Certified Community Behavioral Health Clinics

State of Rhode Island Certification Guide

March 2024

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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, those CCBHC criteria were further amended in March of 2023. 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..

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. In March of 2023, BHDDH was one of the 15 states awarded a CCBHC one-year planning grant to prepare for the application to be selected as a demonstration state in 2024.

From 2018 until the present, SAMHSA has awarded CCBHC expansion grants directly to 7 community providers, 5 of whom were Community Mental Health Centers. This helped in creating a critical mass of providers familiar with the CCBHC model in Rhode Island.

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 and EOHHS'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, including screening for HIV and Viral Hepatitis (4.g.1)
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 is also required:

- 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. The CCBHC may deliver the 9 required services + ACT, directly or through formal agreements with Designated Collaborating Organization (DCO). The CCBHC must have the capacity to directly provide mental health and substance use services to people with serious mental illness and serious emotional disorders, as well as developmentally appropriate mental health and substance use care for children and youth separate from any DCO relationship. This DCO relationship shall include provisions that assure that the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria. To this end, DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with care coordination partners.

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."

This guide describes requirements associated with each criterion, 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 SAMHSA Certified Community Behavioral Health Clinic Certification Criteria 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. Rhode Island reserves the right to specify additional community needs assessment requirements to evaluate the need to implement additional CCBHCs.

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.
2. Be a qualified Medicaid provider or be in process at the time of application.
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
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 with populations of focus and priority consumer populations and ability to provide a majority of the required services and perform all required functions listed in the SAMHSA CCBHC criteria.
6. In service areas where one or more CCBHCs are already operational, proposed new CCBHCs must demonstrate that there is currently an unmet need for CCBHC services and describe how they will meet that need

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. CCBHCs will be designated and certified by service area in accordance with Rhode Island General Laws section 40.1-8.5-1 et seq. Applicants 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
5. BHDDH intends to certify CCBHCs per catchment area. The data related to the needs of a given catchment area, following SAMHSA guidelines, will inform the need to certify additional CCBHCs.
6. CCBHCs should have the ability to directly, or through a DCO, provide all the required CCBHC services throughout their catchment area. A CCBHC must have the capacity to directly provide 51% of all encounters of required CCBHC services, excluding crisis service encounters. CCBHCs must have the capacity to directly provide mental health and substance use services to populations of focus across the lifespan.

7. CCBHCs shall be required to accept and maintain involuntary patients under Civil Court Outpatient Certification orders 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.
8. 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, adult and children's residential programs, individuals being released from the juvenile and adult justice systems, as well as state hospital discharges.
9. Individuals seeking services will be free to select a CCBHC of their choice and are not restricted to a CCBHC 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?

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) and the SAMHSA 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.**

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] and Childrens Behavioral Health Organization (CBHO) licensure when finalized
2. Accreditation by CARF, Joint Commission, 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.

When and if new application periods are announced, the application will include criteria for certification and scoring and evaluation criteria. Upon receipt of the application, BHDDH will conduct a preliminary review of the documentation provided and may request additional or clarifying information. If BHDDH deems the documentation to be complete, BHDDH and an Interagency Review team will conduct a review of the application as well as an on-site assessment. Prior to the onsite assessment BHDDH, and the Interagency Review team will share an anticipated agenda, schedule and requested materials for review.

[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).

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

1. **“Certified**” as meeting all the standards of a qualified CCBHC, EOHHS Readiness Criteria, and approved cost report will be eligible to participate in the CCBHC program for a two-year period. Certified entities would be subject to recertification every two years.
2. **“Not Certified”** and required to make specified enhancements prior to participating in the CCBHC program.

- Organizations with **“Contingent Certification”** status prior to 7/1/2024 may maintain their status until deemed “Certified”

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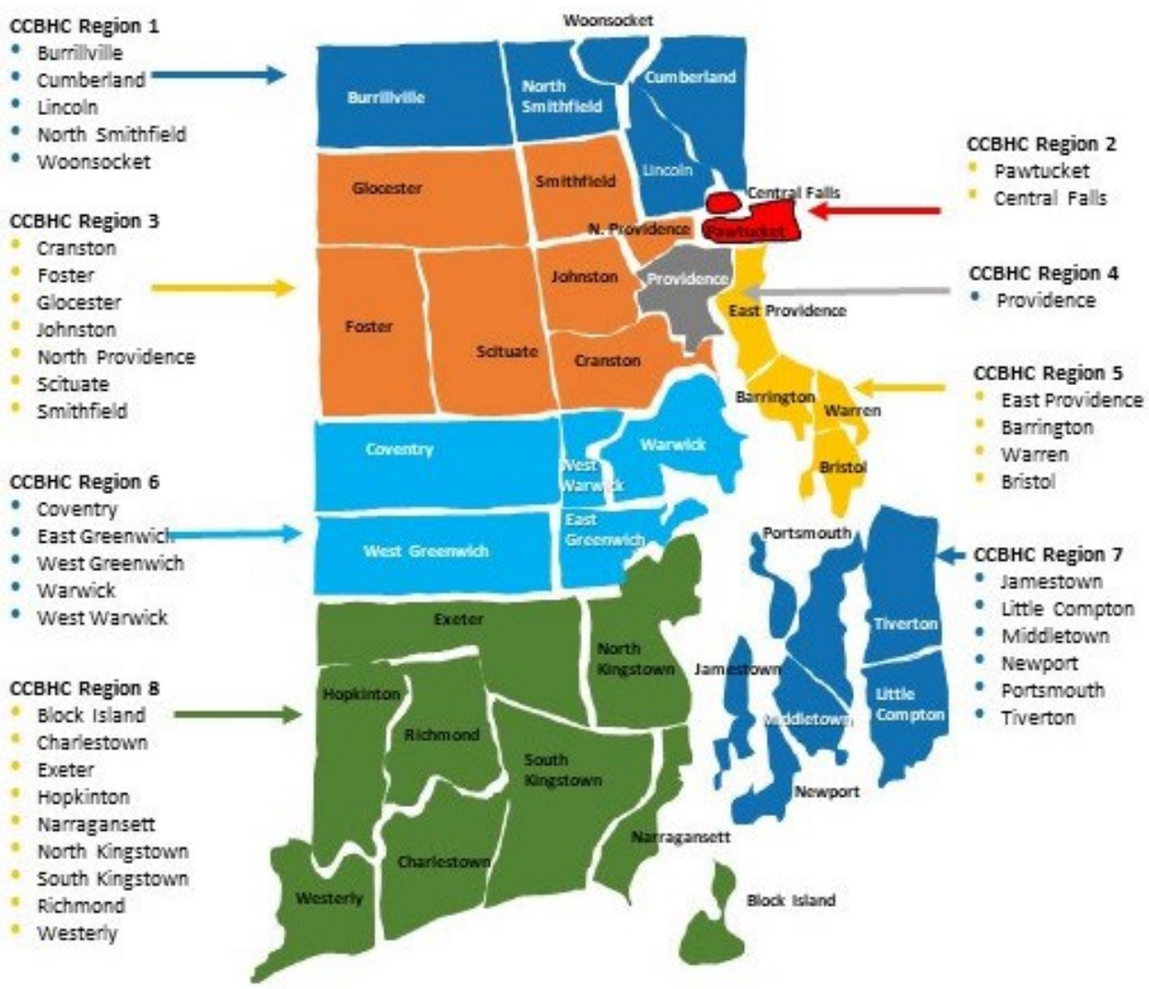
State of Rhode Island CCBHC Regions



Section 1 - STAFFING

General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
1.a.1 As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment (see Appendix A: Terms and Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years. Certifying states may specify additional community needs assessment requirements.	The CCBHC will need to demonstrate that they have done a population-level community needs 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 community needs assessment that addresses cultural, linguistic, treatment and staffing need 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* **. A statewide community needs assessment will be completed by the State of Rhode Island in 2024.** A community needs assessment for the purpose of identifying appropriate staffing and services for the area served by the CCBHC is required every 3 years, at a minimum. The state conducts a community needs assessment to meet requirements of the SAMHSA Combined Substance Use and Mental Health Block Grant. The Block Grant Needs Assessment Report describes the unmet service needs and critical gaps within the current system as well as any advances that have been made. The data provided is state level	1. The applicant will provide a summary of community 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 applicant'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 the 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 applicant. 2. Please describe how many individuals did the applicant 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 submission of state requested staffing workbook will, include clinical staff and clinical leadership providing services to the populations of focus (SPMI, SUD and SED), including the clinical groupings and identify Qualified Mental Health Professionals (QMHPs) and their availability. (Can be used to demonstrate compliance with 1.a.2)

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General Staffing Requirements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	aggregate data and identifies priority needs related to the provision of behavioral health services. For the purposes of the initial CCBHC application period, this will serve as the state needs assessment. See: fy2022-2023-combined-mental-health-and-substance-abuse-block-grant-application-behavioral-health-assessment-and-plan.pdf (ri.gov) Block Grant Needs Assessment Reports pp.269-294. The needs assessment process utilized can be adapted for use within a catchment or service area. Applicants who have not completed a needs assessment or those who have a needs assessment that is over three years old will be expected to complete a needs assessment within a year of certification. CCBHCs will be required to participate in the needs assessment process for Combined Block Grant Report no later than 2025. This assists the state in acquiring more comprehensive sub-state data concerning behavioral health needs, resources and gaps. This information will be used to prioritize needs and develop strategies to fund services that are needed. TJC accreditation cannot 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.	5. For applicant without a completed community needs assessment Provide an attestation that needs assessment or update will be completed within 1 year of certification. 6. For applicant with a current community needs assessment: Provide an attestation that the organization commits to meeting standard 1.a..1 requiring a needs assessment be conducted every three years.

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General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	TJC: LD.03.06.03, EP 1-6,	
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 population* The CCBHC services or programs should be organized or coordinated to maximize accessibility and client flow among those services, consistent with the role of the CCBHC as a fixed point of accountability for clinical care. This could include transition between services and/or access to additional services needed and provided by the applicant. 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 state requested staffing workbook (fulfilled by 1.a.1). 3. A description of how the CCBHC services or programs are organized or coordinated to maximize accessibility and client flow among those services including transition between services and/or access to additional services needed and provided by the applicant. 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 Use Disorders (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.*

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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, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/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 or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care and provide guidance to foster the integration[3] and coordination of behavioral health and primary care. **Note:** If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if	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. **See Addendum 1 for a sample job description for the CCBHC Medical Director.**	1. The applicant 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 **Approval to fill medical director position with personnel other than a psychiatrist must be approved by BHDDH**. *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.*

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General Staffing Requirements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.		
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	1. The applicant is currently licensed as a Behavioral Health Organization by BHDDH. 2. The applicant 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 applicant that applies to operate as a CCBHC and for any DCO proposed to deliver clinical services*

Section 1 - STAFFING

General Staffing Requirements

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	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.	

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 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. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.	CCBHCs will need to be appropriately licensed by BHDDH to provide clinical services and accredited by Joint Commission, CARF, or COA. 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.	1. The applicant and DCO is licensed as a behavioral health organization (BHO) by BHDDH for any clinical service proposed. 2. The applicant has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 3. Copy of accreditation document including any relevant endorsements or certifications. 4. Attestation that the applicant'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**
	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 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	CARF and COA accreditation address the need for licensure, accreditation and certification as required by	1. The applicant is required to supply:

Licensure and Credentialing of Providers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, 1. The CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. 2. CCBHC staff 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 FDA- approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. 3. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. 4. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced[4] addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. 5. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and	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**	a. 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. b. A staffing plan must include medically trained behavioral healthcare providers to prescribe FDA approved medications for SUD/MAT 2. The applicant 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. 3. The applicant will provide documentation of a care coordination agreement with an OTP. *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**
adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: a. psychiatrists (including general adult psychiatrists and subspecialists) b. nurses, c. licensed independent clinical social workers, d. licensed mental health counselors, e. licensed psychologists, f. licensed marriage and family therapists, g. licensed occupational therapists, h. staff trained to provide case management, i. certified/trained peer specialist(s)/recovery coaches, j. licensed addiction counselors, k. certified/trained family peer specialists, l. medical assistants, and m. community health workers. 6. The CCBHC supplements its core staff as necessary in order to adhere to 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[8]: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies, to the extent possible, to alleviate shortages, provided*		

Licensure and Credentialing of Providers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision. ★ Certifying states should specify which staff disciplines they will require as part of certification.		

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
1.c.1 The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on: • Evidence-based practices • Cultural competency (described below) • Person-centered and family-centered, recovery-oriented planning and services • Trauma-informed care • The clinic's policy and procedures for continuity of operations/disasters • The clinic's policy and procedures for integration and coordination with primary care • Care for co-occurring mental health and substance use disorders	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. The applicant 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	1. The applicant 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. 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 those topics listed in CCBHC criteria 1.c.1 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

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
• At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff. Trainings may be provided on-line. • Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)[6] to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website,[7] the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration. ***Note:*** *See criteria 4.k relating to cultural competency requirements in services for veterans.*	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 **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 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.	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.
1.c.2 The CCBHC regularly assesses 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	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	1. The applicant has one or more of following accreditations: CARF/BH and/or, COA/MHSU and/or TJC/BH 2. The applicant provides the policy or procedure titles, numbers, dates of issuance or revision dates, and/or page numbers for assessing skills

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.	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 is 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.	and competence of staff (CCBHC and/or DCO) providing CCBHC required, age-appropriate services.
1.c.3 The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. CCBHCs are encouraged to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.	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 applicant has one or more of following accreditations: CARF/BH and/or, COA/MHSU and/or TJC/BH 2. The applicant provides the 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

Cultural Competence and Other Training		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
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 applicant has one or more of following accreditation CARF/BH and/or COA/MHSU and/or TJC/BH 2. The applicant 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. The applicant submits a 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 The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.	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 applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH 2. The applicant provides a 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 readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or 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 applicant 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	CARF COA and TJC accreditation address ADA compliance but additional documentation is needed to determine if the	1. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH

Linguistic Competence and Confidentiality of Consumer Information		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
consumers with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).	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	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 3. Attestation of availability of auxiliary aids and services that are ADA compliant and responsive to the needs of consumers with disabilities.
1.d.4 Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.	The applicant 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 applicant 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.
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. These include, but are not limited to, the requirements of the 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.	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-Cj; 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	1. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH 2. The applicant attests that DCO agreements include language requiring compliance with applicable federal and state statutes and regulations related to confidentiality and privacy.

Linguistic Competence and Confidentiality of Consumer Information		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	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.	

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, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.	CARF, COA and TJC accreditation address environment of care and can be used to demonstrate full compliance with the standard. **CARF**: 1.H.1. **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	1. The applicant and DCO are licensed as BHOs by BHDDH and licensed as a CBHO by DCYF (when available) if applicable. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH.
2.a.2 Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate	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 to demonstrate partial compliance with the standard. Additional information on operating hour is necessary.	1. The applicant has one or more of following accreditations: CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant lists the location of services/programs that will be available, the times that they will be available including evening

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES

General Requirements of Access and Availability

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.	**CARF**: 3.O.3.a.-c. **COA**: MHSU 5 & MHSU 6.01. **TJC**: CTS 01.01.01, EP 27.	and weekend hours for the CCBHC service area. (This can also be used to satisfy 2.a.3.)
2.a.3 Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.	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 applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant and DCOs list the locations of services/programs at each location, and the times that they will be available including evening and weekend hours for the CCBHC service area
2.a.4 The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.	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.	1. The applicant 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.
2.a.5 The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support 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	1. The applicant provides a description of the applicant's use of mobile in-home, telehealth/telemedicine, and on-line treatment services. 2. The applicant provides a copy of the policies or procedures related to services that are provided outside of the clinic including but not limited to mobile crisis; case management; care

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES		
General Requirements of Access and Availability		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	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.	coordination; telehealth; outreach and engagement activities, and provision of Individual Placement and Supports
2.a.6 . Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.	The CCBHC must have staff dedicated to outreach and engagement who do not carry a caseload. 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 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. The CCBHC must have policies and procedures to describe how outreach and engagement activities will occur to assist clients and families to access care and to address behavioral health conditions and needs	1. The applicant 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 applicant provides a description of special populations prioritized for outreach and engagement based on the needs assessment (see standard 1.a.1; information provided to demonstrate compliance with 1.a.1 may be used to satisfy this standard).

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES		
General Requirements of Access and Availability		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	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.	
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. **TJC**: LD 04.01.01, EP 2 & 3. 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.	1. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant indicates whether the applicant currently has facility status with BHDDH or provide an attestation indicating that the applicant or DCO has a pending application for facility status to provide court order outpatient services, if the applicant does not have facility status at the time of application. 3. The applicant attests that it has trained staff with appropriate credentials to provide individuals who are ordered by the court to obtain substance use treatment after a Driving Under the Influence or Refusal charge. .

Section 2 - AVAILABILITY AND ACCESSIBILITY OF SERVICES

General Requirements of Access and Availability

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
2.a.8 The CCBHC has a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occur, or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.	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 applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant is licensed by BHDDH as a BHO. If the 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. 3. The applicant attests that the disaster plan includes all elements of criteria 2.a.8

Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in- person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.	This criterion describes a five-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. 1. CCBHCs will determine whether the need for services is an emergency/crisis need, urgent, or routine, as well as the types of services required. 2. CCBHCs will complete a comprehensive screening on the same day the consumer presents to the clinic.	1. The applicant attests that it will be capable of reporting the mean number of days before an initial, comprehensive, diagnostic and planning evaluations are completed. 2. The applicant 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 applicant 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**
• If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made. • If the triage 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 by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. • The preliminary triage and risk assessment will be followed by an initial evaluation and a comprehensive evaluation, with the components of each specified in program requirement • At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. • subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of	3. If the screening identifies routine needs, services will be provided, and the initial evaluation completed within 10 business days 4. All new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services 5. CCBHCs will monitor the number of days from first request for services to completion of the comprehensive evaluation • In part the intent of this criterion is 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; 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	

Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
the comprehensive evaluation, or the provision of treatment during the 60-day period. ***Note:*** *Requirements for these screenings and evaluations are specified in criteria 4.d.*	standard.: 212-RICR-10-10-1.6.1; 212-RICR-10-10-1.6.2; 212-RICR-10-10-1.6.7	
2.b.2 The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or applicable accreditation standards are more stringent.	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 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 applicant attests that everyone's person-centered and family – centered treatment plan is reviewed and updated with the cooperation of the person receiving services. 2. The applicant attests that treatment plan will be updated when there are changes in status, responses to treatment, or goal achievement and/or at least every 6 months 3. The applicant 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.
2.b.3 People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if	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: • Urgent needs (emergency/crisis) who began receiving required	1. The applicant 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

Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
necessary. If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.	clinical services within 1 business day, and • Routine needs for began receiving required clinical services within 10 business days.	within 1 business day, and the number and percentage of individuals with routine needs who began receiving required services within 10 business days.

Access To Crisis Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2.c.1 In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.	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.	1. The applicant 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 A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made 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. RI regulation addressing crisis response can be used for partial demonstration of compliance: 212-RICR-10-10-1.6.7	1. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant attests those 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. The applicant provides a link to the website where the information is posted.

Access To Crisis Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
2.c.3 Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. 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.d).	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 applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant provides CCBHC or DCO policies and procedures, number and titles, issuance or revision date related to accessing crisis management services, coordination with 988 Suicide and Crisis Lifeline and other area hotlines and warmlines, and overdose prevention and related topics covered at the time of initial evaluation.
2.c.4 In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services 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.:	1. The applicant provides 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**
	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.	
2.c.5 Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations. ***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.	1. The applicant 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, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.	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.	1. The applicant 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**

Access To Crisis Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
Note: *See criterion 3.a.4 where precautionary crisis planning is addressed.*	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.	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)) 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 i in clause (1).
2.d.2 The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.	The applicant employs a standard means test and implements a sliding fee scale.	1. The applicant provides a copy of the applicant's sliding fee schedule 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. 2. Policy governing the sliding scale fee must indicate that services will continue to be provided regardless of the individual receiving services ability to pay the sliding scale fee.

No Refusal of Services Due to Inability to Pay		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
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 applicant employs a standard means test. A 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.	1. The applicant 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 applicant employs a standard means test. A 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.	1. The applicant 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, homelessness or lack of a permanent address.	The applicant's policies provide that no individual will be denied services due to place of residence or homelessness	1. The applicant attests that it will not deny services to individuals who do not have a current permanent address.
2.e.2 The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area 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 the CCBHC to refer and track individuals seeking non- crisis services to the CCBHC or other clinics		1. The applicant 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.

Provision of Services Regardless of Residence		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience out-of- home placements and adults who are displaced by incarceration or housing instability.		

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
3.a.1 Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes 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. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare. ***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 for adults and children; ambulatory and medical detoxification, stepdown or residential programs; Department of Corrections (probation and parole as well); community groups serving individuals and families from diverse cultural, ethnic and racial background, District Court, Federally Qualified Health Centers and Accountable Entities, regional substance misuse prevention coalitions, Health Equity Zones and Family Care Community partnerships (FCCPs). CCBHCs must work with the Continuum of Care Collaborative Applicants to take referrals from the housing programs for eligible participants needing Home Stabilization services in their catchment area. 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. **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.	1. Please describe the applicant's strategies to develop, maintain and continually evaluate effective inter-organizational care coordination partnerships within and outside the healthcare system. 2. The applicant provides a copy of its policies, procedures and protocols related to care coordination. 3. Care coordination agreements are required to include specific information and protocols that include (at a minimum) referrals, discharges, tracking, information sharing, performance measures, key contacts and review and monitoring of agreement. 4. The applicant attests that they will work with the Continuum of Care Collaborative applicants to take referrals from the housing program for elligible participants needing Home Stabilization services in their catchment area.

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	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.**	
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 laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is 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. ***Note:*** *CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.*[10]	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. **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, 2.G.1.a-c & 2.G.4.b, t and 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	1. The applicant and/or DCO are licensed as a BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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 the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of		1. The applicant's policies and procedures include a requirement that when an individual is referred to external providers or resources,

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.		CCBHC tracks participation in services to ensure care coordination and necessary supports are provided.
3.a.4 The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services.[11] Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.	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. **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	1. The applicant has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 2. The applicant provides policy or procedure titles, numbers, issuance or revision dates and/or page numbers related to: a. Crisis planning policies and protocols (must include requirements listed in 3.a.4 and 1.d which addresses how individuals with LEPs and disabilities can access information and referrals b. Care coordination policies and protocols.

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
3.a.5 Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required 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 applicant 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, policy must include required consultation with the Prescription Drug Monitoring Program (PDMP) prior to prescribing medication and during the comprehensive evaluation.
3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its DCOs, or with any other provider.	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 applicant provides an attestation indicating that the CCBHC/DCO agreements include a provision regarding the consumer's freedom to choose their provider with the CCBHC, DCO or any other provider.

Section 3 - CARE COORDINATION

General Requirements of Care Coordination

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
3.a.7 The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.		1. The applicant attests that it assists people receiving services with accessing benefits, including Medicaid, and assistance with enrolling persons served in other beneficial programs or supports.

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.	CCBHCs 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.	1. The applicant attests that their information systems maintain electronic health information including electronic health records.

Care Coordination and Other Health Information Systems		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.b.2 The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange.[12] For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.		1. The applicant provides information on its' HIT system and its' capability to conduct activities such as population health management, quality improvement, reducing disparities, research and outreach. 2. The applicant attests that their information systems comply with the requirements in 3.b.2
3.b.3 The CCBHC uses technology that has been certified to current criteria[13] under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities (see footnotes for citations to the required health IT certification criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs:[14] • Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).[15]		1. The applicant attests that their information systems comply with these requirements (3.b.3) and if it does not it includes a detailed plan on implementing these requirements including a personal health portal.

Care Coordination and Other Health Information Systems		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
• At a minimum, support care coordination by sending and receiving summary of care records.[16] • Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice.[17] • Provide evidence-based clinical decision support. [18] • Conduct electronic prescribing. [19] ***Note:*** *Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.*		
3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are 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.	1. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant provides copies of consent forms utilized for HIT from the applicant and any DCOs and/or copies of agreements with DCO reflecting compliance with these criteria. 3. The applicant 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

Care Coordination and Other Health Information Systems		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	TJC IM 02.01.01, EP 1,3&4; IM 02.01.03, EP1,2, 5,6 & 7.	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 The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes 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. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.		1. The applicant provides a plan to improve care coordination between the CCBHC and all DCOs within two years utilizing health information technology to streamline and support integrated evaluation planning, treatment and care coordination as further detailed in 3.b.5.

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
3.c.1 The CCBHC has a partnership 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 people receiving services who are served by other primary care providers, including but not limited to FQHC	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 everyone PCP. <u>CCBHC Requirements:</u>	1. The applicant provides evidence of partnerships (as defined in the 3.c.1) regarding care coordination from FQHCs serving CCBHC consumers; or identify that no FQHC/ Rural Health Clinics exist in the proposed service area. 2. The applicant provides care coordination protocols for any other primary care providers

Care Coordination Agreements		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*	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 everyone'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 partnerships with FQHCs as appropriate. Prior to certification, CCBHCs should seek informal partnerships (e.g., letters of support, agreement or commitment) regarding care coordination from FQHCs serving CCBHC consumers.	
3.c.2 The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the	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 applicant provides documentation of partnerships with programs that provide inpatient psychiatric treatment, ambulatory and medical detoxification, post-detoxification step-down services, residential programs, OTP services, medical withdrawal management facilities and tribal operated mental health and substance use services, to promote care coordination, including 988 and BH LINK. 2. The applicant 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

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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, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.* ★ Certifying states are encouraged to find ways to incentivize inpatient treatment facilities to partner with CCBHCs to establish protocols and procedures for transitioning individuals, including real time notification of discharge and record transfers that support the seamless delivery of care,	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, residential programs, OTP services, medical withdrawal management facilities and tribal operated mental health and substance use services. 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. ★ CCBHCs should have partnerships with 9-8-8 and BH Link. 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.	appropriate transitions to safe community settings, including overdose prevention services during transfer

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maintain recovery, and reduce the risk of relapse and injury during transitions.		
3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: • 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. CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people	<u>CCBHC Requirements</u>: The CCBHC establishes collaborative working relationships, and prior to certification seeks partnerships 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 partnerships with such other community or regional services, supports, and providers as may be necessary given the population served and the needs of individual consumers. CCBHCs should have partnerships with 9-8-8 and BH Link.	1. The applicant provides a list of the community and regional services, supports and providers with which it has established partnerships to promote care coordination. 2. The applicant provides documentation of partnerships regarding care coordination from key community and regional services, supports and providers 3. The applicant 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.

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receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following • Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders • Suicide and crisis hotlines and warmlines • Indian Health Service or other tribal programs • Homeless shelters • Housing agencies • Employment services systems • Peer-operated programs • Services for older adults, such as Area Agencies on Aging • Aging and Disability Resource Centers • State and local health departments and behavioral health and developmental disabilities agencies • Substance use prevention and harm reduction programs • Criminal and juvenile justice, including law enforcement, courts, jails, prisons, • and detention centers • Legal aid • Immigrant and refugee services • SUD Recovery/Transitional housing • Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs • Coordinated Specialty Care programs for first episode psychosis		

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• Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs) • In addition, the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located. **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 decide whether the contingency plans are sufficient or require further efforts.* ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.* ★ Certifying states may require CCBHCs to establish additional partnerships		

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3.c.4 The CCBHC has partnerships 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 work to establish care coordination agreements with facilities of each type. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities*		1. The applicant provides documentation of partnerships regarding care coordination with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facilities of the VA. These partnerships should be supported by a formal written agreement detailing the roles of each party. Other forms of partnership documentation are indicated in 3.c.4.

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should be documented to support partnerships independent of any staff turnover.		
3.c.5 The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission -Discharge- Transfer (ADT) system. The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these	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 partnerships, to promote care coordination with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, in the area served by the CCBHC. Expectations of use of peer recovery specialists/coaches to help individuals transition from these facilities to community care.	1. The applicant lists inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, and providers of peer-based recovery support services/Recovery Community Centers with which it has established collaborative relationships to promote care coordination. 2. The applicant provides documentation of partnerships regarding care coordination with such programs and services (3.c.5) 3. The applicant 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.

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settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk. ***Note:*** *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*		

Treatment Team, Treatment Planning and Care Coordination Activities		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**

3.d.1 The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person- and family-centered and align 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.	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 applicant is licensed by as a BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides policy or procedure number, title, issuance or revision date or page numbers that reflect compliance with this standard.
3.d.2 The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for	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.	1. The applicant is licensed as BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides a list of policy numbers, titles and issuance or revision dates that reflect compliance with this requirement.

people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. ***Note:*** *See criteria 4.k relating to required treatment planning services for veterans.*	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.	

Section 4 - SCOPE OF SERVICES

General Service Provisions

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
4.a.1 Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-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 U.S. Armed Forces and veterans. • The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.	CCBHC Requirement: CCBHCs must provide directly or through a DCO agreement, any of the nine services required by PAMA, provided however that the CCBHC provides a substantial proportion (51% or more of encounters) across the required services (excluding crisis services) 1. Crisis mental health services 2. Screening, assessment, and diagnosis including risk assessment 3. Person-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 The following service enhancements will also be required: • Screening for Hepatitis A, B and C and HIV for populations at risk as defined by the US Preventive Services Task Force • Assertive Community Treatment (ACT)	1. The applicant describes its' capacity to provide each of the nine required services and ACT as part of its CCBHC application including: a. Years of experience providing each. b. The numbers served, separating adults and children, in each category for the most recent one-year period. c. Capacity to provide these services. 2. The applicant 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 applicant provides a list of all MOUs or other agreements that pertain to referral arrangements for treatment, detailing expectations, conditions and time frame. 4. The applicant's contracts with DCOs include all the elements required to comply with the SAMHSA certification criteria as detailed in Addendum 3 Within the scope of the DCO agreement with the CCBHC, DCOs will need to accept all referrals from the CCBHC evaluation including all payers and free care. 5. The applicant attests to theability to capture all encounters whether directly provided or through a DCO arrangements.

Section 4 - SCOPE OF SERVICES		
General Service Provisions		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	CCBHCs must have the capacity to directly provide mental health and substance use services to people with serious mental illness and serious emotional disorders, as well as developmentally appropriate mental health and substance use care for children and youth separate from any DCO relationship. CCBHCs may 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 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 freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if		1. The applicant 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**
a needed specialty service is unavailable through the CCBHC or DCO entities.		
4.a.3 With regard to either CCBHC or DCO services, people receiving services will be informed of and 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 or state authorities.		1. The applicant 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 people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. 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.		1. The applicant attests that DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.

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. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach. ***Note:*** *See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.*	CARF, COA and TJC accreditation address this issue can only be used to demonstrate partial compliance. **CARF** 1. E.1.a. -l. & 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 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	1. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant's contracts with DCOs include all the elements required to comply with the SAMHSA certification criteria, including shared decision-making approach for engagement.
4.b.2 Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.	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 applicant is licensed as a BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or, COA/MHSU and/or TJC/BH. 3. The applicant's proposed or contracted DCOs include providers with demonstrated experience with the prominent cultural groups including those who have identified through the needs assessment process. 4. The applicant 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

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

Crisis Behavioral Health Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.c.1 The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so.[21] Certifying states must request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.[22] PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO: • **Emergency crisis intervention services:** The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC)[23] systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality	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. • **See Addendum 7 – Scope of Services** CCBHC Requirements: *The CCBHC provides* • *24-hour staffed hotline* • *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.* *CCBHC crisis response policies and procedures specify the role of Community Mental Health Liaisons and local law enforcement.*	1. The applicant 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. Provision 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 applicant will be certified under the DCYF Regulation (214-RICR-40-00) and attest that DCOs providing emergency or mobile crisis services to children and youth will also meet this regulatory requirement. 3. The applicant provides a list of which Crisis Behavioral Health Services it provides and those delivered by a DCO, as well as copies of these DCO agreements. 4. The applicant provides an attestation that a. The applicant provides directly ASAM Level1-WM and provides directly, or through a DCO: ASAM Level 2- WM services, including the medical staff trained to provide

Crisis Behavioral Health Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care. • **24-hour mobile crisis teams:** The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan.[24] • **Crisis receiving/stabilization:** The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting	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.	buprenorphine and other medications to assist with withdrawal b. The applicant has referral relationship to access ASAM Level 3.2 (Social Setting Detox) services. c. The applicant has a referral relationship to access ASAM Level 3.7 (Modified Medical Detox) services. 5. The applicant provides the care coordination agreement with 988 Suicide and Crisis Lifeline Center 6. The applicant attests that mobile crisis response arrive within 1 hour (or 2 hours in rural or frontier settings) from the time that they are dispatched. 7. The applicant attests that they have the capacity and ability to connect with individuals in crisis through telehealth if needed. 8. The applicant attests they are able to participate in the local air traffic control system when available, this is a real time coordination of crisis care and linkage to crisis response that involves connection to GPS enabled mobile teams, system wide access to available beds and outpatient appointment scheduling. 9. The applicant attests that crisis services include suicide prevention and intervention services ensuring access to naloxone for overdose reversal to individuals who are at risk for opioid overdose. 10. The applicant provides documentation that indicates their level of compliance with each major aspect of the SAMHSA National Guidelines for Behavioral Health Crisis Care, including 2-person mobile crisis response. 11. 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

Crisis Behavioral Health Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. • Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part		

Crisis Behavioral Health Services		
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of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises. ***Note:*** *See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.*		

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.d.1 The CCBHC directly, or through a DCO, 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., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. ***Note****: See program requirement 3 regarding coordination of services and treatment planning.*	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 applicant is licensed as a BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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**
	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 7 - Scope of Services for service descriptions.**	
4.d.2 Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.	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 applicant is licensed as BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides policy or procedure numbers, titles and issuance or revision dates that reflect compliance with this requirement

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum: • Preliminary diagnoses • The source of referral • The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved • Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services • A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications • A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful • The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications • An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors • An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence • Assessment of need for medical care (with referral and follow-up as required)	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 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.	1. The applicant is licensed as BHO by BHDDH. 2. The applicant has one or more of following accreditations: CARF/BH and/or COA/MHSU and/or TJC/BH 3. The applicant attests that during initial evaluations a determination is made regarding whether the individual presently is, or ever has been a member of the U.S. Armed Forces; For children and youth, whether they have system involvement (such as child welfare and juvenile justice), and this information is regularly reported to BHOLD and included in the individual's electronic health record.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
• A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services • For children and youth, whether they have system involvement (such as child welfare and juvenile justice)		
4.d.4 A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include: • Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. • An overview of relevant social supports; social determinants of health; and health- related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. • A description of cultural and environmental factors that may affect the treatment plan of the person receiving services,		1. The applicant provides a list of policy or procedure numbers, titles and issuance or revision dates that reflect a. The Comprehensive evaluation will be completed within 60 days of the first request for services. b. The applicant attests that it monitors and can report the length of time from preliminary screening to completion of a comprehensive evaluation.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
including the need for linguistic services or supports for people with LEP. • Pregnancy and/or parenting status. • Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments. • Relevant medical history and major health conditions that impact current psychological status. • A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. • An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement- based care) and substance use disorders (including tobacco, alcohol, and other drugs). • Basic cognitive screening for cognitive impairment. • Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. • The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. • Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services,		

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
targeted case management, psychiatric rehabilitation services). • Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. • An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. • The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.		
4.d.5 Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix B of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix B as a reason not to provide clinically indicated behavioral health screening or assessment.	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.)	1. The applicant 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**
★ The state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.4 or Appendix B.	6. Depression Screening using 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: Screening for Hepatitis A, B and C and HIV for populations at risk as defined by the US Preventive Services Task Force.	2. Attestation indicating that the applicant uses primary care screening for all individuals served as described in "Explanation/Interpretation' for criteria/standard 4.d.6 if not covered in applicant policies and procedures from the organization.
4.d.6 The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.	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.**	1. The applicant provides a description of the specific functional assessments and screening tools it employs and how brief motivational interviewing techniques are utilized.
4.d.7 The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy	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	1. The applicant is licensed as BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH.

Screening, Assessment and Diagnosis		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.	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 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	3. The applicant provides a list of the screening tools used and the policy numbers, titles and issuance or revision dates that reflect compliance with this requirement.
4.d.8 If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referred to a more appropriate level of care. If the screening identifies more in 2.b.1	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 applicant is licensed as BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis planning (CCBHCs may work collaboratively with DCOs to complete these activities). 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 person receiving services 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 applicant is licensed as BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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 The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the	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.	1. The applicant is licensed as a BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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

plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.	RI regulation addressing engagement of consumer, and family involvement and consumer preferences in treatment planning: 212-RICR-10-10-1.6.3.	• Intensive Family Based Services.
4.e.3 The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services 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 the applicant to provide 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 applicant is licensed as BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides copy of organizational policies and procedures including policy numbers, titles and issuance or revision dates related to use of initial evaluation, comprehensive evaluation and ongoing screening and 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 words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.	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 person centered treatment planning: 212-RICR-10-10-1.6.3	1. The applicant is licensed as BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides copy of organizational policies and procedures including policy numbers, titles and issuance or revision dates related to inclusion of the person receiving service needs, strengths, abilities, preferences, and goals in words of the person receiving services 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, including recovery supports, with provision for monitoring	CARF, COA and TJC accreditation address this issue and can be used when combined with BHO licensure and	1. The applicant is licensed as BHO by BHDDH

of progress towards goals. The treatment plan is built upon a shared decision-making approach.	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	2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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 as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking).	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 applicant is licensed as BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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, traumatic brain injury, I/DD, interpersonal violence and human trafficking)
4.e.7 The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services. Consistent with the criteria in 4.e.1 through 4.e.7, certifying states should specify other aspects of person-centered and family-centered treatment planning they will require based upon the needs of the population served.	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.	1. The applicant is licensed as BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides policies and procedures or policy numbers, titles and issuance or revision dates and/or page numbers related to any additional treatment planning components such as:

Treatment planning components that certifying states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery 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, tailored treatment to ensure cultural and linguistically appropriate services).	RI regulation relevant to advanced directives related to treatment and crisis management: 212-RICR-10-10-1.6.2; 212-RICR-10-10-1.6.3	a. Community inclusion and support (housing, employment, social supports) b. involvement of family/caregiver and other supports c. recovery planning d. safety planning e. 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) f. The applicant attests that those persons receiving services health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented.

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.f.1 The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. ***Note:*** *See also program requirement 3 regarding coordination of services and treatment planning.*	CARF, COA and TJC accreditation address assuring that the applicant 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. Relevant RI regulations: 212-RICR-10-10-1.6.7A. & B ; 212-RICR-10-10-1.6.9. **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 community needs assessment.: DCYF will review and approve any additional children's services EBPs that a CCBHC wants to implement.	1. The applicant or the DCO is licensed as a BHO by BHDDH. 2. The applicant or proposed DCO has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant describes outpatient mental health and substance use disorder services, including services delivered through evidence based or best practices, as well as treatment that aligns with ASAM level 1 outpatient and ASAM level 2.1 (intensive outpatient services), including tobacco use disorders that it directly provides or identifies the DCO responsible for the service. 4. Applicant indicates the harm reduction strategies that are utilized in promoting safety and reduced substance use. a. The applicant describes current specialty services, structures and processes including the following: b. Non-high acuity mental health services c. Substance use disorder d. Transition age populations (16-25) e. Children and adolescents (0-15) 5. A list of organizations with whom there are referral arrangements. 6. A list of the applicant'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.

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.g.1 Based upon the findings of the community needs assessment as required in program requirement 1, certifying 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 Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Long-acting injectable medications to treat both mental and substance use disorders; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management Training; Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation. This list is not intended to be all- inclusive. Certifying states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.	**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) 6. Integrated Dual Diagnosis Treatment (IDDT) 7. Screening, Brief Intervention, and Referral to Treatment (SBIRT) 8. Trauma informed care (population and age appropriate) 9. Zero Suicide **Adult Required EBPs** 10. Assertive Community Treatment (ACT) 11. Permanent Supportive Housing/Housing First (National Model) 12. Individual Placement and Support (IPS) 13. Medication Assisted Treatment (MAT) a. For Opioid Use Disorder (2 out of 3 medication types) b. For Alcohol Use Disorder c. Nicotine Replacement Therapy 14. 12-Step Facilitation Therapy/Matrix Model **Children Required EBP** **1. Mobile Response and Stabilizing Services (MRSS)**	1. The applicant or the DCO is licensed as a BHO by BHDDH. 2. The applicant or proposed DCO has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides a description of its' ability to implement the required EBPs and such elements as relevant training and staff development and quality improvement initiatives. 4. The applicant 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. 5. The applicant provides a list of current Evidence Based Practices implemented for children and adults for all required services. 6. The applicant provides a plan and timetable for complying with required EBP training, coaching and fidelity; or that one will be created and submitted before certification. 7. The applicant provides a training calendar for EBPs 8. The applicant describes how it will provide ongoing coaching in each of the EBP's. 9. The applicant describes the way the need for new EBPs or adaptation of existing EBPS will be evaluated. 10. The applicant provides 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. 11. The applicant provides a list of other EBP's that are utilized and the names of individuals who are trained in those clinical practices. 12. The applicant provides the names of employed or contracted physicians who prescribe buprenorphine or naltrexone for the treatment of opioid use disorder.

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	2. Seven Challenges **See Addendum 6** for detailed information concerning the required EBPs, type and percentage of staff who are required to be trained and by when.	13. The applicant provides a description of how the applicant employs a trauma informed/trauma responsive care approach.
4.f.2 Treatments are provided that are appropriate for the phase of life and development of the person receiving services, 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. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth- guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services 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. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC)[25] to improve service outcomes.	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 applicant is licensed as BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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. 4. The applicant provides their plan and timetable for implementing measurement-based care
4.f.3 Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, 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.	1. The applicant is licensed as BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant provides policies and procedures, or those of a DCO if services are provided by the DCO, including number, title

Outpatient Mental Health and Substance Use Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
	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.	and issuance/revision date related to the treatment approaches used for children and adolescents. Additional endorsements that could be used to demonstrate compliance: • CARF Intensive Family-Based Services (IFB) • CARF Children and Adolescents (CA)

Outpatient Clinic Primary Care Screening and Monitoring		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.g.1 The CCBHC is responsible for outpatient 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. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions: • HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and other Reporting and Appendix B • Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population.	**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 11. Screening for social drivers of health 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 applicant 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. **OR** 3. The applicant attests that it is responsible for outpatient primary care screening and monitoring of key health indicators and health risk, as well as social drivers of health, as described in 4.g.1 “Explanation/Interpretation.” 4. The applicant provides document listing the medical director established protocols for HIV and Viral Hepatitis; primary care quality measures; and other clinically indicated primary care key health measures.and key health indicators for the service area informed by the needs assessment. 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

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.	

Outpatient Clinic Primary Care Screening and Monitoring		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.g.2 The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols will include: • Identifying people receiving services with chronic diseases; • Ensuring that people receiving services are asked about physical health symptoms; • and • Establishing systems for collection and analysis of laboratory samples, fulfilling the • requirements of 4.g. • In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.		1. The applicant provides document listing the medical director established protocols for HIV and Viral Hepatitis; primary care quality measures;other clinically indicated primary care key health measures and key health indicators for the service area informed by the needs assessment . 2. The applicant provides evidence of a formal agreement indicating the CCBHCs ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab.

Outpatient Clinic Primary Care Screening and Monitoring		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.g.3 The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following: ○ ensuring individuals have access to primary care services; ○ ensuring ongoing periodic laboratory testing and physical measurement of health ○ status indicators and changes in the status of chronic health conditions; ○ coordinating care with primary care and specialty health providers including ○ tracking attendance at needed physical health care appointments; and ○ promoting a healthy behavior lifestyle. ***Note**: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.* ***Note:** See also program requirement 3 regarding coordination of services and treatment planning.* ★ Certifying states may elect to require specific other screening and monitoring to be provided by the CCBHCs in addition to the those described in 4.g.		1. The applicant will provide copies of policy and protocols pertaining to six required monitoring activities listed in standard 4.g.3, as well as pediatric monitoring of developmental milestones. 2. The applicant attests that is has the capacity to capture data, report and monitor each of the six required activities

Targeted Case Management Services		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.h.1 The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC targeted case management should also be used accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services.		1. The applicant 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. 2. The applicant will provide a description of the case management protocols specifically for people at high risk for suicide and/or overdose, as well as those transitioning from higher levels of care. Applicable endorsements from accreditation bodies that can be used to demonstrate compliance: • CARF Case Management (CM) • COA Case Management

Targeted Case Management Services		
(CCBHC targeted case management services are separate from and do not follow state targeted case management rules under the Medicaid state plan or waivers.) ★ Based upon the needs of the population served, states should specify the scope of other CCBHC targeted 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 providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services includes: • services and recovery supports that help individuals develop skills and functioning to facilitate community living • support positive social, emotional, and educational development • facilitate inclusion and integration and • support pursuit of their goals in the community These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property	**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 applicant 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 applicant provides a policy and procedures including title, number issuance or revision date related to provision of psychiatric rehabilitation services to ensure the provision of: a. supportive employment b. supports for social inclusion c. supported education d. medication education e. Self-management f. family and caregiver Psycho - Education g. finding and maintaining stable housing

managers, paying bills, and interacting with neighbors or co-workers. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with ongoing support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to: • Participate in supported education and other educational services • Achieve social inclusion and community connectedness • Participate in medication education, self-management, and/or individual and • family/caregiver psycho-education and • Find and maintain safe and stable housing. Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers ***Note:*** *See program requirement 3 regarding coordination of services and treatment planning*		

★ Certifying states should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served above the minimum requirements described in 4.i.		

Peer Supports, Peer Counseling, and Family/Caregiver Supports		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
4.j.1 The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites[28]; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support. ***Note:*** *See program requirement 3 regarding coordination of services and treatment planning.* ★ Certifying states should specify the scope of peer and family services they will require based upon the needs of the population served.	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 applicant/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 applicant. **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 providing directly, or through a DCO, 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 the CCBHC 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.	1. Applicant 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. Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:	**CCBHC Requirement:** CCBHCs must ask all individuals inquiring about services if they have ever served in the U.S. military. 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	1. Documentation of compliance related to 4.d.3 may be used to demonstrate compliance with this standard. 2. Applicant provides policy or procedure indicating that upon initial evaluation, persons affirming former military status are offered assistance to enroll in VHA. Those declined or ineligible for VHA services will be served by the CCBHC.

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
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. <u>Veterans:</u> Persons affirming former military service (veterans) are offered assistance to 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. These include 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).	Members of the Armed Forces and Veterans. Relevant accreditation information is provided for reference.	

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
Note: *See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.* .		
4.k.3 The CCBHC ensures 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 applicant attests to the following: 1. The applicant identifies and appoints a person/person to work on outreach and engagement with the ADSM, Veterans and veteran serving organizations. 2. The applicant 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 health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:		1. The applicant is licensed as a BHO by BHDDH. 2. The applicant 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. Adherence to Care coordination requirements for active-duty services members and veterans. c. Adherence to other requirements listed in 4.k.4

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
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 VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis. 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.[29] 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		

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
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 make a decision 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.		
4.k.5 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 and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery: • Hope		1. The applicant is licensed as a BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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.

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
• Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect[30] As implemented in VHA recovery, the recovery principles also include the following: • Privacy • Security • Honor Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.		
4.k.6 All behavioral health care is provided with cultural competence. • Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.		1. The applicant provides a training plan that includes specialized training for key staff and clinicians on treatment issues and military culture.

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
• All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.		*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. There is a behavioral health treatment plan for all veterans receiving behavioral health services. • The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. • 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. • As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness. • 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.		1. The applicant or DCO is licensed as a BHO by BHDDH. 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant 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.

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. characteristics of people receiving service 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. outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Appendix B. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards. ***Note:*** *See criteria 3.b for requirements regarding health information systems.*	**See Addendum 8 for detailed information on required data, sources of data and how and whom each data element will be reported.**	1. The applicant attests that it will collect all required data and submit monthly to the RI Behavioral Health Online Data (BHOLD) system and submit a quarterly report.

Section 5 - QUALITY AND OTHER REPORTING

Data Collection, Reporting and Tracking

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
5.a.2 Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants beginning in 2022, must collect and report the Clinic-Collected quality measures identified as required in Appendix B. Reporting is annual and, for Clinic- Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA. • States participating in the Section 223 Demonstration must report State-Collected quality measures identified as required in Appendix B. The State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications. Certifying states also may require certified CCBHCs to collect and report any of the optional Clinic-Collected measures identified in Appendix B. Section 223 Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State-Collected or Clinic-Collected). Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12 months after the end of the measurement year, as that term is defined in the technical specifications. • States participating in the Section 223 Demonstration program are expected to share the results from the State-	This criterion establishes expectations regarding annual reporting of data. **See Addendum for detailed information on required data, sources of data and how and whom each data element will be reported.**	1. The applicant describes how they will submit required data annually and report monthly into the BHOLD to capture all required quality measures. 2. The applicant will provide copies of contract language that establish that all contracts the applicant has with prospective DCOs include provisions that the DCO: a. Provide required data to the CCBHC in a timely manner b. Obtain appropriate consumer consent for the sharing of information and comply with all federal and state privacy and confidentiality requirements

Section 5 - QUALITY AND OTHER REPORTING		
Data Collection, Reporting and Tracking		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
Collected measures with their Section 223 Demonstration program CCBHCs in a timely fashion. For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. • Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report. ***Note:*** *CCBHCs may be required to report on quality measures through DCOs as a result of participating in a state CCBHC program separate from the Section 223 Demonstration, such as a program to support the CCBHC model through the state Medicaid plan.*		
5.a.3 In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC- identifiable Medicaid	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.	1. The applicant 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**
claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and, as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.	**See Addendum 8 for detailed information on required data, sources of data and how and whom each data element will be reported.**	

Section 5 - QUALITY AND OTHER REPORTING

Data Collection, Reporting and Tracking

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
5.a.4 CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS. ***Note**: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.*		1. The applicant 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 In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use,	CARF, COA and TJC accreditation address this issue and can be used in combination with BHO licensure to demonstrate full compliance with this standard. **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.	1. The applicant is licensed as a BHO by BHDDH. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 2. The applicant provides an attestation the CQI plan includes CCBHC specific activities and data as per listed in section 5.b.1 in the criteria.

Continuous Quality Improvement		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.	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	
5.b.2 The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: 1. deaths by suicide or suicide attempts of people receiving services 2. fatal and non-fatal overdoses 3. all-cause mortality among people receiving CCBHC services; (4) 30-day hospital readmissions for psychiatric or substance use reasons; and 4. 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: a. deaths by suicide or suicide attempts of people receiving service b. fatal and non-fatal overdoses c. all-cause mortality among people receiving CCBHC services d. 30-day hospital readmissions for psychiatric or substance use reasons e. abuse of person receiving services by CCBHC or abuse of staff by CCBHC person receiving services f. Urgent appointments not scheduled within 24 hours

Continuous Quality Improvement		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
5.b.3 The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC- collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.		1. The CQI plan must use quantitative and qualitative data (including quality data measures) and focus on populations experiencing health disparities as further detailed in 5.b.3.

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		1. The applicant is licensed as a BHO by BHDDH 2. The applicant provides a copy of correspondence from the Internal Revenue Service related to its' tax-exempt status **OR** 3. The applicant provides a description of which other statutory criteria applies and attests that they are eligible based on it.

Section 6 - ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

General Requirements of Organizational Authority and Finances

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
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.		
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, CCBHCs shall 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 tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.	Rhode Island does not have an Indian Health Service Facility. The Narragansett Indian Tribe operates a health facility that operates as a stand-alone.	1. Any CCBHC applicant that proposes to serve Washington County must provide evidence that they have reached out to the Narragansett Indian Health Center.
6.a.3 An independent financial audit is performed annually for the duration that the clinic is designated as a CCBHC 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	1. The applicant is licensed as a BHO by BHDDH 2. The applicant has one or more of following accreditations CARF/BH and/or COA/MHSU and/or TJC/BH. 3. The applicant attests that an independent financial audit is performed annually.

Section 6 - ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

General Requirements of Organizational Authority and Finances

SAMHSA Criteria	Explanation/Interpretation	Documenting Compliance
	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	4. The applicant 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 CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision	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: **Option 1:** At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families. **Option 2:** Other means are established to demonstrate meaningful participation in board governance involving people	1. The applicant can attest to following standards 6.b.1 to 6.b.4 and that that they comply or will comply according to proposed time frame. 2. The applicant attestation indicates 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.4, 3. Regardless of which option is selected, applicant attests that it will comply with addendum 9 regarding community/consumer advisory council. 4. The CCBHC will provide a description of how governance criteria will be met; BHDDH will review the plan for

Governance		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
making.[32] CCBHCs reflect substantial participation by one of two options: **Option 1:** At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families. **Option 2:** Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board. Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into: 1. Identifying community needs and goals and objectives of the CCBHC 2. Service development, quality improvement, and the activities of the CCBHC 3. Fiscal and budgetary decisions 4. Governance (human resource planning, leadership recruitment and selection, etc.)	with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board, refer to 6.b.1.	application and measures will be established for subsequent monitoring and recertification.

Governance		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website.		
6.b.2 If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so. If option 2 is chosen, for CCBHCs not certified by the state, the federal grant funding agency will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes. For certifying states, if option 2 is chosen then states will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.		

Governance		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
6.b.3 To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6.b.1.		

Governance		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
6.b.4 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 accounting, 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	1. As part of its CCBHC application, the applicant describes and documents its compliance with these requirements. See **Addendum 9** which details the development of a Community/Consumer Advisory Council which will meet the 51% standard required**.** ***Addendum 9 applies to all CCBHCs***

Accreditation		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
6.c.1 The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.	**See Addendum 2.**	1. The applicant is licensed as BHO by BHDDH for both mental health and substance use disorder services. 2. The applicant attests that the CCBHC will obtain children's behavioral health organizational licensure (CBHO) licensure when available. 3. The applicant is enrolled as a Medicaid provider 4. The applicant attests that it will participate in SAMHSA Behavioral Health Treatment Locator 5. The applicant is accredited by CARF, COA and/or TJC for children, adolescents, and adults. 6. The applicant describes which accreditation body program standard the applicant or proposed DCO is using to demonstrate compliance with the standards or any other certification or endorsements relevant to the service proposed 7. The applicant must be certified by the State as detailed in 6.c.2
6.c.2 CCBHCs must be certified by their state as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services. CCBHC expansion grant recipients are encouraged to seek state certification if they are in a state that certifies CCBHCs. • State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. Certifying states may use an independent accrediting body as a part of their certification process as long as it meets state		

Accreditation		
SAMHSA Criteria	**Explanation/Interpretation**	**Documenting Compliance**
standards for the certification process and assures adherence to the CCBHC Certification Criteria.		
6.c.3 States are encouraged to require accreditation of the CCBHCs by an appropriate independent accrediting body (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

CCBHC Medical Director - Specific Requirements and Duties

The Medical/Clinical Director or Chief Medical Officer must be a qualified psychiatrist (as further described in criteria 1.a.3) 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 persons being served by the CCBHC 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, this would include ensuring that health screenings are completed and there is compliance with a system of collection and analysis of lab samples, as further detailed in CCBHC criteria 4.g of the standards.
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) in the CCBHC's continuous quality improvement (CQI) plan 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. For the purposes of this application, DCOs will need to be a Medicaid provider A DCO is required to be licensed as a BHO (and/or CBHO when available) and enrolled in Medicaid to provide clinical services.
3. The CCBHC will attest that DCO has at least three years' experience providing a particular service type or treatment modality unless written approval is obtained from BHDDH or DCYF.
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). This formal written agreement shall have provisions that assure that the requirements of CCBHC services that the DCO provides under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria. The CCBHC will provide a plan in sufficient detail to BHDDH on how it will monitor DCO compliance with the agreement and provide the results of this monitoring activity to BHDDH as directed. 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. Describes the CCBHC and DCO agreement to take active steps to reduce administrative burden on people receiving services and their family members when accessing DCO services through measures such as coordinating intake process, coordinated treatment planning, information sharing, and direct communication between CCBHC and DCO.
    c. The CCBHC and DCO will list specific steps that are implemented to assure intense collaboration across the two organizations will take place.
    d. 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
    e. The agreement will list active steps to reduce administrative burden on people receiving services and their family members when accessing DCO services such as coordinating intake process, coordinated treatment planning and information sharing.
    f. 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)
    g. Agreement will indicate that the CCBHC retains the responsibility for care coordination.
    h. 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)
    i. If the DCO provides a 24-hour crisis line or 24-hour mobile crisis teams, or directly provides emergency services, requiring evidence that the clinicians include QMHPs, and the applicant is certified under the Mental Health Emergency Service Intervention for Children, Youth and Families (Regulation 214-RICR-40-00) 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)
    j. Requiring CCBHC training plans address training of DCO staff.
    k. Requiring DCO clinical staff are trained in relevant EBP's and that the CCBHC monitors DCOs use of EBP's including training, coaching and fidelity compliance.
    l. Requiring DCO staff be appropriately licensed, certified, registered and credentialed as required by state and federal statute and regulation (1.b.1)

m. Requiring that DCO services must be trauma informed, person centered, recovery based and culturally appropriate.
n. Requiring that DCO provided services for CCBHC consumers meet the same quality standards as those required of the CCBHC (4.a.4)
o. Requiring that individuals receiving services from DCO's have access to CCBHC grievance procedures. (4.a.3)
p. 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. Outpatient MH and SUD Services
        i. Licensed Independent Practitioner
        ii. --- or ---Master's Degree with license to provide relevant behavioral health service or with one (1) year post master's degree full time experience providing behavioral health services
        iii. --- or Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or with one (1) year post RN license full time experience providing behavioral health services
        iv. --- or --- Licensed Chemical Dependence Clinical Supervisor
        v. --- or ---Licensed Chemical Dependency Professional
        vi. --- or Principal Counselor with, at a minimum, two hours of individual clinical supervision each month
        vii. --- or ---Master's Degree staff working toward licensure, Master's Degree interns, and staff working toward Counselor-in-Training certification with no less than one (1) hour of individual clinical supervision per week and additional supervision as required by their respective training or licensing programs.
        viii. And Clinical Supervisor/Manager
    b. Crisis Response
        i. Directly, **or** through contract, a 24-hour staffed hotline
        ii. Directly, **or** through contract with a DCO, 24-hour mobile crisis teams
        iii. Directly employ or through DCO Qualified Mental Health Professionals (QMHPs) to provide community and clinic-based crisis intervention services
        iv. Licensed/Credentialed Mental Health Professionals (see list for Outpatient Services)
    c. Screening, Evaluation and Diagnosis
        i. Psychiatrists/Advanced Practice Registered Nurses
        ii. Licensed/Credentialed Mental Health Professionals (see list for Outpatient Services)
            iii. Credentialed SUD Professionals
            iv. Licensed Chemical Dependency Clinical Supervisor (LCDCS)
            v. Licensed Chemical Dependency Professional (LCDP)
            vi. Certified Alcohol and Drug Counselor (CADC)
            vii. Certified Co-Occurring Disorder Professional Diplomate
            viii. Certified Advanced Alcohol and Drug Counselor (CAADC); or
            ix. Certified Co-Occurring Disorder Professional.
        x. 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)
    e. Primary Care Screening and Monitoring
        i. Associate's Level staff with relevant experiences
        ii. Nurse including licensed practical nurse
        iii. Treating psychiatrist
        iv. Physician/MD
    f. Peer and Family Support

i. Certified Peer Recovery Specialist
ii. BHDDH Certified Providers of Peer Based Recovery Support Services
iii. Clinical Supervisor

2. Targeted Case Management
    i. Associates degree Level Case Manager
3. Psychiatric Rehabilitation
    a. Supervisor/Manager with relevant master's degree with at least two (2) years' experience or a relevant bachelor's degree with at least three (3) years' experience in a program or environment that provides community integration services.
    b. Rehabilitation Professionals
4. Community Psychiatric Support Team Specialists (CPST) [2]
    a. (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
5. Assertive Community Treatment
    a. Registered Nurse
    b. Licensed Mental Health Professional
    c. Bachelor Level Professional with specialized vocational services training
    d. Community Psychiatric Supports and Treatment Specialists (minimum of associate degree with case management training)
    e. Certified Peer Recovery Specialist
    f. Psychiatrist
    g. Licensed Independent Practitioners
    h. Clinical Interns
    i. Clinical Supervisors/managers

6. 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.

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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.

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

8. The CCBHC includes a medically trained behavioral health provider, either employed or through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA approved medications used to treat Opioid, Alcohol and Tobacco Use Disorders.

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

10. 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.

11. 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 applicant does not have the necessary expertise.

ADDENDUM 5 - Populations of Focus

High Acuity Populations Diagnostic and Assessment Criteria

High Acuity Adult

1. An individual is in the High Acuity Adult Population if they are 18 or over and:
    a. They are eligible for Rhode Island's I/DD waiver, **and** they have any behavioral health diagnosis; **or**
    b. 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.

    c. 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**

    d. 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)

2. An individual is in the High Acuity Adult Population if they are transition aged Individuals between the ages of 16 and 25, and:
    a. Experienced first episode psychosis or early onset of serious mental illness with high prevalence of co-occurring substance use disorders.
    b. Have or at imminent risk of developing a serious mental health condition.
    c. 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
    d. Individuals in a residential setting are not eligible for CSC services and individuals with autism spectrum disorder are eligible only by exception.

e. Request for exceptions to eligibility criteria may be made at any time in writing to BHDDH.
f. Individuals in the high acuity group must be re-evaluated every 90 days to determine if they continue to need this level of service intensity.

High Acuity Children and Youth

Year 1

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

1. They meet at least one of the following criteria:

a. At least 1 inpatient psychiatric admission in the past year
b. A history of suicide attempts within the last 2 years
c. Have engaged in self-harm or have had homicidal ideation within the past year
d. At least 2 emergency department visits within the past 6 months putting them at risk of psychiatric hospitalization or out-of-home placement
e. Are being referred for treatment as a step down from higher levels of care within the past 90 days such as a crisis stabilization facility, partial hospital program, mobile response stabilization service (MRSS), acute residential treatment service (ARTS), a correctional facility, or a residential treatment program
f. Have experienced an acute crisis that has disrupted their functioning across multiple settings (home, school, community) in the past 6 months requiring treatment intensity greater than general outpatient but lower than inpatient services
g. Have a co-occurring moderate or severe substance use disorder, as defined by the DSM-5 criteria
h. Have a history of trauma exposure, such as physical, sexual, or emotional abuse, neglect, domestic violence, community violence, natural disasters, or terrorism resulting in complex trauma, acute stress disorder, or an adjustment disorder
i. Involvement with multiple systems, such as child welfare, juvenile justice, special education, or foster care, currently or within the past year
j. Are currently homeless or have been homeless in the last 90 days; and

2. Have a diagnosis of an Anxiety Disorder, Bipolar Disorder, Psychotic Disorder, Disruptive Mood Dysregulation Disorder, Impulse-Control Disorder, Conduct Disorder, Gender Dysphoria, Depressive Disorder, Obsessive-Compulsive Disorder, Oppositional Defiant Disorder, Panic Disorder, Personality Disorder, Post-Traumatic Stress Disorder or
    a. a documented history that includes DSM- 5 V or Z codes that correspond to a history of childhood abuse/neglect, family history of childhood abuse/neglect, forced labor or sexual exploitation in childhood, forced labor or sexual exploitation, or other V or Z code that may reflect sexual exploitation; and
3. A score of 37 or higher on the problem severity scale or a 34 or lower on the functional scale of the Ohio Youth Problem, Functioning and Satisfaction assessment. **All attributed members in this category must have a Child and Adolescent Needs and Strengths (CANS) assessment completed by the end of Year 1, in support of transitioning to the eligibility criteria specified below for Year 2.
4. Individuals in the high acuity group must be re-evaluated every 90 days to determine if they continue to need this level of service intensity.
5. We recognize there are situations in which a youth or family have not previously sought treatment for several reasons (e.g., cultural beliefs, stigma, immigration/migration issues, language barriers, financial reasons, distrust of the healthcare system, limited knowledge of behavioral healthcare) and will not meet the criteria above. Request for exceptions to eligibility criteria may be made at any time in writing to DCYF.

Year 2

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

1. They meet at least one of the following criteria:

a. At least 1 inpatient psychiatric admission in the past year
b. A history of suicide attempts
c. Have engaged in self-harm, or have had homicidal ideation within the past year
d. At least 2 emergency room visits within the past 6 months putting them at risk of psychiatric hospitalization or out-of-home placement
e. Are being referred for treatment as a step down from higher levels of care within the past 30 days such as a Crisis Stabilization facility, Partial Hospital Program, Mobile Response Stabilization Services, Acute Residential Treatment Service (ARTS), a Correctional facility, or a residential treatment program
f. Have experienced an acute crisis that has disrupted their functioning across multiple settings (home, school, community) requiring treatment intensity greater than general outpatient but lower than inpatient services
g. Have a co-occurring moderate or severe substance use disorder, as defined by the DSM-5 criteria
h. Have a history of trauma exposure, such as physical, sexual, or emotional abuse, neglect, domestic violence, community violence, natural disasters, or terrorism resulting in complex trauma, acute stress disorder, or an adjustment disorder
i. Have a history of involvement with multiple systems, such as child welfare, juvenile justice, special education, or foster care, currently or within the past year
j. Are currently homeless or have been homeless in the last 90 days; and

2. Have a have a diagnosis of an Anxiety Disorder, Bipolar Disorder, Psychotic Disorder, Disruptive Mood Dysregulation Disorder, Impulse-Control Disorder, Conduct Disorder, Gender Dysphoria, Depressive Disorder, Obsessive-Compulsive Disorder, Oppositional Defiance Disorder, Panic Disorder, Personality Disorder, Post-Traumatic Stress Disorder or
    a. a documented history that includes DSM- 5 V or Z codes that correspond to a history of childhood abuse/neglect, family history of childhood abuse/neglect, forced labor or sexual exploitation in childhood, forced labor or sexual exploitation, or other V or Z code that may reflect sexual exploitation; and
3. They received at least one score of 3 or two scores of 2 on the CANS Risk Behavior Screen or received at least one score of 3 or scores of 2 on the CANS Needs Screen.
4. Individuals in the high acuity group must be re-evaluated every 90 days to determine if they continue to need this level of service intensity.
5. We recognize there are situations in which a youth or family have not had previously sought treatment for several reasons (e.g., cultural beliefs, distrust of the healthcare system, limited knowledge of behavioral healthcare) and will not meet the criteria above. Request for exceptions to eligibility criteria may be made at any time in writing to DCYF.

High Acuity Substance Use Disorder

Year 1-2

In Years 1 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 by 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. Individuals in the high acuity group must be re-evaluated every 90 days to determine if they continue to need this level of service intensity.

Year 2+

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, if available.
3) Individuals in the high acuity group must be re-evaluated every 90 days to determine if they continue to need this level of service intensity.

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

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. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
8. Trauma informed care (population and age appropriate
9. 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

CCBHC REQUIRED EVIDENCE BASED CLINICAL PRACTICES AND PROGRAMS (EBPs) – ALL POPULATIONS		
EBP	**Staff Training Requirements**	**Time Frame**
Motivational Interviewing	Required of all direct service staff within clinical programs and services	50% trained by end of year 1 (7/1/24-7/1/25)
		90% trained by end of year two
		Maintain level of 90% trained
Cognitive Behavioral Therapy Age/population appropriate	Required of all clinical staff	50% trained by end of year 1
		75% trained by end of year 2
		Maintain minimum level of 75% trained
Dialectical Behavioral Therapy (DBT)	Required of all clinical staff	50% trained by end of year 1
		75% trained by end of year 2
		Maintain minimum level of 75% trained
Family Psychoeducation (FPE) For example: Family to Family, *CRAFT*	Required of clinical staff as detailed in addendum 7, table 2 and 3	with 50% being trained by end of year 1
		75% by end of year 2
		Maintain a minimum level of 75% trained

CCBHC REQUIRED EVIDENCE BASED CLINICAL PRACTICES AND PROGRAMS (EBPs) – ALL POPULATIONS		
EBP	**Staff Training Requirements**	**Time Frame**
Integrated Dual Diagnosis Treatment (IDDT)	Appropriate clinical and direct service staff as detailed in addendum 7, table 2 and 3	Designated staff trained in IDDT model by end of year 1
		Implementation of IDDT team for year 2
SBIRT	All direct care staff performing screening functions	Implement service by end of year 1
Coordinated Specialty Care (Healthy Transitions)	This service/program is required as a condition of application	Model must be operational at time of CCBHC implementation
Zero Suicide	This service/program is required as a condition of application	organizational training and implementation of key protocols and procedures by end of year 1
		Roll out and implementation of Zero Suicide model throughout organization to fidelity by end of year 2

Adult Required EBPs		
EBP	**Staff Training Requirements**	**Time Frame**
Assertive Community Treatment	This service/program is required as a condition of application	Model must be operational at time of CCBHC implementation
Permanent Housing/Housing First (National Model)	*Required of community psychiatric support team staff* as detailed in addendum 7, table 2 and 3	25% being trained by end of year 1
		75% by end of year 2
		Maintain a minimum level of 75% trained.
Individual Placement and Supports	Train staff and implement service by end of year 1 as detailed in addendum 7, table 2 and 3	50% staff trained end of year 1
		90% trained by end of year 2
		Maintain level of 90% trained
Medication Assisted Treatment (not including Methadone)	Opioid Use Disorder	Service must be operational at time of CCBHC implementation
	For Alcohol Use Disorder	Service must be operational at time of CCBHC implementation

Adult Required EBPs		
EBP	**Staff Training Requirements**	**Time Frame**
	Nicotine Replacement Therapy	Service must be operational at time of CCBHC implementation
12-Step Facilitation Therapy/Matrix Model	Clinical staff	50% trained by end of year 1
		75% trained by end of year 2
		Maintain level of 75% trained

Child Required EBPs		
EBP	**Staff Training Requirements**	**Time Frame**
Mobile Response and Stabilization Services (MRSS)	All clinical staff providing emergency and crisis services	Model must be operational at time of CCBHC implementation
Seven Challenges	All clinical staff (LCDP/LCSW/LICSW/ LMHC) providing services to children and youth in the high acuity SUD population	Designated staff trained in Seven Challenges model by end of year 1
		Implementation of Seven Challenges model for year 2

Fidelity: General requirement that all required EBPs 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.

Coaching: Coaching will be necessary and required for many of the clinical EBPs. Evidence of ongoing coaching and evaluation is required to maintain CCBHC certification.

*** CCBHC also requires ongoing training such as person/family centered care training, recovery-oriented treatment planning, cultural competency, trauma informed care and crisis de-escalation training.**

ADDENDUM 7: Scope of Services

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**.

1. 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.
2. **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.
3. Health Home services would be provided by the ACT team
4. ACT services and operations would include
    a. Ten (10) hours of team active operation during weekdays and 4 hours per day on weekend and holidays
    b. On call 24/7 for client emergencies to triage with crisis workers
    c. Team would serve as individual's health home
    d. 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.
5. 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.
6. Additional guidelines and/or requirements may be issued pertaining to services and operations of ACT teams.

★ **SEE TABLE 1**

Table 1 -Assertive Community Treatment Staffing Patterns, Credentials and Best Practices Implemented

Staff		Credential	Other Responsibilities	Best Practices
1	Team Lead	LICSW/LCSWLMHC/LMFT/ BSN		**Assertive Community Treatment**
2	RN-1	RN	Health Home/Care Coordination Medication Administration Treatment	
3	RN-2	RN	Health Home/Care Coordination	

Table 1 -Assertive Community Treatment Staffing Patterns, Credentials and Best Practices Implemented				
Staff		**Credential**	**Other Responsibilities**	**Best Practices**
4	RN-3	RN	Health Home/Care Coordination	
5	Clinician	Principal Counselor/ Counselor/ LICSW/LCSW/LMHC/LMFT	Clinical Specialist	Lead/Psychotherapeutic intervention Family Psychoeducation
6	Rehabilitation Specialist	BS/BA IPS Certified	Community Integration Specialist	Individual Placement and Supports
7	Co-Occurring Clinician	LICSW/LCSW/LMHC/LMFT	Clinician must have experience with SUD	Integrated Dual Diagnosis Treatment (IDDT) - Criminal Justice Liaison
8	SUD Specialist	BA /LCDP	SA Specialist	IDDT
9	CPST-1 Community Psychiatric Supportive Treatment Specialist	CPST/ Associate Degree	CPST-IPS	
10	CPST-2	CPST/ Associate Degree	Rehabilitation counseling including recovery activities/interventions to support independent community living (supportive housing) and support community integration	Motivational Interviewing
11	CPST-3	CPST/ Associate Degree		
12	CPST-4	CPST/ Associate Degree		
13	Peer	CPRS	Peer supports	
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.
e. Additional guidelines and/or requirements may be issued pertaining to services and operations of ICTT teams.

★ **SEE TABLE 2**

Table 2 - Integrated Community Treatment Teams

Staff		Credential	Other Responsibilities	Best Practices
1	Team Lead	LICSW,LCSW LMFT, LMHC		
2	RN-1	RN	Pharmacology management Assisting with management of co-morbid/co-occurring health issues Physical health care coordination	
3	RN-2	RN		
4	RN-3	RN		
5	Clinician	Principal Counselor Counselor/LICSW/LCSW/LMFT/LMHC	Clinical Specialist Lead/Psychotherapeutic intervention	Family Psychoeducation
6	Rehabilitation Specialist 1	MA/OT	Rehab Lead Vocational	IPS Model
7	Rehabilitation Specialist 2	BS/BA	Vocational	IPS Model

Table 2 - Integrated Community Treatment Teams				
Staff		**Credential**	**Other Responsibilities**	**Best Practices**
8	Co-Occurring Clinician	LICSW/LCSW/LMHC/LMFT/	Co-Occurring Clinician/SA Specialist	IDDT - Criminal Justice Liaison
9	SUD Specialist	BA/LCDP	SA Specialist	IDDT
10	CPST-1	Associate Degree /CPST	IPS Illness self- management Recovery skills training and support Community integration and housing supports/Permanent Supportive Housing	
11	CPST-2	Associate Degree /CPST		
12	CPST-3	Associate Degree/CPST		
13	CPST-4	Associate Degree/CPST		
14	Peer	CPRS	Recovery Supports	
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 Master's level Team Leader; 1 Master's 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

★ **SEE TABLE 3**

Table 3 – Transition Age Individuals/Coordinated Specialty Care

Staffing	Credential	Role
1 Team Lead	LICSW/LCSW/LMHC/LMFT	• Clinical Supervision
.5 Prescriber	Psychiatrist, Psychiatric Nurse Practitioner	• Pharmacotherapy
1 Licensed Clinician	LICSW/LCSW/LMHC/LMFT	• Individual, group, family psychotherapy • Psychoeducation and support
1 SUD clinician	BA/LCDP	• Co-occurring clinician

1 RN	RN	• Medication monitoring • Care coordination with Primary Care
1 CPST	Associate Degree/CPST	• Coordinate services • Case Management
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.*

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. The wrap around model is strongly suggested for children with SED.

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

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:

Ambulatory Withdrawal Management

(ASAM Level 1 W.M) with extended on-site monitoring
(ASAM Level 2 W.M) for moderate withdrawal not requiring 24-hour support.

Table 1
Ambulatory and Medical Withdrawal Management 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 or DCO can provide this service, SAMHSA recommends that CCBHC provides this service directly.
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 must have 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 must have a referral relationship

Outpatient services
(ASAM level 1) less than 9 hours of services per week.

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 persons 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

Intensive Outpatient Services (IOP)
(ASAM level 2.1) of more than 9 hours of services per week.

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.

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

ASAM Level 2.5 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*
    a. Didactic sessions: 3 hours/week minimum
    b. Family education and information sessions as clinically indicated

SERVICES FOR ADOLESCENTS WITH SUBSTANCE- RELATED DISORDERS

(with or without co-occurring with a mental health condition):

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 persons 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 ten (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

ASAM Level 2.1 Intensive Outpatient Program (IOP) This care approximates ASAM Level 2.1 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: two (2) hours/week minimum
   b. Family education and information sessions as clinically indicated.

ADDENDUM 8: Quality Measures Reporting Requirements

The Behavioral Health Clinic (BHC) quality measures that CCBHCs will use were updated in 2023. Below is a list, divided into clinic-collected and state-collected measures, required and optional.

For Section 223 Demonstration or other state-certified CCBHCs, it is a state decision as to whether to require reporting of measures designated as optional. For later cohorts of CCBHCs that are required to report quality measures, only the clinic-collected required measures are mandated.

Clinic-Collected Measures

The first five (5) are required measures and the rest are optional. Presently Rhode Island is not including any optional measures.

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)[1]	Notes
Time to Services (I-SERV)	SAMHSA	n/a	Will include sub-measures of average time to: Initial Evaluation, Initial Clinical Services, Crisis Services
Depression Remission at Six Months (DEP-REM-6)	MN Community Measurement	n/a	Changed from the Twelve-Month version of the measure
✓ **Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)**	NCQA	n/a	n/a
✓ **Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)**	CMS	Adult and Child	Child was added to the Medicaid Child Core Measure Set
✓ **Screening for Social Drivers of Health (SDOH)**	CMS	n/a	Using the 2023 Merit-Based Incentive Payment System (MIPS) version
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	n/a	n/a
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)	Mathematica	n/a	n/a

	Steward	CMS Medicaid	Notes

Measure Name and Designated Abbreviation		Core Set (2023)[1]	
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)	Mathematica	n/a	n/a
Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	NCQA	Child	Measure modified to coincide with change in Medicaid Child Core Measure Set
Controlling High Blood Pressure (CBP-AD)	NCQA	Adult	n/a

[1] The CMS Medicaid Core Set describes two separate core sets (the 2023 Child Core Set and the 2023 Adult Core Set). The table specifies if a measure is in only one or both of the core sets.

State-Collected Measures

The first thirteen (13) measures are required , the rest are optional. Presently Rhode Island is not including any optional measures.

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)	Notes
✓ **Patient Experience of Care Survey**	SAMHSA	n/a	n/a
✓ **Youth/Family Experience of Care Survey**	SAMHSA	n/a	n/a
✓ **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)**	CMS	Adult	n/a
✓ **Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)**	NCQA	Adult	n/a
✓ **Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)**	NCQA	Child	n/a
✓ **Initiation and Engagement of Alcohol and Other Drug**	NCQA	Adult	n/a

Dependence Treatment (IET-AD)			
✓ **Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)**	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
✓ **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)**	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
✓ **Plan All-Cause Readmissions Rate (PCR-AD)**	NCQA	Adult	n/a
✓ **Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)**	NCQA	Child	n/a
✓ **Antidepressant Medication Management (AMM-BH)**	NCQA	Adult	n/a
✓ **Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)**	CMS	Adult	n/a
✓ **Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)**	NCQA	Adult	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	Child	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	Child	n/a

ADDENDUM 9 – CCBHC Standard on Governance and Meaningful Consumer/Family Participation - Community/Consumer Advisory Council

1. The CCBHC will develop a Community Advisory Council ("Council") for each catchment area served. For Governing Boards that meet the fifty-one percent (51%) standard in criteria 6.b.1 option 1 of the CCBHC standards, those boards have the option of functioning as that Council or creating a separate Council(s). The functions of the Governing Boards serving as the Council are listed in this addendum. If the fifty-one percent (51%) standard is not met, the organization must create a separate Council.
    a. The bylaw of all CCBHC governing boards would be amended to reflect this requirement and the duties and responsibilities listed below.
    b. The Governing Board would establish protocols for complying with Option 2 of CCBHC standard 6.b.1 by incorporating input and representation from the Council and from individuals with lived experience and family members into the CCCBH's governance, policies, plans and budget.
    c. Member or members of the Council must be invited to Board meetings with the opportunity to regularly address the Board directly, share comments and recommendations and have them reflected in the Board minutes.
2. The CCBHCs would have the option of developing separate Councils for Children/youth/families and another for adults, for each Service (Catchment) area.
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 and administrative 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 Designated Collaborating Organizations (DCO) and collaborative arrangements.
    b. Identify community needs and goals and objectives of the CCBHC
    c. Perform fiscal and budgetary reviews and submit recommendations to the Governing Board.
    d. Review quality and client outcome data and identify areas for improvement
    e. Support the creation of locally organized systems of care for persons with behavioral health issues.
    f. 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 (6) 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 review and discussion on the Council recommendations, as further detailed in 1.c above.
7. The CCBHC will post an annual summary of the recommendations of the Council on the CCBHC website.
8. 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.
9. The Council would be required to meet at least twice before the end of the first year as a CCBHC (i.e. By June 30, 2025)

ADDENDUM 10: Community Needs Assessment

Community Needs Assessment:

A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. CCBHCs will conduct or collaborate with other community stakeholders to conduct a community needs assessment. The assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. Specific CCBHC criteria are tied to the community needs assessment including staffing, language and culture, services, locations, service hours and evidence- based practices. Therefore, the community needs assessment must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families. If a separate community needs assessment has been completed in the past year, the CCBHC may decide to augment, or build upon the information to ensure that the required components of the community needs assessment are collected.

The community needs assessment is comprised of the following elements:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.

2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.

3. Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.

4. Cultures and languages of the populations residing in the service area.

5. The identification of the underserved population(s) within the service area.

6. A description of how the staffing plan does and/or will address findings.

7. Plans to update the community needs assessment every three (3) years.

8. Input with regard to:

- cultural, linguistic, physical health, and behavioral health treatment needs;
- evidence-based practices and behavioral health crisis services;
- access and availability of CCBHC services including days, times, and locations, and telehealth options; and
- potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.

Input should come from the following entities if they are in the CCBHC service area:

- People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment;
- Health centers (including FQHCs in the service area);
- Local health departments (Note: these departments also develop community needs assessments that may be helpful);
- Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics;
- One (1) or more Department of Veterans Affairs facilities;
- Representatives from local K-12 school systems; and

- Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.

CCBHCs must engage also with other community partners, especially those who also work with people receiving services from the CCBHC and populations that historically are not engaging with health services, such as:

- Organizations operated by people with lived experience of mental health and substance use conditions;
- Other mental health and SUD treatment providers in the community;
- Residential programs;
- Juvenile justice agencies and facilities;
- Criminal justice agencies and facilities;
- Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers as applicable;
- Child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service; and
- Crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines.
- Specialty providers of medications for treatment of opioid and alcohol use disorders;
- Peer-run and operated service providers;
- Homeless shelters and housing agencies;
- Employment services systems;
- Services for older adults, such as Area Agencies on Aging;
- Aging and Disability Resource Centers; and
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).