understand the unique experiences and contributions of those who have served their country. All staff receives cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.		The organization provides a training plan that includes specialized training for key staff and clinicians on treatment issues and military culture. *Note: information provided to demonstrate compliance with 1.c.1 may be used for compliance related to cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity*
4.k.7. In keeping with the general criteria governing CCBHCs, there is a behavioral health treatment plan for all veterans receiving behavioral health services. 1. The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. 2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself. 3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.		1. The organization or DCO is licensed as a BHO by BHDDH. 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization provides an attestation that policies and procedures provide for documenting all required items in 4.k.7.and if current policies do not meet the requirements of 4.k.7 they will be revised within 6 months.

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments. The treatment plan is developed with input from the veteran, and when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.		

Section 5 - QUALITY AND OTHER REPORTING		
Data Collection, Reporting and Tracking		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
5.a.1 The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes . Data collection and reporting requirements are elaborated below.	**See Addendum 8 for detailed information on required data, sources of data and how and whom each data element will be reported.**	The organization attests that it will collect all required data and submit via the quarterly report or to the RI Behavioral Health Online Data system.
5.a.2 Reporting is annual, and data are required to be reported for all CCBHC consumers, or where data constraints exist (for example, the measure is calculated from claims), for all Medicaid enrollees in the CCBHCs.	This criterion establishes expectations regarding annual reporting of data.	1. The organization describes how they will submit required data annually and report monthly into the Behavioral Health On-Line Data System to capture all required quality measures.

Section 5 - QUALITY AND OTHER REPORTING		
Data Collection, Reporting and Tracking		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	See Addendum 8 for detailed information on required data, sources of data and how and whom each data element will be reported.	
5.a.3 To the extent possible, these criteria assign to the state responsibility for data collection and reporting where access to data outside the CCBHC is required. Data to be collected and reported and quality measures to be reported, however, may relate to services CCBHC consumers receive through DCOs. Collection of some of the data and quality measures that are the responsibility of the CCBHC may require access to data from DCOs and it is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs and to ensure adequate consent as appropriate and that releases of information are obtained for each affected consumer.		The organization will provide copies of contract language that establish that all contracts the organization has with prospective DCOs include provisions that the DCO: 1. Provide required data to the CCBHC in a timely manner, 2. Obtain appropriate consumer consent for the sharing of information and comply with all federal and state privacy and confidentiality requirements
5.a.4 States must provide CCHBC-level Medicaid claims or encounter data to the evaluators of this demonstration program annually. At a minimum, consumer and service-level data should include a unique consumer identifier, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. These data must be reported through MMIS/T-MSIS to support the state's claim for enhanced federal matching funds made available through this demonstration program. For each consumer, the state must obtain and link the consumer level administrative Uniform Reporting System (URS) information to the claim (or be able to link by unique consumer identifier). CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and	This criterion establishes expectations for the state but also requires CCBHCs to submit data to the state and participate in the evaluation of the project. **See Addendum 8 for detailed information on required data, sources of data and how and whom each data element will be reported.**	The organization provides an attestation that it agrees to submit required data to the state and to participate in the evaluation of the project.

Section 5 - QUALITY AND OTHER REPORTING		
Data Collection, Reporting and Tracking		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
outpatient claims, and any other claims or encounter data necessary to report the measures identified in Appendix A. These linked claims or encounter data must also be made available to the evaluator. In addition to data specified in this program requirement and in Appendix A that the state is to provide, the state will provide such other data, including Treatment Episode Data Set (TEDS) data and data from comparison settings, as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs are responsible for provision of data, the data will be provided to the state and as may be required elsewhere, to HHS and the evaluator. If requested, CCBHCs will participate in discussions with the national evaluation team.		
5.a.5 CCBHCs annually submit a cost report with supporting data within six months after the end of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS. **Note:** For a clinic to receive payment using the CCBHC PPS, it must be certified as a CCBHC.		The organization attests that it will provide to the state a cost report with supporting data according to the time frames required by OHHS/RI Medicaid.

Continuous Quality Improvement		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
5.b.1 The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinical services and clinical management. The CQI projects are clearly defined, implemented,	CARF, COA and TJC accreditation address this issue and can be used in combination with BHO licensure to demonstrate full compliance with this standard.	1. The organization is licensed as a BHO by BHDDH. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH.

Continuous Quality Improvement		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity, and past performance of the CCBHC's services and operations. The CCBHC-wide CQI plan addresses priorities for improved quality of care and client safety and requires all improvement activities be evaluated for effectiveness. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals are designated as responsible for operating the CQI program.	**CARF**: 1.M.1.- 1.M.10.& 1.N.1.- 1.N.4. **COA**: PQI 2; PQI 2.01; PQI 2.02- PQI 2.04; PQI 4.02- PQI 4.05; PQI 7.03 & PQI 7.04. **TJC**: LD.03.07.01 EP 1-2; PI.02.01.01 EP1. RI regulation relevant to this issue: 212 RICR 212-10-00-1.18; 212 RICR 212-10-00-1.19; 212 RICR 212-10-00-1.20	2. The organization provides an attestation the CQI plan includes CCBHC specific activities and data as per listed in section 5.b.1 in the criteria.
5.b.2 Although the CQI plan is to be developed by the CCBHC and reviewed and approved by the state during certification, specific events are expected to be addressed as part of the CQI plan, including: (1) CCBHC consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30 day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.	CCBHC's CQI plans related to incidents involving suicide attempts or completion; readmission to inpatient services (MH, SUD, or Medical) will be submitted within 30 days; failures to respond to individuals within 24 hours for urgent calls	1. The organization submits a copy, or summary, of its CQI plan for review and approval by BHDDH. 2. The CQI plan must address: (1) CCBHC consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30-day hospital readmissions for psychiatric or substance use reasons; (3) urgent appointments not scheduled within 24hr hours and (4) fatal and non-fatal overdoses, (5) abuse of consumer by CCBHC staff or abuse of staff by CCBHC consumer and (6) such other events the state, the CCBHC or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

Section 6 - ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

General Requirements of Organizational Authority and Finances

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
6.a.1. The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria: • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code. • Is part of a local government behavioral health authority. • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.); • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). **Note:** A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.		1. The organization is licensed as a BHO by BHDDH 2. The organization provides a copy of correspondence from the Internal Revenue Service related to its' tax-exempt status Or 3. The organization provides a description of which other statutory criteria applies and attests that they are eligible based on it.
6.a.2 To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, states, based upon the population the prospective CCBHC may serve, should require CCBHCs to reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to AI/AN consumers and to inform the provision of services to those consumers. To the extent the CCBHC and such entities jointly provide	Rhode Island does not have an Indian Health Service Facility. The Narragansett Indian Tribe operates a health facility that operates as a stand-alone.	Any CCBHC applicant that proposes to serve Washington County must provide evidence that they have reached out to the Narragansett Indian Health Center.

Section 6 - ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

General Requirements of Organizational Authority and Finances

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.		
6.a.3 An independent financial audit is performed annually for the duration of the demonstration in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.	CARF, COA and TJC accreditation addresses this issue and can be used in combination with BHO licensure to demonstrate full compliance with the standard. CARF: 1.F.9 COA: FIN 6.02; FIN 6.03 & PQI 7.01. TJC: LD.04.01.03 EP 3-5, EP 7 & EP14. RI regulations addressing the requirement of an independent financial audit: RICR 212-10-00-1.17.1.A.8	1. The organization is licensed as a BHO by BHDDH 2. The organization has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The organization attests that an independent financial audit is performed annually. 4. The organization provides a copy of any corrective action plan to address any findings related reportable conditions, materials weaknesses, or management letter issues in the Audit Report.

Governance

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
6.b.1 As a group, the CCBHC's board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. The CCBHC will incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers, either through 51 percent of the board being families, consumers or people in recovery from behavioral health conditions, or through a substantial portion of the governing board	There are a variety of ways for CCBHCs to accomplish and demonstrate meaningful participation. CCBHC Requirement: CCBHCs shall adopt one of the following approaches to securing meaningful participation in the CCBHCs policies, processes and services by individuals and families receiving services from CCBHCs: • At least 51% of the governing body consists of individuals, or family members of individuals, recovering from serious	1. The organization can attest to following standards 6.b.1 to 6.b.6 and that that they comply or will comply according to proposed time frame. Attestation needs to indicate which option of advisory Council applicant will select while also indicating which SAMHSA criteria they meet for governing board composition. The attestation will be considered to meet requirements for standards 6.b.1 to 6.b.6,

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.	mental illness or a serious emotional disorder, and individuals, or family members of individuals, recovering from substance use disorders, who are receiving or have received behavioral health services from the CCBHC; • A substantial portion of the governing body consists of individuals, or family members of individuals, recovering from serious mental illness or a serious emotional disorder, and individuals, or family members of individuals, recovering from substance use disorders, who are receiving or have received behavioral health services from the CCBHC; • Develop a transition plan, with timelines appropriate to its governing board size and target population, designed to establish a governing body with either at least 51%, or a substantial portion, of the governing body consisting of individuals, or family members of individuals, recovering from serious mental illness or a serious emotional disorder, and individuals, or family members of individuals, recovering from substance use disorders, who are receiving or have received behavioral health services from the CCBHC; • If the CCBHC is a subsidiary or part of a larger corporate organization that cannot meet these requirements for board members, the CCBHC has or develops an advisory structure and other specifically described methods for	
6.b.2 The CCBHC will describe how it meets this requirement or develop a transition plan with timelines appropriate to its governing board size and target population to meet this requirement.		
6.b.3 To the extent the CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership, the state will specify the reasons why the CCBHC cannot meet these requirements and the CCBHC will have or develop an advisory structure and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.		
6.b.4 As an alternative to the board membership requirement, any organization selected for this demonstration project may establish and implement other means of enhancing its governing body's ability to ensure that the CCBHC is responsive to the needs of its consumers, families, and communities. Efforts to ensure responsiveness will focus on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. The state will determine if this alternative approach is acceptable and, if it is not, will require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families.		

Governance		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
Each organization will make available the results of their efforts in terms of outcomes and resulting changes.	consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services, • Establish and implement other means, approved by BHDDH, of enhancing its governing body's ability to ensure that the CCBHC is responsive to the needs of individuals, and family members of individuals, recovering from serious mental illness or a serious emotional disorder, and individuals, and family members of individuals, recovering from substance use disorders, who are receiving or have received behavioral health services from the CCBHC, as well as the communities it serves. CCBHC should be able to document consumer, family, and community input and the impact of that input on CCBHC's policies, processes, and services.	

Governance		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
6.b.5 Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.	CCBHC Requirement: To the extent practicable, CCBHC governing and/or advisory boards should be representative of the population being served in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation. CCBBHC governing board or advisory board members should be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one-half (50%) of the governing board members may derive more than 10 percent of their annual income from the health care industry. RI regulations addressing cultural representation among board membership and staffing of licensed organizations and professional development including cultural competency and health equity training: RICR 212-10-00-1.17.1. A.4; 212-RICR-10-10-1.3.1A.14; 212-RICR-10-10-1.4.2.C & C.1; 212-RICR-10-10-1.4.3; 212-RICR-10-10-1. 4.2D, E, F; 10-10-1.4.3 and 10-10-1.6. A	As part of its CCBHC application, the organization describes and documents its compliance with these requirements. See **Addendum 10** which details the development of a Community/Consumer Advisory Council which will meet the 51% standard required. ***Addendum 10 applies to all CCBHCs***
6.b.6 States will determine what processes will be used to verify that these governance criteria are being met.	BHDDH will require submission of a plan and develop monitoring measure	The CCBHC will provide a description of how these governance criteria will be met; the plan will be reviewed initially for application and measures will be established for subsequent monitoring and recertification

Accreditation		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
6.c.1 CCBHCs will adhere to any applicable state accreditation, certification, and/or licensing requirements.	**See Addendum 2.** *CCBHCs will be expected to comply with children's behavioral health organizational licensure (CBHO) requirements when they become available.*	1. The organization is licensed as BHO by BHDDH, 2. The organization is accredited by CARF, COA and/or TJC for children, adolescents, and adults: 3. Please describe which accreditation body program standard the organization or proposed DCO is using to demonstrate compliance with the standards or any other certification or endorsements relevant to the service proposed
6.c.2 States are encouraged to require accreditation of the CCBHCs by an appropriate nationally recognized organization (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean "deemed" status.		

ADDENDA

ADDENDUM 1 - CCBHC Medical Director - Specific Requirements and Duties

CCBHC Medical Director - Specific Requirements and Duties

The Medical/Clinical Director or Chief Medical Officer must be a qualified psychiatrist with the authority to ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated. The Medical Director is a member of the CCBHC management team. The specific responsibilities include the following:

1. Assuring that all CCBHC patients receive appropriate evaluation, diagnosis, treatment, medical screening, and medical/psychiatric evaluation whenever indicated, and that all medical/psychiatric care is appropriately documented in the medical record.
2. Assuring psychiatric involvement in the development, approval, and review of all Policies, Procedures, and Protocols that govern clinical care and integration of behavioral healthy and primary care.
3. Ensuring the availability of adequate psychiatric staffing to provide clinical, medical, administrative leadership, and clinical care throughout the system.
4. Developing job descriptions for staff psychiatrists that are comprehensive, and permit involvement in therapeutic and program development activities, as well as application of specific medical expertise.
5. Recruiting, evaluating, and supervising physicians (including residents and medical students), and overseeing the peer review process.
6. Assuring that all clinical staff receive appropriate clinical supervision, staff development, and in service training.
7. Assuring, through an interdisciplinary process, the appropriate credentialing, privileging, and performance review of all clinical staff.
8. Providing direct psychiatric services.
9. Advising the CEO regarding the development and review of the CCBHC's programs, positions, and budgets that impact clinical services. Participating in community-wide behavioral health gap analysis and program development
10. Assisting the CEO by participating in a clearly defined and regular relationship with the Board of Directors.
11. Participate with the CEO in making liaisons with private and public payors, with medical directors or equivalent clinical leadership in payor organizations.
12. Assuring the quality of treatment and related services provided by the System's professional staff, through participation (directly or by designee) in the CCBHC's ongoing quality improvement and audit processes.
13. Providing oversight to ensure appropriate utilization of services throughout the CCBHC, by developing an appropriate continuum of programs, identifying level of care criteria, standards of practice for internal review of level of care determinations and appeal of adverse UR decisions.
14. Participating in the development of a clinically relevant, outcome evaluation process.
15. Providing liaison for the CCBHC with community physicians, hospital staff, and other professionals and agencies regarding psychiatric services.
16. Developing and maintaining, whenever possible, training programs in concert with various medical schools and graduate educational programs. supervision for each program.

By licensure, training and prior clinical and administrative experience, the medical/clinical director or chief medical officer shall be qualified to carry out these functions. The medical/clinical director or chief medical officer must be board certified or board qualified. Specifically, he or she should be knowledgeable about contemporary therapeutic and rehabilitative modalities necessary to work with the population served by the program.

ADDENDUM 2 - Accreditation Bodies and Standards, Relevant Endorsements and Certifications for Behavioral Healthcare Services

The following accreditation standards, endorsements and certifications may be used to demonstrate compliance with a CCBHC standard.

Commission on Accreditation of Rehabilitation Facilities Behavioral Health Accreditation

- CARF ACT Endorsement
- CARF Assessment and Referral (AR) Endorsement
- CARF Call Centers Endorsement
- CARF Case Management (CM) Endorsement
- CARF Crisis Intervention Endorsement
- CARF Detoxification/Withdrawal Management (Ambulatory)
- CARF Health Home (HH) Endorsement
- CARF Intensive Family-Based Services (IFB) Endorsement
- CARF Intensive Outpatient Treatment (IOP) Endorsement
- CARF Outpatient Treatment (OT) Endorsement
- CARF Children and Adolescents (CA) Endorsement

Council on Accreditation

- COA Services for Mental Health and/or substance use disorders (MHSU)
- COA Case Management
- COA Crisis Response
- COA Integrated Care Health Homes
- COA Psychiatrique Réhabilitation Services (PSR)

The Joint Commission

- Behavioral Health Care and Human Services Accreditation
- Behavioral Health Home Certification

ADDENDUM 3 - Requirements of Designated Collaborating Organizations (DCO)

CCBHCs must provide the following information for any DCO relationship that is proposed, for each service where a DCO relationship is proposed.

1. For Medicaid reimbursable services, a CCBHC can partner with a DCO that is licensed or certified to provide that Medicaid reimbursable service. There is no required process for state approval of the DCO itself, rather the DCO service delivery would be approved as part of the CCBHC application and certification process
2. The state anticipates seeking authority for CCBHC allowable services that are not currently Medicaid reimbursable (i.e., outreach) under the CCBHC model. DCOs will not be required to be licensed or certified by Medicaid to provide these services
3. The CCBHC will attest that DCO has at least three years' experience providing a particular service type or treatment modality.
4. Prior to operating as a CCBHC, a formal written agreement (MOU or contract) with a DCO needs to be established that includes all the elements required to comply with SAMHSA certification and state criteria and is reflected in the scope of work by the DCO (4.a.1). The DCO agreement will include the following provisions:
    a. describing each party's mutual expectations, deliverables, and establishing accountability of services to be provided.
    b. Clearly articulating the role and function of the CCBHC and DCO in developing treatment plans, and care coordination, and that the CCBHC coordinates care and services by the DCO in accordance with the current treatment plan. (3.d.3
    c. Operationalizing the CCBHC's continued clinical responsibility function.
    d. Articulating the DCO requirement to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO agreement and in compliance with all CCBHC quality standards pertaining to access requirements, use of evidence-based practices, care coordination, outcomes, and provision of services regardless of place of residence and ability to pay. (4.a.4)
    e. Requiring a copy of the proposed DCO staffing pattern detailing the positions, required credentials for each position, and indicate whether the position(s) are currently filled or vacant. (1.a.1 &1.a.2) and (2.a.6)
        i. including a provision regarding the consumer's freedom to choose their provider (3.a.6)
    f. If the DCO provides a 24-hour crisis line or 24-hour mobile crisis teams, or directly provides emergency services, requiring evidence that the clinical are qualified QMHP's, and
        i. Requires a copy of the policies and procedures title, number and effective date that specify the role and responsibilities in working with local law enforcement and first responders. (4.c.1)
    g. Requiring CCBHC training plans address training of DCO staff.
    h. Requiring DCO clinical staff are trained in relevant EBP's and that the CCBHC monitors DCO's use of EBP's including training, coaching and fidelity compliance.
    i. Requiring DCO staff be appropriately licensed, certified, registered and credentialed as required by state and federal statute and regulation (1.b.1)
    j. Requiring that DCO services must be trauma informed, person centered, recovery based and culturally appropriate.
    k. Requiring that DCO provided services for CCBHC consumers meet the same quality standards as those required of the CCBHC (4.a.4)
    l. Requiring that individuals receiving services from DCO's have access to CCBHC grievance procedures. (4.a.3)
    m. Requiring that DCOs collect and maintain all documentation necessary for CCBHC data collection and reporting as required by BHDDH, OHHS and the agreement between the CCBHC and the Managed Care Organizations (MCO). (5.a.3)

ADDENDUM 4 – Staffing Requirements

CCBHC's are to specifically address the behavioral health and related needs of the following targeted populations: Adults with severe mental illnesses; children and youth with severe emotional disorders; under-resourced populations; health equity disparities; individuals who are homeless; justice involved individuals; and transition age youth.

1. At a minimum, the CCBHC provides the following services and staff:
    a. Crisis Response
        i. Directly, **or** through contract with a DCO, a 24-hour staffed hotline
        ii. Directly, **or** through contract with a DCO, 24-hour mobile crisis teams
        iii. Directly employ Psychiatrists/Advanced Practice Registered Nurses (APRN)
        iv. Directly employ Qualified Mental Health Professionals (QMHPs) to provide community and clinic-based crisis intervention services
    b. Screening, Evaluation and Diagnosis
        i. Psychiatrists/Advanced Practice Registered Nurses
        ii. Licensed/Credentialed Mental Health Professionals
            iii. Licensed Marriage and Family Therapist (LMFT)
            iv. Licensed Mental Health Counselor (LMHC)
            v. Licensed Independent Clinical Social Worker (LICSW)
            vi. Registered Nurses with American Nurses Credentialing Center (ANCC) certification as a Psychiatric and Mental Health Nurse (PMH-BC)
            vii. Counselor-in-Training with, at a minimum, two hours of individual clinical supervision each month
        c. Master's Degree staff working toward licensureMaster's Degree internsRegistered nurse with ANCC certificaiton as a Psychiatric and Mental Health Nurse or () year post RN license full time experience provising bheavioral health servicesCredentialed SUD Professionals
            i. Licensed Chemical Dependency Clinical Supervisor (LCDCS)
            ii. Licensed Chemical Dependency Professional (LCDP)
            iii. Certified Alcohol and Drug Counselor (CADC)
            iv. Certified Co-Occurring Disorder Professional Diplomate
            v. Certified Advanced Alcohol and Drug Counselor (CAADC); or
            vi. Certified Co-Occurring Disorder Professional.
        vii. Clinical Supervisors
    d. Person-Centered and Family-Centered Treatment Planning
        i. Psychiatrists/APRNs
        ii. Licensed/Credentialed Mental Health Professionals (see above)
        iii. Credentialed SUD Professionals (see above)
        iv. Clinical Supervisors
        v. Community Psychiatric Support Team Specialists (CPST)
        vi. Nurses
    e. Outpatient MH and SUD Services
        i. Psychiatrists
        ii. Licensed/Credentialed Mental Health Professionals (see above)
        iii. Credentialed SUD Professionals (see above)
        iv. Clinical Supervisors
        v. Community Psychiatric Support Team Specialists
        vi. Nurses
    f. Primary Care Screening and Monitoring
        i. Health Home staff
        ii. Nurses including licensed practical nurses
        iii. Treating psychiatrists,
        iv. Physicians/MDs
    g. Peer and Family Support
        i. Certified Peer Recovery Specialist
        ii. BHDDH Certified Providers of Peer Based Recovery Support Services
    h. Psychiatric Rehabilitation

1. Rehabilitation Professionals
2. Community Psychiatric Support Team Specialists (CPST) [2]

i. Targeted Case Management (note – RI does not specifically implement TCM for high acuity adult populations with serious and persistent mental illness, but rather Community Psychiatric Support Team (CPST) which provides direct treatment, rather than TCM – see description of CPST at footnote 2)
   i. Community Psychiatric Support Specialists/Case Managers
   ii. Licensed/Credentialed Mental Health Professionals (see above)
   iii. Credentialed SUD Professionals (see above)
   iv. Community Mental Health Liaison
   v. Associates Degree Level Case Manager

2. Assertive Community Treatment
   a. Registered Nurse
   b. Licensed Mental Health Professional
   c. Bachelor Level Vocational Specialists
   d. Community Psychiatric Supports and Treatment Specialists (minimum of Associate's Degree with case management training)
   e. Certified Peer Recovery Specialist

3. The CCBHC directly provides, or contracts with a DCO to provide, or has a referral relationship with an organization that provides, General Adult, Adolescent and Women & Children Substance Use Disorder Treatment Program services including Medication Assisted Treatment.

4. The CCBHC provides certified peer recovery specialists to assist consumers moving from one level of care to another or has a DCO contract that facilitates access to

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[2] CPST is designed to help individuals with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. Services includes:

a. Assist individuals to identify strategies or treatment options associated with mental health disorder, with the goal of minimizing mental health symptoms and associated environmental stressors, which interferes the person's daily living and community integration.
b. Provide individual and their family supportive counseling, solution-focused interventions, with the individual, with the goal of assisting the individual with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living.
c. Provision of strengths-based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.
d. Provision of rehabilitation and supportive counselling, recovery activities and interventions that enables the person to:
   - Develop coping strategies and effective functioning skills (e.g., evidence-based, and best practice techniques drawn from cognitive behavioral therapy, and other evidence-based psychotherapeutic interventions) that ameliorate targeted symptoms and develops the person's capacity to cope with psychiatric symptoms that interfere abilities to remain in various community environments e.g. home, school, work, and community.
   - Support the Implementation of learned skills as it relates to living in the community, including: personal autonomy (e.g. learning to manage stress, addressing unexpected daily events and disruptions, relapse triggers/cravings, etc.); pursuing health (e.g., managing chronic medical conditions, medications, establishing good health routines and practices, etc.); wellnesses (e.g., meal planning, healthy shopping, nutritional awareness, exercise, recreational activities; managing time); personal care (grooming, managing finances, managing housing or other independent living skills) or education and employment goals.

Ongoing assessment of the individual's progress toward recovery, functional skill and impairment levels that is used to select psycho-social interventions and periodically assess their effectiveness in achieving goals.

Recovery Supports offered by a provider certified by BHDDH to provide Peer Based Recovery Support Services on behalf of Medicaid.

5. The CCBHC includes a medically trained behavioral health provider, either employed or through formal arrangement, who can prescribe and manage medications independently.

6. The CCBHC has individuals trained to provide Medically Assisted Treatment (MAT) including buprenorphine and naltrexone for opioid and alcohol use disorders and a DCO relationship with an Opioid Treatment Program to allow for consumer choice and access to methadone.

7. The CCBHC must be able to access professional treatment for consumers suffering the effects of trauma by employing or contracting with professionals with expertise in the treatment of trauma.

8. The CCBHC must be able to refer for specialized behavioral health services from other providers (e.g. treatment for sexual trauma, eating disorders, neurological testing, etc.) to meet the needs of consumers when the organization does not have the necessary expertise.

ADDENDUM 5 - Populations of Focus – High Acuity Populations Diagnostic and Assessment Criteria

High Acuity Adult

An individual is in the High Acuity Adult Population if they are 18 or over and:

1) They are eligible for Rhode Island's I/DD waiver, **and** they have any behavioral health diagnosis; **or**
2) They have a diagnosis of:
    - Schizophrenia
    - Schizoaffective
    - Schizoid Personality Disorder
    - Delusional disorders
    - Psychosis
    - Bipolar
    - Major Depression
    - Severe OCD
    - Post-Traumatic Stress Disorder
    - Borderline personality disorder, **or**
    - Severe panic disorder; **and**
    - A DLA score of four or less.
3) In addition, there is an exception process for assignment to the High Acuity Adult Population. CCBHCs serving individuals who pass the below test can apply to BHDDH to include the individual in the High Acuity Adult Population if:
    - They have been discharged from an inpatient psychiatric unit in past 30 days: **or**
    - They have been released from incarceration within the past 30 days: **or**
    - They are homeless; **or**
    - They have been homeless within the last 30 days; **or**
    - ; **or**
    - They meet at least three of the following conditions:
        - They have utilized crisis services at least three times in a 30-day period in the past six months
        - They have been homeless in the past six months
        - They are at risk of homelessness (unstably housed)
        - They have been charged with a crime in the past six months
        - They are at risk of becoming involved in the criminal justice system
        - They live in a supported environment and could move to a less restrictive setting if provided with intensive services
        - They are consistently unable to engage and benefit from other community-based mental health services
        - They are unable to perform practical daily tasks required for adult functioning
        - They have intractable severe major symptoms (i.e. affective, psychotic, suicidality)

OR

1. They are transition aged Individuals between the ages of 16 and 25, and
    - Experienced first episode psychosis or early onset of serious mental illness with high prevalence of co-occurring substance use disorders.
    - Have or at imminent risk of developing a serious mental health condition.
    - Conditions including not employed, or in school; currently homeless or at risk; having recent contact with the juvenile or criminal justice system; at risk of hospitalization
2. Individuals in a residential setting are not eligible for CSC services and individuals with Autism Spectrum Disorder are eligible only by exception.
3. Request for exceptions to eligibility criteria may be made at any time in writing to BHDDH.

High Acuity Children and Youth

Year 1-2

In Years 1 and 2, this population will be defined based on eligibility for Enhanced Outpatient Services (EOS). All attributed members in this category must have a Child and Adolescent Needs and Strengths (CANS) assessment completed in Year 1, in support of transitioning to the eligibility criteria specified below for Year 3.

Year 3+

An individual is in the High Acuity Children and Youth population if they are under 18 and:

1) They had an inpatient psychiatric admission in the past 6 months; **or**
2) They are currently homeless or have been homeless in the last thirty days; **or**
3) They have a diagnosis of:
    - Adjustment Disorder
    - Anxiety Disorder
    - Any Feeding and Eating Disorders
    - Bipolar Disorder
    - Borderline Personality Disorder
    - Delusional Disorder and/or Psychotic Disorder
    - Disruptive Mood Dysregulation Disorder Disruptive
    - Impulse-Control and Conduct Disorder
    - Gender Dysphoria
    - Major Depressive Disorder, recurrent
    - Obsessive-Compulsive Disorder
    - Oppositional Defiance Disorder
    - Panic Disorders
    - Personality Disorder
    - Phobic Disorders
    - Pica
    - Post-Traumatic Stress Disorder
    - Psychosis/dx w/psychotic features or episode
    - Pyromania
    - Reactive Attachment Disorder
    - Schizoaffective Disorder
    - Schizoid Personality Disorder
    - Schizophrenia
    - Selective Mutism
    - Somatic Symptom and Related Disorders
    - A similar diagnosis or condition that adversely impacts the child or youth's daily functioning; **or**
    - They have a documented history that includes:
        - Sexual Exploitation related V or Z codes that may correspond to a history personal (of) abuse childhood, history family (of) abuse childhood, forced labor or sexual exploitation in childhood, forced labor or sexual exploitation, or other V or Z code that may reflect sexual exploitation; **and**
4) They received at least one score of 3 **or** two scores of 2 on the CANS Risk Behavior Screen; **or**
5) They received at least one score of 3 **or** two scores of 2 on the CANS Needs Screen.

High Acuity Substance Use Disorder

Year 1-2

In Years 1 and 2, this population will include any individual with a primary diagnosis of a substance use disorder regardless of degree of severity or complexity (who does not otherwise meet the criteria for the High Acuity Adult or High Acuity Children and Youth rate). The ASAM

assessment criteria will be added in Year 2. In Year 1, all attributed members in this category must have an ASAM assessment completed, in support of transitioning to the eligibility criteria specified below for Year 2.

Year 2/3+

An individual is in the High Acuity Substance Use Disorder Population if:

1) They have a diagnosis of:
    - Opioid use
    - Marijuana use
    - Stimulant use
    - Sedative use
    - Hallucinogen use; **or**
    - Alcohol use; **and**
2) They were assigned a score of 2.1 or higher by the ASAM Criteria Assessment Interview or the ASAM Continuum software.

General Population

An individual is in the General Population if:

1) They are not included in one of the High Acuity populations

ADDENDUM 6 - Required Evidence-Based Clinical Practices or Programs

See Table below for detailed information.

Required Evidence Based Clinical Practices or Programs - All Populations (Adults and Children)

1. Motivational Interviewing/Motivational Enhancement Therapy
2. Cognitive Behavioral Therapy (CBT) Age/population appropriate
3. Coordinated Specialty Care (CSC) or equivalent program
4. Dialectical Behavioral Therapy (DBT)
5. Family Psychoeducation (FPE)/ Family to Family
6. Integrated Dual Disorder Treatment (IDDT)
7. Medication Treatment, Evaluation and Management (MedTEAM)
8. Screening, Brief Intervention, and Referral to Treatment (SBIRT
9. Trauma informed care (population and age appropriate
10. Zero Suicide

Adult Required EBPs

1. Assertive Community Treatment (ACT)
2. Permanent Housing/Housing First (National Model)
3. Individual Placement and Support (IPS)
4. Medication Assisted Treatment (MAT)
   a. For Opioid Use Disorder (2 out of 3 medication types)
   b. For Alcohol Use Disorder
   c. Nicotine Replacement Therapy
5. 12-Step Facilitation Therapy/Matrix Model

Children's' Required EBPs

1. Teen ACT

DCYF will review and approve any children's services EBPs (other than Teen ACT) that a CCBHC wants to implement.

CCBHC REQUIRED EVIDENCE BASED CLINICAL PRACTICES AND PROGRAMS (EBPs) – ALL POPULATIONS			
EBP	**Staff Training Requirements**	**Time Frame**	**Implementation Support and/or Fidelity Tool**
Motivational Interviewing	Required of all direct service staff	50% trained by end of year 1 90% trained by end of year two. Maintain level of 90% trained	**URI Fidelity Tool available.**
Cognitive Behavioral Therapy Age/population appropriate	Required of all clinical staff	30% trained by end of year 1 60% trained by end of year 2 Maintain minimum level of 60% trained	**URI Fidelity Tool available.**

CCBHC REQUIRED EVIDENCE BASED CLINICAL PRACTICES AND PROGRAMS (EBPs) – ALL POPULATIONS			
EBP	**Staff Training Requirements**	**Time Frame**	**Implementation Support and/or Fidelity Tool**
Dialectical Behavioral Therapy (DBT)	Required of all clinical staff	30% trained by end of year 1 60% trained by end of year 2 Maintain minimum level of 60% trained	**URI Fidelity Tool available**
Family Psychoeducation (FPE)/ Family to Family *for substance use disorder:* Community Reinforcement and Family Training (CRAFT)	Required of clinical staff	with 50% being trained by end of year 1 50% by end of year 2 Maintain a minimum level of 75% trained	Family Psychoeducation: How to Use the Evidence-Based Practices KITs (samhsa.gov)
Integrated Dual Diagnosis Treatment (IDDT)	Appropriate clinical and direct service staff	50% trained by end of year 1 90% by end of year 2 Maintain 90% training level	Clinical Guide for Integrated Dual Disorder Treatment | Center for Evidence-Based Practices | Case Western Reserve University [case.edu]
Medication Treatment, Evaluation and Management (MedTEAM):	RNs APRN Psychiatrists MDs	Medical staff should be trained at time of award.	MedTEAM (Medication Treatment, Evaluation, and Management) Evidence-Based Practices (EBP) KIT | SAMHSA **URI Fidelity Tool available.**
SBIRT	All staff	Implement service by end of year 1	Screening, Brief Intervention, and Referral to Treatment (SBIRT) | SAMHSA Alcohol Screening and Brief Intervention for Youth (nih.gov)
Coordinated Specialty Care or equivalent program	Establish team and service by end of year 1 with all staff trained	100% trained end of year 1	**URI Fidelity Tool available (Healthy Transitions).**

CCBHC REQUIRED EVIDENCE BASED CLINICAL PRACTICES AND PROGRAMS (EBPs) – ALL POPULATIONS			
EBP	**Staff Training Requirements**	**Time Frame**	**Implementation Support and/or Fidelity Tool**
Trauma informed care	Basic training in trauma for all staff and additional specialized training for all direct service staff and age-appropriate training for staff at clinical levels	50% by end of year 1 90% by end of year 2 Maintain 90% level of training	TIP 57 Trauma-Informed Care in Behavioral Health Services (samhsa.gov)
Zero Suicide	Implement protocols and processes by end of year 1	50% staff trained by end of yr. 1 90% of staff trained by end of year 2 Maintain 90% training level	Zero Suicide Toolkit | SAMHSA

Adult Required EBPs			
EBP	**Staff Training Requirements**	**Time Frame**	**Implementation Support and/or Fidelity Tool**
Assertive Community Treatment	This service/program is required as a condition of application	Staff should be trained at time of award.	More about the TMACT - UNC Center for Excellence in Community Mental Health **URI Fidelity Tool available.**
Permanent Housing/Housing First (National Model)	*Required of community psychiatric support team staff*	25% being trained by end of year 1 25% by end of year 2 Maintain a minimum level of 75% trained.	Permanent Supportive Housing Evidence-Based Practices (EBP KIT) | SAMHSA **URI Fidelity Tool available.**
Individual Placement and Supports	Train staff and implement service by end of year 1	50% staff trained end of year 1 90% trained by end of year 2 Maintain level of 90% trained Maintain 90% training level	**URI Fidelity Tool available.**

Adult Required EBPs			
EBP	**Staff Training Requirements**	**Time Frame**	**Implementation Support and/or Fidelity Tool**
Medication Assisted Treatment	Opioid Use Disorder (2 out of 3 medication types). Staff would need to be appropriately trained.	Implement this service/program at least for SPMI by end of year 1	**URI Fidelity Tool available.**
		fully implemented by end of year 2	
	For Alcohol Use Disorder	Implement this service/program by end of year 1	
		fully implemented by end of year 2	
	Nicotine Replacement Therapy	Implement this service/program by end of year 1	
		fully implemented by end of year 2	
12-Step Facilitation Therapy/Matrix Model	Clinical staff	50% trained by end of year 1	
		90% trained by end of year 2	
		Maintain level of 75% trained	

CHILDREN'S REQUIRED EBPS			
EBP	**Staff Training Requirements**	**Time Frame**	**Implementation Support and/or Fidelity Tool**
Teen ACT	This program would need to be fully implemented within the first year and staff trained appropriately according to plan formulated by CCBHC and approved by DCYF.		

Fidelity: General requirement that all required EBP's would be subject to annual fidelity evaluation (in addition to 6 months after implementation) using appropriately developed fidelity measures. Results of fidelity evaluation and follow up plans if any would be included in annual CCBHC report to BHDDH/DCYF/OHHS.

Other trainings required for CCBHC Standards:

1. Person/family centered care training: BHDDH review and approval of CCBHC plan for training.
2. Recovery oriented treatment planning: BHDDH review and approval of CCBHC plan for training.
3. Cultural Competency: Minimum level of annual training for 90% of all staff (and 6 months within hire) and additional specialized training for direct service staff as detailed in CCBHC training plan as reviewed and approved by BHDDH
4. Eight Dimensions of Wellness BHDDH review and approval of CCBHC plan for training
5. Crisis De-escalation training: BHDDH and DCYF will review and approve CCBHC plan for training.

ADDENDUM 7: Scope of Services

CRISIS BEHAVIORAL HEALTH SERVICES

Mobile Crisis

Mobile crisis coverage for overnight (11pm -7am), weekends and hoildays

1. Any CCBHC serving a geographic area with fewer than 200,00 people must form a partnership with another CCBHC and establish a primary mobile crisis team (MCT) for that combined region overnight.
2. CCBHC must contract with a state approved vendor for children's mobile crisis.

SUBSTANCE USE DISORDER – AMBULATORY AND MEDICAL DETOXIFICATION

Table 1
RI CCBHC Crisis Services - Ambulatory and Medical Detoxification Requirements

ASAM Level	Description	Responsible entity
ASAM Level 1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery.	CCBHC must directly provide this service.
ASAM Level 2-WM	Moderate withdrawal with all day withdrawal management supports and supervision; at night has supportive family or living situation, likely to complete withdrawal management.	CCHBC must directly provide this service.
ASAM Level 3.2-WM (Social Setting Detox)	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery	CCBHC has a referral relationship.
ASAM 3.7-WM (Modified Medical Detox	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring.	CCBHC has a referral relationship

OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT – HIGH ACUITY POPULATIONS

INDIVIDUALS WITH COMPLEX, SEVERE AND PERSISTENT MENTAL ILLNESS (COMPLEX SPMI)

Services to Complex SPMI would be provided by an Assertive Community Treatment team (ACT) for individuals with a **DLA score of 3 or less**.

A. ACT team with staff to client ratios of approximately 1:7 (100 clients per team) and average services per individual to follow the TEAM ACT fidelity model and with potential minimum monthly/hourly requirements by BHDDH.
B. **Minimum** staffing would include 1 team leader; 1 FTE Psychiatrist (or APRN), 3 RN's; 1 clinician; 1 Co-occurring Clinician; 1 SUD specialist; 1 rehab specialist and 4 CPST workers; and 1 certified Peer specialist for a total of 14 FTE's. Additional specific FTE positions and staffing patterns may be proposed specific to the needs of a Complex SPMI population by provider organizations and is subject to approval by BHDDH.
C. Health Home services would be provided by the ACT team
D. ACT services and operations would include
    1) Ten (10) hours of team active operation during weekdays and 4 hours per day on weekend and holidays
    2) On call 24/7 for client emergencies to triage with crisis workers
    3) Team would serve as individual's health home

4) Core services would include integrated treatment, clinical treatment, rehabilitative and supportive services such as: crisis intervention; psychiatric medication; psychosocial rehab; Individual Placement and Support services; mental health and/or SUD evidenced based treatment; case management services; care coordination; health home services; and social skills and interpersonal relationship training.

E. Use of wide range of evidence- based practices including for example Individual Placement and Support (IPS), Integrated Dual Diagnosis Treatment (IDDT), Family Psychoeducation, Housing First, and Peer Support.

F. Additional guidelines and/or requirements may be issued pertaining to services and operations of ACT teams.

Table 2 -Assertive Community Treatment Staffing Patterns, Credentials and Best Practices Implemented

Staff		Credential	Other Responsibilities	Best Practices
1	Team Lead	MA		**Assertive Community Treatment**
2	RN-1	RN	Health Home/Care Coordination Medication Administration Treatment	MedTEAM
3	RN-2	RN	Health Home/Care Coordination	MedTEAM
4	RN-3	RN	Health Home/Care Coordination	MedTEAM
5	Clinician	MA/MSW	Clinical Specialist	Lead/Psychotherapeutic intervention Family Psychoeducation
6	Rehabilitation Specialist	BA/BS	Community Integration Specialist	Permanent Supportive Housing
7	Co-Occurring Clinician	MA/MSW	SA Specialist	Integrated Dual Diagnosis Treatment (IDDT) - Criminal Justice Liaison
8	SUD Specialist	LCDP	SA Specialist	IDDT
9	CPST-1 Community Psychiatric Supportive Treatment Specialist	CPST/ Associate Degree	CPST-IPS	Illness Management
10	CPST-2	CPST/ Associate Degree	Rehabilitation counseling including recovery activities/interventions to support independent community living (supportive housing) and support community integration	Illness Management
11	CPST-3	CPST/ Associate Degree	CPST-IPS	Illness Management
12	CPST-4	CPST/ Associate Degree	CPST-IPS	Illness Management

Table 2 -Assertive Community Treatment Staffing Patterns, Credentials and Best Practices Implemented				
Staff		Credential	Other Responsibilities	Best Practices
13	Peer	CPRS	Peer supports	Illness/Management
Ratio 1:8; Total Clients/Team=100				
14	MD or APRN			

INDIVIDUALS SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI)-ADULTS

Services to SPMI populations are provided by Integrated Community Treatment Team (ICTT) to individuals with a **DLA score of 3.1 to 4.**

1. The Integrated Community Treatment Team (ICTT) has a staff to client ratio of approx. 1:14 (200 per team).
2. **Minimum** staffing would include: 1 team leader; 1 FTE Psychiatrist (or APRN); 3 RN's; 2 clinicians; 1 SUD specialists; 2 rehab specialists; 4 CPST workers; and 1 certified peer specialist for a total of 15 FTE's. Additional specific FTE positions may be proposed to address needs specific to the SPMI population by provider organizations and is subject to approval by BHDDH.
3. Integrated community treatment team services and operations would include treatment and health home services:

a. Clinical, rehabilitation, recovery, prevention and supportive services, and crisis intervention as necessary to assist the individual in their treatment and recovery.
b. Use of wide range of evidence- based practices including for example IPS, IDDT, Family Psychoeducation; Housing First; and Peer Support.
c. Ten (10) hours of team active operation during weekdays and 4 hours per day on weekend and holidays.
d. Providers would have the option to propose to BHDDH the establishment of ICCT teams serving 100 individuals with prorated FTE staffing.
a. Additional guidelines and/or requirements may be issued pertaining to services and operations of ICCT teams.

Table 3 - Integrated Community Treatment Teams				
Staff		Credential	Other Responsibilities	Best Practices
1	Team Lead	MA		
2	RN-1	RN	Pharmacology management Assisting with management of co-morbid/co-occurring health issues Physical health care coordination	MedTEAM
3	RN-2	RN		MedTEAM
4	RN-3	RN		MedTEAM
5	Clinician	MA/MSW	Clinical Specialist Lead/Psychotherapeutic intervention	Family Psychoeducation
6	Rehabilitation Specialist 1	MA/OT	Rehab Lead Vocational	Permanent Supported Housing
7	Rehabilitation Specialist 2	BS/BA	Vocational	IPS Model
8	Co-Occurring Clinician	MA	Co-Occurring Clinician/SA Specialist	IDDT - Criminal Justice Liaison
9	SUD	LCDP	SA Specialist	IDDT

Table 3 - Integrated Community Treatment Teams				
Staff		**Credential**	**Other Responsibilities**	**Best Practices**
10	CPST-1	Associate Degree /CPST	IPS Illness self- management Recovery skills training and support Community integration	Illness Management
11	CPST-2	Associate Degree /CPST		Illness Management
12	CPST-3	Associate Degree/CPST		Illness Management
13	CPST-4	Associate Degree/CPST		Illness Management
14	Peer	Peer CPRS	Recovery Supports	Illness Management
Ratio 1:14 Total Clients per ICCT Team =200				
15	Psychiatrist or APRN			

TRANSITION AGED INDIVIDUALS/COORDINATED SPECIALTY CARE

Service Definition:

1. Overall goal of treatment is recovery based and maximizing functioning through timely and rapid access to services and through shared decision making to insure client and family involvement.
2. Services include:
    a. Assistance and support in accessing and engaging in vocational and educational services and activities
    b. Medication management
    c. Recovery oriented psychotherapy and counseling pertaining to substance use and/or mental health condition
    d. Care coordination with primary care physician/provider
    e. Family support, therapy education and interventions, and
    f. wrap around case management services; health assessment and monitoring; and overall care coordination.
3. Staffing includes 1 Masters level Team Leader; 1 Masters level clinicians with competencies is treating the population of focus; 1 SUD clinician; 1 Registered Nurse; .5 FTE Prescriber; 1 CPST; 1.5 employment/education specialist.
4. The Coordinated Specialty Care team will staff to client ratios of approximately 1:7 (50 clients maximum per team)
5. Services are culturally and linguistically appropriate
6. Extended hours of operation including weekends and holidays.
7. Staffing will be based on an assertive community treatment standard with reduced caseload sizes and weekly multidisciplinary team meetings.

Teams maintain a caseload that is small enough to allow for intensive and highly individualized services.

FTE ratio of 1:7 and never to exceed 1:10

Table 4 – Transition Age Individuals/Coordinated Specialty Care		
Staffing	**Credential**	**Role**
1 Team Lead	MA	Clinical Supervision coordinates the outreach and recruitment activities for the team. He/she organizes and tracks presentations to publicize team activities, screens individuals referred to the program, and evaluates potential clients for eligibility
.5 Licensed Medical Providers	Psychiatrist, Psychiatric Nurse Practitioner	Pharmacotherapy r engages the patient in shared decision making about medication and the next steps in medication treatment. The team Psychiatrist also plays a key role during episodes of crisis and provides ongoing assistance and support for coping with relapses. In addition, the team Psychiatrist plays a key role in ongoing diagnosis.
1 Licensed Clinician	MA, MSW	Individual, group, family psychotherapy Psychoeducation and support
1 SUD clinician	LCDP	Co-occurring clinician
1 RN	RN	works with the Psychiatrist to provide medication monitoring, assessment of side effects, and wellness activities. Care coordination with Primary Care Coordination
1 CPST	Bachelor's Degree	Coordinate services for consumers to minimize stressors and to facilitate the reduction of psychiatric and substance abuse disorder symptoms. Encourage consumers to attain the highest possible levels of independence.
1.5 Supported Employment/Education Specialists	Bachelor's Degree with training in Individual Placement and Supports	IPS The SEE Specialist meets with all clients to assess work/school interests and assists clients in identifying and selecting options for school or work. At this point, some clients will opt to work with

		the SEE Specialist and others will not. Individualized assessments, training and supports integrated with treatment to achieve or maintain educational or vocational success

Core Components of services

- Multidisciplinary team
- Small caseload
- Weekly team meetings
- Prompt intake appointments
- Used shared decision making
- Provides recovery focused treatment plan
- Provides supported employment/supported education services
- Works with families
- Promotes skills building

CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE

Intensive services and supports shall be made available to children and youth up to age 21 who are assessed as high acuity. These intensive behavioral health services are delivered in the home and other community settings and are focused on safety planning, ameliorating the child or youth's acute symptomology, and improving parent and child functioning through the development of targeted knowledge and skills. Treatment includes individual and family therapy, skills training, care coordination, 24/7 emergency response, and medication management, when indicated. The long-term goal is to prepare the family for the transition to longer-term outpatient treatment to achieve lasting positive outcomes. Home visits occur 2-3 times per week with an average length of treatment from 12-16 weeks.

Service Descriptions:

1. Behavioral Health Therapy includes individual and family therapy provided in the home/community by a master's level clinician for at least 2-3 hours/week.
2. Skills Training and Development includes at least 2-3 hours/week of education, coaching in behavior plans, or other interventions defined in the treatment plan, and care coordination, as a distinct set of activities from the behavioral health therapy. This service can be provided by either a master's or bachelor's level staff member. Any bachelor's level staff member providing the service must possess a degree in a human services field and one year of direct, relevant experience with the targeted population (e.g., substance abuse, developmental disabilities, sexual abuse, and post-traumatic stress disorder). If a staff member does not possess the required education and experience, the staff member must be approved for a waiver to provide services.
3. A combination of Behavioral Health Therapy and Skills Training and Development services may take place simultaneously as deemed clinically appropriate by the provider with the expectation that separate and distinct services are being provided.
4. Services are provided primarily in the home with some occurring in community-based settings as designated in the treatment plan.
5. The provider maintains an on-call system that allows a member access to clinical staff 24 hours per day/7 days per week. Response to the child and family is required within one hour of member outreach

6. Provider staff coordinate treatment planning and aftercare with the child or youth's primary care physician, outpatient providers, and other community-based providers, involved state agencies, including court officials and the Rhode Island Training school, educational systems, community supports and family, guardian, and/or significant others when applicable.
7. Medication management through the CCBHC shall be made available, when needed. Otherwise, service delivery shall be coordinated with the prescribing physician.
8. Staffing should reflect the cultural, gender, and linguistic needs of the community it serves.
9. Translation services appropriate to the needs of the population served shall be available.
10. The provider ensures that all staff delivering services are provided regularly scheduled weekly supervision by an independently licensed, master's level clinician or above.

INDIVIDUALS WITH COMPLEX OR SEVERE SUBSTANCE- RELATED DISORDERS (WITH OR WITHOUT MENTAL HEALTH CONDITIONS)

SERVICES FOR INDIVIDUALS WITH COMPLEX OR SEVERE SUBSTANCE-RELATED DISORDERS

Integrated Dual Diagnosis Team (IDDT) based service would include use of evidence based therapeutic practices, pharmacological intervention, MAT services, active physical health care management, individual, family and group treatment, case management and outreach services, and care coordination services as clinically appropriate. Treatment could be delivered through

A. Partial hospitalization (ASAM level 2.5) of 20 or more hours of services per week

B. Intensive outpatient services (ASAM level 2.1) of more than 9 hours of services per week.

C. Ambulatory Withdrawal Management with extended on-site monitoring (ASAM 2-WM) for moderate withdrawal not requiring 24-hour support.

D. **ASAM Level 1-Outpatient substance use treatment** is provided in a licensed Outpatient facility which provides regularly scheduled individual, group and/or licensed family counseling for less than nine (9) hours per week. Services may be provided to patients discharged from a more intensive level of care but are not necessarily limited to this. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Counseling Services. This care approximates ASAM PPC-2R Level 1.
   1) **Counseling / Therapy Services**
      a. Individual: in a full session, which includes face to face and documentation for one (1) hour
      b. Individual: in a half-session, which includes face to face and documentation for thirty (30) minutes
      c. Group: minimum sixty (60) minutes, no more than 10 per group
      d. Family: To be included during course of treatment as clinically indicated
   2) **Psychoeducation**
      a. Didactic sessions focused on harm reduction and relapse prevention
      b. Family education and information sessions as clinically indicated
   3) **Team based services**
      a. Pharmacological intervention
      b. Evidence based therapeutic practices
      c. Medication Assistant Treatment (MAT) (excluding Methadone) services
      d. Active physical health care management
      e. Individual, family and group treatment, case management and outreach services
      f. Care coordination services
      g. Primary care liaison

E. **ASAM Level 2.1 Intensive Outpatient Program (IOP)** This care approximates ASAM Level II.I care. This level of substance use treatment is provided in a licensed IOP facility which provides a broad range of highly clinically intensive clinical interventions. A minimum of three (3) hours of treatment services must be provided on each billable day

to include one individual session per week. IOP treatment will generally include intensive, moderate, and step-down components. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Substance Abuse Counseling Services.

1) **Counseling / Therapy Services**
   a. Individual: 1 hour/week minimum
   b. Group: 9 hours/week minimum
   c. Family: To be included during course of treatment as clinically indicated
2) **Psychoeducation**
   a. Didactic sessions: 2 hours/week minimum
   b. Family education and information sessions as clinically indicated.

F. **ASAM Level II.5 PARTIAL CARE SUBSTANCE ABUSE TREATMENT**

Partial Care substance use treatment is provided in a licensed facility which provides a broad range of highly clinically intensive interventions. Services are provided in a structured environment for no less than 20 hours per week. **A minimum of four (4) hours of treatment services must be provided on each billable day to include one individual session per week.** Lunch is not a billable hour. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Substance Abuse Counseling Services. Programs have ready access to psychiatric, medical and laboratory services. This care approximates ASAM PPC-2 Level II.5 care.

1) **Counseling / Therapy Services**
   a. Individual: 1 hour/week minimum
   b. Group: 8 hours/week minimum
   c. Family: To be included during course of treatment as clinically indicated
2) **Psychoeducation**

   Didactic sessions: 3 hours/week minimum
   Family education and information sessions as clinically indicated

SERVICES FOR ADOLESCENTS WITH COMPLEX OR SEVERE SUBSTANCE-RELATED DISORDERS (with or without co-occurring with a mental health condition):

A. **ASAM Level 1-Outpatient substance use treatment** is provided in a licensed Outpatient facility which provides regularly scheduled individual, group and/or licensed family counseling for less than nine (9) hours per week. Services may be provided to patients discharged from a more intensive level of care but are not necessarily limited to this. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Counseling Services. This care approximates ASAM PPC-2R Level 1.
   1) **Counseling / Therapy Services:**
      a. Individual: in a full session, which includes face to face and documentation for one (1) hour
      b. Individual: in a half-session, which includes face to face and documentation for thirty (30) minutes
      c. Group: minimum sixty (60) minutes, no more than 10 per group
      d. Group staffing ratio 2:10
      e. Family: To be included during course of treatment as clinically indicated
   2) **Psychoeducation**
      a. Didactic sessions focused on harm reduction and relapse prevention
      b. Family education and information sessions as clinically indicated

B. **ASAM Level 2.1 Intensive Outpatient Program (IOP)** This care approximates ASAM Level II.I care. This level of substance use treatment is provided in a licensed IOP facility which provides a broad range of highly clinically intensive adolescent specific clinical interventions. A minimum of three (3) hours of treatment services must be provided on each billable day to include one individual session per week. IOP treatment will generally include intensive, moderate, and step-down components. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Substance Abuse Counseling Services.
   1) **Counseling / Therapy Services:**
      a. Individual: 1 hour/week minimum
      b. Group: 9 hours/week minimum
      c. Group staffing ratio 2:10

d. Family: To be included during course of treatment as clinically indicated

2) Psychoeducation:

a. Didactic sessions: 2 hours/week minimum
b. Family education and information sessions as clinically indicated.

ADDENDUM 8: Additional Requirements for Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans

4.k.1 & 4.k.5 Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. See: VHA Uniform Mental Health Services Handbook

The following are the 10 guiding principles of recovery: *(Substance Abuse and Mental Health Services Administration [2012]).*

1. Hope
2. Person-driven
3. Many pathways
4. Holistic
5. Peer support
6. Relational
7. Culture
8. Addresses trauma
9. Strengths/responsibility
10. Respect

As implemented in VHA recovery, the recovery principles also include the following:

1. Privacy
2. Security
3. Honor

4.k.2 All individuals inquiring about services are asked whether they have ever served in the U.S. military.

1. Active-Duty Service Members (ADSMs) who reside within 50 miles of, or one hour's drive time from, a Military Treatment Facility (MTF) must use their serving MTF. If such an ADSM seeks services from a CCBHC, CCBHCs must contact the individual's MTF Primary Care Manager for a possible referral for services.
2. If the individual is an Active-Duty Service Member (ADSM) or an activated Reserve Component member who resides more than 50 miles or one hour's drive time from a Military Treatment Facility (MTF), then CCBHCs must contact the individual's TRICARE PRIME Remote Primary Case Manager for possible referral for specialized services.
3. If the individual is a Selected Reserve member not on active duty and the CCBHC is an authorized TRICARE Reserve Select provider, or the individual is a veteran but declines, or is ineligible, to enroll in the Veterans Health Administration, CCBHCs must provide services in a manner consistent with the minimal clinical guidelines promulgated by the Veterans Health Administration (VHA).
4. If the individual is a veteran not currently enrolled in the VHA, CCBHCs must offer to assist the individual in enrolling in the VHA.

5. Current Military Personnel: Persons affirming current military service will be helped in the following manner:

    A. Active-Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF.
    B. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide; and works with the regional managed care support contractor for referrals/authorizations.

C. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE-authorized provider, network, or non- network.

Veterans: Persons affirming former military service (veterans) are aided enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA, including clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). **Note:** See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs

The Principal Behavioral Health Provider ensures the following requirements are fulfilled:

1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
2. A psychiatrist, or such other independent prescriber as satisfies the current requirements of the reviews and reconciles each veteran's psychiatric medications on a regular basis. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).
3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).
4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
5. The treatment plan is revised, when necessary.
6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to decide about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

ADDENDUM 9: Quality Measures Reporting Requirements

All CCBHCs will have to have the proper health information technology and capacity to report nine federally required quality measures. CCBHC's will be required to report four of the nine measures into the BHDDH Behavioral Health On-Line Data platform, known as BHOLD. BHDDH will submit the measures captures in BHOLD on the CCBHC's behalf. The CCBHC will be responsible for the remaining five measures from their electronic health records or through other means.

CCBHC Federally Required Quality Measures Data Source and Party Responsible for Providing Data			
Measure Name		RI Source of Data	Party Responsible for reporting
1	Time to Initial Evaluation (Percent of new consumers with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients)	CCBHC EHR (Quarterly Report)	CCHBC
2	Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up	BHOLD Based on CCBHC entry	BHDDH Based on CCBHC entry
3	Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	BHOLD *Based on CCBHC entry*	BHDDH
4	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	BHOLD *Based on CCBHC entry*	BHDDH
5	Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	BHOLD *Based on CCBHC entry*	BHDDH
6	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	CCBHC EHR (Quarterly Report)	CCHBC
7	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	CCBHC EHR (Quarterly Report)	CCHBC
8	Screening for Clinical Depression and Follow-Up Plan	CCBHC EHR (Quarterly Report)	CCHBC
9	Depression Remission at Twelve Months	CCBHC EHR (Quarterly Report)	CCHBC

See table next page detailing additional required measures for which the state is responsible for reporting as part of the CCBHC Demonstration Project.

Federally Required Measures to be Reported by the state as part of the CCBHC Demonstration Program: *These measures will be used to evaluate participant performance but will be captured by State via Claims Data			
	Measure Name	RI Source of Data	Responsible Reporting Party
10	Follow-up after Emergency Department Visit for Mental Health Illness	MMIS	BHDDH
11	Follow-up after Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence	MMIS	BHDDH
12	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	MMIS	BHDDH
13	Adherence to Antipsychotic Medications for Individuals with Schizophrenia*	MMIS	BHDDH
14	Follow-up after Hospitalization for Mental Illness, ages 21+ (adult)	MMIS	BHDDH
15	Follow-up after Hospitalization for Mental Illness, ages 6-21 (child/adolescent)	MMIS	BHDDH
16	Follow-Up Care for Children Prescribed ADHD Medication*	MMIS	BHDDH
17	Antidepressant Medication Management*	MMIS	BHDDH
18	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	BHOLD/MMIS	BHDDH
19	Housing Status *	URS	BHDDH
20	Plan All-Cause Readmissions Rate*	MMIS	BHDDH
21	Patient Experience of Care Survey	OEI	BHDDH
22	Youth/Family Experience of Care Survey*	**Survey Under Development**	BHDDH
Additional Measures Required by Rhode Island			
1	Adult Access to Preventive/Ambulatory Health Services (AAP)		CCBHC

ADDENDUM 10 – CCBHC Standard on Governance and Meaningful Consumer/Family Participation - Community/Consumer Advisory Council

1. The CCBHC will develop a Community/Consumer Advisory Council ("Council") for each service area served. For Governing Boards that meet the 51% standard in criteria 6.B of the CCBHC standards, those board has the option of functioning as that Council or creating a separate Council(s). If the 51% standard is not met, the organization must create a separate Council. The bylaw of all CCBHC governing boards would be amended to reflect this requirement and the duties and responsibilities listed below.
2. The CCBHCs would have the option of developing separate Councils for children/youth/families and another for adults.
3. The Council would be a vehicle for the formation of strong local partnerships to address local communities across the lifespan, assist in the implementation of state behavioral health policies, provide a forum for meaningful participation and input by consumers and family members into CCBHC governing policies and practices, and create centers of excellence for community services. The CCBHC will assign and fund the necessary behavioral health planning position(s) to support and assist the functioning of the Council.
4. The Council would
    a. review and assess the performance of the CCBHC including accessibility of services for all populations; staff competency and training; review of internal CQI processes and effectiveness of collaborative arrangements.
    b. Review quality and client outcome data and identify areas for improvement
    c. Support the creation of locally organized systems of care for persons with behavioral health issues.
    d. Help align/integrate local service delivery with statewide priorities and provide input into the statewide planning processes.
5. The Council would meet at least six times per year and comprise of at least two governing board members, with the majority consisting of consumers and family members. Collaboration, involvement, and networking with consumer, family, and advocacy and community provider groups such as NAMI, RICARES, and MHARI as well as HEZ, Prevention Coalitions, homeless providers and local educational authorities are strongly encouraged.
6. Minutes of each meeting will be of sufficient detail to reflect attendance, topics and issues discussed, information reviewed, and recommendations made to management and/or to the governing Board. The Governing Board minutes reflect the quarterly review and discussion on the Council recommendations.
7. Additional guidance and requirements for the Council and related functions may be issued by BHDDH from time to time to support, direct, and clarify the mission and functions of the Council.
8. The Council would be required to meet at least once before the end of the first year as a CCBHC.