

Rhode Island Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria



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Table of Contents

INTRODUCTION.....	3
SECTION 1: STAFFING.....	10
SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES.....	18
SECTION 3: CARE COORDINATION.....	26
SECTION 4: SCOPE OF SERVICES.....	38
SECTION 5: QUALITY AND OTHER REPORTING.....	62
SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION.....	66
ADDENDA.....	72
ADDENDUM 1: CCBHC Medical Director.....	73
ADDENDUM 2: Accreditation Bodies and Standards, Relevant Endorsements and Certifications for Behavioral Health Services.....	75
ADDENDUM 3: Requirements of Designated Collaborating Organizations (DCO).....	76
ADDENDUM 4: Staff Qualifications for Billing.....	78
ADDENDUM 5: Populations of Focus Diagnostic and Assessment Criteria.....	81
ADDENDUM 6: Required Training, Programs, Evidence-Based Clinical Practices and Fidelity.....	85
ADDENDUM 7: Mandatory Treatment Models By Population of Focus.....	88
ADDENDUM 8: CCBHC Community/Consumer Advisory Council.....	102
ADDENDUM 9: Community Needs Assessment.....	104

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 Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is designated by SAMHSA as both the State's adult mental health authority and the State's child and adult substance use disorder authority and is charged with administration and oversight of federal block grant and discretionary funding.

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, Rhode Island was one of fifteen states awarded a CCBHC one year planning grant to prepare for reapplication to become a Demonstration State in 2024.

From 2018 until the present, SAMHSA has also awarded direct CCBHC expansion grants to seven community providers in Rhode Island, five of whom were Community Mental Health Centers. This helped create a critical mass of providers familiar with the CCBHC model in the State.

In 2021, the Executive Office of Health and Human Services (EOHHS) worked with BHDDH, and the Department of Children, Youth and Families (DCYF) to produce the Rhode Island Behavioral Health System Review, in partnership with Faulkner Consulting Group and Health Management Associates. As a part of that process, EOHHS requested that the consultants propose strategies to meet the identified gaps in Rhode Island's behavioral health system. Implementation plans were developed for both CCBHCs and a statewide Mobile Crisis system.

Over the next year, the State developed a CCBHC proposal with input from a group of community providers and advocates. In the State Fiscal Year 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS, as the single state Medicaid authority, to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to establish CCBHCs in Rhode Island, in accordance with the federal model. The General Assembly further directed BHDDH, in concert with EOHHS, to define the criteria to certify the clinics.

In 2023, Rhode Island applied to become one of ten new states to enter into the federal CCBHC Demonstration Program via a competitive process. In 2024, Rhode Island was awarded entrance into the Demonstration and went live with eight CCBHCs on October 1, 2024.

An interagency State team, hereby referred to as the 'CCBHC Interagency Team' has, and continues to work together to design, implement, and enhance Rhode Island's CCBHC program under the federal Demonstration. The CCBHC Interagency Team is comprised of staff from BHDDH as the State's adult and child substance use disorder treatment authority and adult mental health authority, DCYF as the State's child mental health authority, and EOHHS as the state's Medicaid authority and convenor of interagency State initiatives. The CCBHC Interagency Team maintains shared advisory and decision-making powers. Responsibilities include, but are not limited to, developing and updating the RI CCBHC program certification requirements, compliance and quality oversight, and program evaluation.

Together, we are pleased to share this Rhode Island State CCBHC Certification Guide.

Purpose of CCBHC State Certification Guide

This CCBHC Certification Guide is a tool used by the State's CCBHC Interagency Team, under the authority of EOHHS, to certify and/or recertify providers to deliver services as a CCBHC in the designated service areas depicted on the map on page 10. These certification standards may be updated to incorporate additional federal requirements, program refinements based on learnings to date, and/or additional application requirements for applicants proposing a new CCBHC in a service area where one or more CCBHCs are operational.

This tool is an adaptation of a template provided by SAMHSA and provides an overview of key criteria and program requirements established under PAMA § 223 to assess the qualifications of prospective CCBHCs. CCBHCs are required to meet 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

These standards shall be achieved across the nine federally required CCBHC services (listed below), as well as any additional Rhode Island required services:

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

CCBHCs are required to provide these services in a manner that is appropriate for the populations in 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 of their age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay. CCBHCs are required 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 disorders.

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, unhoused, or from other under-resourced communities. The State refers to the people in these groups as our "priority consumer populations."

The CCBHC may deliver the nine federally required services and any additional Rhode Island required services, directly or through formal arrangements with Designated Collaborating Organizations (DCOs) but must directly provide services for at least 51% of all CCBHC encounters (excluding crisis services). CCBHCs shall execute a contract with all DCO partners that include provisions to ensure the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set forth in the RI 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. DCO arrangements also include a payment element; these expenses are integrated into a CCBHC's prospective payment system (PPS) rate.

This guide describes requirements associated with each criterion, or standard, identified by SAMHSA in depth along with any Rhode Island enhancements or additional requirements to each criterion, or standard. . The first column of the requirements table below includes the SAMHSA standard, verbatim, as it was published in the SAMHSA Certified Community Behavioral Health Clinic Certification Criteria updated in March 2023. Please note that any items denoted by a star in the first column apply only to demonstration states. Rhode Island is currently a demonstration state; thus, these items are considered a federal SAMHSA standard. The second column provides Rhode Island specific CCBHC requirements that are an enhancement to the federal criteria.

There are addenda that provide important information, e.g., criteria for the different CCBHC populations, required services for high acuity adult and child populations, CCBHC staffing qualifications and credential requirements, required evidence-based practices, etc. The addenda are considered a core component of the certification standards. All providers seeking certification or recertification shall demonstrate compliance with the standards contained in the body of this guide and with the additional requirements provided in the addenda.

Eligibility to Apply to be Certified as a CCBHC

All providers must submit an application for initial certification and recertification. The application is designed to minimize the burden on the applicant by providing a set of response categories for each standard that reflect the range of ways the standard may be met.

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

1. Be licensed in Rhode Island (RI) as a behavioral healthcare organization (BHO) and, within the scope of its license, provide CCBHC required services; or have a pending application for BHO licensure; or have submitted a request to add service(s) at the time of request for certification as a CCBHC.
2. Be a qualified Medicaid provider or be in the process of becoming enrolled as a Medicaid provider at the time of application.
3. Be accredited by a nationally recognized accreditation body (i.e., The Joint Commission, The Commission on Accreditation of Rehabilitation Facilities, or The Council on Accreditation), or have a pending application, with standards specific to the delivery of behavioral healthcare services and substance use disorder services.
4. Have at minimum three 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 (SUD), or a track record of providing person-centered, recovery oriented, and trauma informed care.
5. Demonstrated experience with the Rhode Island targeted and priority consumer populations listed above, and ability to provide a majority of the required services and perform all required functions listed in the SAMHSA CCBHC certification criteria.

CCBHC Service Areas

CCBHCs shall be certified to serve one or more of the State's designated CCBHC service areas. The service areas currently align with the 'catchment' areas designated by BHDDH for community mental health centers (CMHCs) pursuant to Rhode Island General Laws section 40.1-8.5-1 et seq.

1. CCBHCs will be certified by service area.
2. Applicants shall meet all federal and state CCBHC standards in each service area for which they are applying.
3. In service areas where one or more CCBHCs are already operational, new applicants shall demonstrate that there is currently an unmet need for CCBHC services and describe how they will meet that need.

CCBHC Service Provision

A provider must ensure the following as part of their certification and/or recertification as a CCBHC:

1. A CCBHC is responsible for ensuring access to all CCBHC required services, either directly or through a DCO agreement. CCBHCs shall ensure that comprehensive, coordinated, and age-appropriate mental health and substance use disorder treatment services and supports are accessible and available across the life span.
2. A CCBHC shall directly deliver the majority (i.e., 51% or more) of encounters across the required services, excluding crisis service encounters.
3. CCBHCs shall accept and serve involuntary clients who are subject to Civil Court Certification orders. This shall include having sufficiently qualified and available physicians and clinical staff to, as necessary, attend and testify in hearings before the Mental Health Court pursuant to Rhode Island General Laws section 40.1-5-1 et seq.
4. CCBHCs shall accept outpatient treatment individuals being discharged from inpatient psychiatric facilities with or without a civil court commitment order; individuals with co-occurring intellectual and/or developmental disabilities; all medically managed (ASAM 4.0) and medically monitored (ASAM 3.7) detoxification service discharges; individuals who are being discharged from adult and child residential programs; individuals being released from the juvenile and adult justice systems; and individuals being discharged from a state hospital.
5. Individuals seeking services are free to select a CCBHC of their choice and are not restricted to a CCBHC designated for the service area where they reside.

The goal of the CCBHC Interagency Team is to ensure that CCBHCs meet the needs of all of Rhode Islanders across the life course as indicated by community needs assessments and ongoing data evaluations.

CCBHCs will also be required to pursue a CCBHC license and a Child Behavioral Health Organization (CBHO) license, when these become available (anticipated in Demonstration Year 2).

RI CCBHC Certification Process

BHDDH licensed Behavioral Health Organizations (BHOs) who wish to be certified as a CCBHC must complete an application for CCBHC certification. During the application process they must demonstrate compliance with all six program areas detailed in the PAMA 2014 (PL 113-93), the federal SAMHSA CCBHC Certification Criteria, and the RI CCBHC Certification requirements.

Compliance with each standard will be reviewed after submission of the CCBHC application and the CCBHC Criteria Compliance Checklist.

CCBHC certification applications will only be accepted during announced application periods. Upon receipt of the application and CCBHC Criteria Compliance Checklist, the CCBHC Interagency Team will conduct a preliminary review of the application and checklist and may request additional information and documents to verify compliance with criteria requirements. The Interagency Team will then conduct a full review of all submitted materials and perform an onsite assessment.

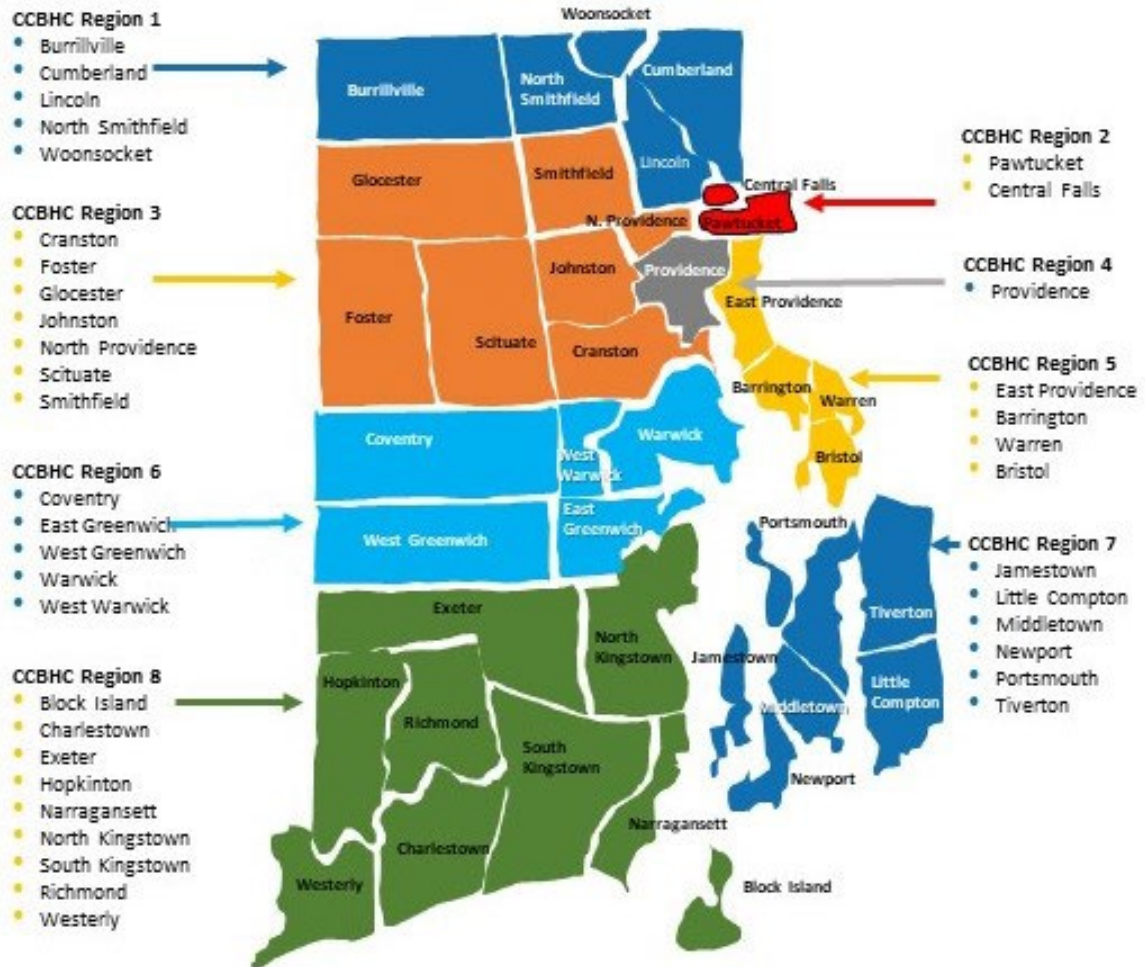
Upon review of the completed application, checklist, and completion of the site assessment, the Interagency Team will make a final determination and inform the applicant of whether they are certified

as a CCBHC, or if their application for certification has been denied.

“Certified” means the applicant has met all of the federal and state standards to qualify as a CCBHC and has been approved to participate in the CCBHC program for a two-year period (contingent upon continued demonstrated compliance with all CCBHC certification requirements).

“Not Certified” means the applicant has not met all of the federal and state standards to qualify as a CCBHC.

State of Rhode Island CCBHC Service Area Regions



SECTION 1: STAFFING
General Staffing Requirements

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>1.a.1</p> <p>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.</p> <p>★ Certifying States may specify additional community needs assessment requirements.</p>	<p>1.a.1</p> <p>CCBHCs shall participate in the needs assessment process for the Combined Block Grant Report. 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.</p>
<p>1.a.2</p> <p>The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.</p> <p>Note: See criteria 4.k relating to required staffing of services for veterans.</p>	
<p>1.a.3</p> <p>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.</p> <p>Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical</p>	

<p>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 integration¹ and coordination of behavioral health and primary care.</p> <p>Note: <i>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 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.</i></p>	
<p>1.a.4</p> <p>The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.</p>	
<p>SECTION 1: STAFFING Licensure and Credentialing of Providers</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>1.b.1</p> <p>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</p>	<p>1.b.1</p> <p>All CCBHCs shall be:</p> <ul style="list-style-type: none"> • Licensed as a Behavioral Health Organization (BHO) by BHDDH for the services they are required to deliver;

¹ While CCBHCs are not required to provide primary care services, they are required to provide Primary Care Screening and Monitoring (See 4.g). CCBHCs may not pay for primary care services under the Section 223 CCBHC Demonstration PPS beyond those defined under 4.g. CCBHCs should coordinate with primary care providers to support integrated provision of primary and behavioral health care.

<p>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.</p>	<ul style="list-style-type: none"> • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), and/or The Joint Commission (TJC) for the services they deliver; • Designated as a “Recovery Friendly Workplace” by BHDDH; • Licensed as a CCBHC provider by BHDDH once the license is available; and • Licensed as a Child Behavioral Health Organization (CBHO) by DCYF for the services they are required to deliver once the license is available. <p>All CCBHCs shall remain in compliance with these requirements for ongoing CCBHC Certification and Re-Certification.</p> <p>All Designated Collaborating Organizations (DCO) shall be licensed, certified, and/or credentialed to provide a Medicaid reimbursable service.</p> <p>All DCO staff shall be appropriately licensed, certified, registered, and/or credentialed as required for the specific service they provide.</p> <p>Compliance with RI regulations related to licensure will be required of organizations providing behavioral healthcare services for adults, children, and families.</p>
<p>1.b.2</p> <p>The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required 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, 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</p>	<p>1.b.2</p> <p>Each CCBHC shall have an identified Substance Use Disorder (SUD) subject matter expert who is the designated point of contact related to SUD services at the CCBHC and who oversees substance use disorder treatment services at the CCBHC. This individual will provide critical input to the community, State, and other</p>

<p>plans, and as required to meet program requirements of these criteria.</p> <p>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. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced² addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).</p> <p>Examples of staff include a combination of the following:</p> <ol style="list-style-type: none"> (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and 	<p>stakeholders regarding the CCBHC's fixed point of responsibility for SUD services within the CCBHC catchment area.</p>
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² CCBHCs should seek practitioners with experience in the assessment and diagnosis of SUD, substance intoxication and withdrawal; pharmacological management of intoxication, withdrawal, and SUDs; ambulatory withdrawal management; outpatient addiction treatment; toxicology testing; and pharmacodynamics of commonly used substances.

<p>(13) community health workers.</p> <p>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.</p> <p>Note: <i>Recognizing professional shortages exist for many behavioral health providers³: (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 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.</i></p> <p>★ Certifying states should specify which staff disciplines they will require as part of certification.</p>	
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SECTION 1: STAFFING
Cultural Competence and Other Training

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>1.c.1</p> <p>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:</p> <ul style="list-style-type: none"> • Evidence-based practices 	<p>1.c.1</p> <p>Each CCBHC shall ensure that all staff (direct care, clinical, operations, administrative, etc.) complete Community First Responder Naloxone Training (offered free online by the University of Rhode Island).</p> <p>Each CCBHC shall ensure that DCO staff who have contact with CCBHC clients and/or their families, are subject to the</p>

³ Find Shortage Areas by State & County, see HPSA Find (hrsa.gov).

<ul style="list-style-type: none"> • 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. <p>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.</p> <p>Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)⁴ 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 website⁵, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.</p> <p>Note: See criteria 4.k relating to cultural competency requirements in services for veterans.</p>	<p>same training requirements as the CCBHC staff for the service they are providing.</p>
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⁴ Access standards at, What is CLAS? - Think Cultural Health (hhs.gov) and Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at National Minority Mental Health Awareness Month — New CLAS Implementation Guide (hhs.gov).

⁵ Suggested resources include the African American Behavioral Health Center of Excellence, LGBTQ+ Behavioral Health Equity Center of Excellence, Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging, and Asian American, Native Hawaiian, and Pacific Islander Behavioral Health Center of Excellence.

<p>1.c.2</p> <p>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 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.</p>	
<p>1.c.3</p> <p>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.</p>	
<p>1.c.4</p> <p>Individuals providing staff training are qualified as evidenced by their education, training, and experience.</p>	
<p>SECTION 1: STAFFING</p> <p>Linguistic Competence and Confidentiality of Consumer Information</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>1.d.1</p> <p>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.</p>	<p>1.d.1</p> <p>Each CCBHC is required to ensure that the DCO is providing meaningful access to services, such as language assistance, interpretation and translation services, ADA compliant auxiliary aids and services, as well as documents and information in commonly spoken languages, are available</p>

	to CCBHC consumers.
<p>1.d.2</p> <p>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.</p>	
<p>1.d.3</p> <p>Auxiliary aids and services are readily available, Americans with Disabilities (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).</p>	
<p>1.d.4</p> <p>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.</p>	

<p>1.d.5</p> <p>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.</p>	
<p>SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES</p> <p>General Requirements of Access and Availability</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>2.a.1</p> <p>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.</p>	
<p>2.a.2</p> <p>Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.</p>	<p>2.a.2</p> <p>Each CCBHC shall be open a minimum of 50 hours per week.</p> <p>Each CCBHC shall have Open Access hours:</p> <ul style="list-style-type: none"> • Open access indicates availability for client walk-ins and same day appointments. • CCBHCs are required to have available designated hours at least 3 days/week for open access services. • CCBHCs are required to educate all staff about the availability of open access.

<p>2.a.3</p> <p>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.</p>	<p>2.a.3</p> <p>In service areas where one or more CCBHCs are already operational, new applicants must demonstrate that there is currently an unmet need for CCBHC services in that service area and describe how they will meet that need. The Interagency Team will review and assess submitted documentation to determine if justification of need is met.</p>
<p>2.a.4</p> <p>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.</p>	<p>2.a.4</p> <p>Each CCBHC shall assist Medicaid enrolled individuals in accessing non-emergency medical transportation, as well as assist all attributed clients with community transportation resources available outside of the Medicaid non-emergency medical transportation benefit.</p>
<p>2.a.5</p> <p>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.</p>	<p>2.a.5.</p> <p>The CCBHC shall comply with all federal and State telehealth laws and regulations, and Medicaid’s telehealth policies for Medicaid beneficiaries.</p>
<p>2.a.6.</p> <p>Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.⁶</p>	<p>2.a.6.</p> <p>Each CCBHC shall have staff dedicated to outreach and engagement who do not carry a caseload.</p> <p>Each CCBHC shall have policies and/or procedures to describe how they will conduct outreach and engagement</p>

⁶ Underserved individuals and populations includes communities as defined in Federal Register: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government as well as individuals or populations that have unmet needs for mental health and substance use disorder treatment and supports

	<p>activities to assist individuals and families to access appropriate services.</p> <p>Each CCBHC shall be able to document, track, and report on outreach and engagement activities to individuals and populations not currently attributed to a CCBHC.</p>
<p>2.a.7</p> <p>Services are subject to all state standards for the provision of both voluntary and court-ordered services.</p>	<p>2.a.7</p> <p>Each CCBHC shall have “Facility Status” designation by BHDDH as a requirement for certification and re-certification.</p> <p>Each CCBHC is required to have staff with appropriate credentials and training to provide court ordered substance use disorder treatment to individuals after a Driving Under the Influence or Refusal charge.</p>
<p>2.a.8</p> <p>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 occurs, 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.</p>	
<p>SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES</p> <p>Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>

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.

- 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 (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. 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 the

<p>comprehensive evaluation, or the provision of treatment during the 60-day period.</p> <p>Note: <i>Requirements for these screenings and evaluations are specified in criteria 4.d.</i></p>	
<p>2.b.2</p> <p>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.</p>	<p>2.b.2</p> <p>Each CCBHC shall inform the individual’s identified Primary Care Physician of any changes in the comprehensive evaluation, including updates to the functional assessment.</p> <p>For Children age 18 years and younger: the person-centered and family-centered treatment plan shall be updated with the cooperation of the individual when changes occur with the individual’s status, based on responses to treatment or when there are changes in treatment goals or goal achievement have occurred, or every 3 months, whichever is sooner.</p>
<p>2.b.3</p> <p>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 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.</p>	
<p>SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES</p> <p>Access To Crisis Management Services</p>	

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>2.c.1</p> <p>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.</p>	<p>2.c.1</p> <p>Each CCBHC that has a courthouse within their catchment area shall provide a Qualified Mental Health Professional (QMHP) assessment onsite within 1 hour of request from the Court.</p>
<p>2.c.2</p> <p>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.</p>	
<p>2.c.3</p> <p>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 limited English proficiency (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).</p>	
<p>2.c.4</p> <p>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.</p>	

<p>2.c.5</p> <p>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.</p> <p>Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.</p>	
<p>2.c.6</p> <p>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.</p> <p>Note: See criterion 3.a.4 where precautionary crisis planning is addressed.</p>	
<p>SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES</p> <p>No Refusal of Services Due to Inability to Pay</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>2.d.1</p> <p>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).</p>	

<p>2.d.2</p> <p>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.</p>	
<p>2.d.3</p> <p>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.</p>	<p>2.d.3</p> <p>Each CCBHC shall employ a standard means test to determine local prevailing rates.</p>
<p>2.d.4</p> <p>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.</p>	<p>2.d.4</p> <p>DCOs are required to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO contract and in compliance with the CCBHC standards on access, regardless of individual ability to pay or insurance status.</p>
<p>SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES</p> <p>Provision of Services Regardless of Residence</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>2.e.1</p> <p>The CCBHC ensures no individual is denied behavioral health care services, including but</p>	

<p>not limited to crisis management services, because of place of residence, homelessness, or lack of permanent address.</p>	
<p>2.e.2</p> <p>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 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.</p>	
<p>SECTION 3: CARE COORDINATION General Requirements of Care Coordination</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>3.a.1</p> <p>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</p>	<p>3.a.1</p> <p>Each CCBHC shall work with the Continuum of Care Collaborative applicants to take referrals from the housing program(s) for eligible individuals needing Home</p>

<p>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. ⁷</p> <p>Note: See criteria 4.k relating to care coordination requirements for veterans.</p>	<p>Stabilization services in their catchment area.</p>
<p>3.a.2</p> <p>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.</p> <p>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.⁸</p>	
<p>3.a.3</p> <p>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 children and youth referred to external providers or resources in obtaining</p>	

⁷ For additional information on care coordination, see Care Coordination | Agency for Healthcare Research and Quality (ahrq.gov).

⁸ The Interoperability Standards Advisory (ISA) process represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and determination of "recognized" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. More information can be found at Interoperability Standards Advisory (ISA) | HealthIT.gov.

<p>an appointment and tracking participation in services to ensure coordination and receipt of supports.</p>	
<p>3.a.4</p> <p>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 Advance Directive, if desired by the person receiving services.⁹ 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.</p>	
<p>3.a.5</p> <p>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.</p>	

⁹ Psychiatric Advance Directives are legal instruments that may be used to document a competent person’s specific instructions or preferences regarding future mental health treatment. Psychiatric Advance Directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. For more information visit NRC PAD | National Resource Center on Psychiatric Advance Directives (nrc-pad.org).

<p>3.a.6</p> <p>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.</p>	<p>3.a.6</p> <p>Each CCBHC care coordination agreement and DCO contract shall include the provision of individual freedom of choice.</p>
<p>3.a.7</p> <p>The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.</p>	<p>3.a.7</p> <p>CCBHCs are required to have care coordination agreements with an agency with SOAR-trained individuals who can support SSI and SSDI applications, unless they have an existing person trained in this in-house. CCBHCs may train additional staff in SOAR but must find funding through other means (not CCBHC).</p>
<p>SECTION 3: CARE COORDINATION</p> <p>Care Coordination and Other Health Information Systems</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>3.b.1</p> <p>The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.</p>	
<p>3.b.2</p> <p>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</p>	

<p>information exchange.¹⁰For 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.</p>	
<p>3.b.3</p> <p>The CCBHC uses technology that has been certified to current criteria¹¹ 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.¹²</p> <ul style="list-style-type: none"> • Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).¹³ • At a minimum, support care coordination by sending and receiving summary of care records.¹⁴ • 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.¹⁵ • Provide evidence-based clinical decision support.¹⁶ • Conduct electronic prescribing.¹⁷ 	

¹⁰ Pursuant to HHS Health IT Alignment policy and Section 13112 of the HITECH Act, recipients and subrecipients of award funding which involves acquiring, upgrading and implementing health IT must utilize health IT that meets standards and implementation specifications adopted by HHS in 45 CFR part 170, Subpart B, if such standards and implementation specifications can support the award activity.

¹¹ As of February 2023, current criteria are the 2015 Edition of health IT certification criteria, as updated according to the 2015 Edition Cures Update

¹² Additional information about health IT products certified to these criteria is available on the Certified Health IT Product List (CHPL).

¹³ United States Core Data for Interoperability (USCDI) standard at 45 CFR 170.213 and “Demographics” criterion at § CFR 170.315(a)(5).

¹⁴ “Transitions of care” criterion at § 170.315(b)(1)

¹⁵ “Application access – patient selection” criterion at § 170.315(g)(7); “Application access – all data request” criterion at § 170.315(g)(9) and “Standardized API for patient and population services” criterion at § 170.315(g)(10).

¹⁶ “Clinical decision support” criterion at § 170.315(a)(9)

¹⁷ “Electronic prescribing” criterion at § 170.215(b)(3).

<p>Note: <i>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.</i></p>	
<p>3.b.4</p> <p>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.</p>	
<p>3.b.5</p> <p>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.</p>	

SECTION 3: CARE COORDINATION

Care Coordination Agreements

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>3.c.1</p> <p>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 Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.</p> <p><i>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.</i></p>	<p>3.c.1</p> <p>Each CCBHC shall inquire whether the consumer has a Primary Care Provider (PCP), assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual's PCP.</p>
<p>3.c.2</p> <p>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 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</p>	

<p>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.</p> <p>Note: <i>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.</i></p> <p>★ 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, maintain recovery, and reduce the risk of relapse and injury during transitions.</p>	
<p>3.c.3</p> <p>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:</p> <ul style="list-style-type: none"> • Schools • Child welfare agencies 	<p>3.c.3</p> <p>RI requires Care Coordination Agreements with:</p> <ul style="list-style-type: none"> • Catchment area hospital/ Emergency Department, • Catchment area Urgent Care, • FQHC, • Catchment area Primary Care Providers, • Catchment area court, • Butler Hospital, • Bradley Hospital,

- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty crisis)
- Indian Health Service youth¹⁸ regional treatment centers
- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- Other social and human services.

CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people 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

- Hasbro Children's Hospital,
- Catchment area Police/Emergency Medical Services (EMS),
- Veterans Administration,
- BH Link,
- 988,
- Catchment area Family Care Community Partnerships (FCCP) providers,
- Accountable Entities (AE),
- Department of Corrections,
- Opioid Treatment Provider (OTP/Methadone),
- Home Stabilization Service provider,
- Eleanor Slater Hospital,
- Rhode Island State Psychiatric Hospital,
- Providers specialized in support and services for adults and children with I/DD, **AND**
- Agency with SOAR-trained individuals who can support SSI and SSDI applications (unless they have an existing person trained in this in-house).

¹⁸ The Indian Health Service is an Operating Division within HHS, responsible for providing federal health services to American Indians and Alaska Natives.

<p>and Early Childhood Mental Health Consultation programs</p> <ul style="list-style-type: none"> • Coordinated Specialty Care programs for first episode psychosis • 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) <p>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.</p> <p>Note: <i>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.</i></p> <p>★ Certifying states may require CCBHCs to establish additional partnerships.</p>	
<p>3.c.4</p> <p>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.</p> <p>Note: <i>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.</i></p>	

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, and Transfer (ADT) system.

The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these 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.*

SECTION 3: CARE COORDINATION
Treatment Team, Treatment Planning, and Care Coordination Activities

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>3.d.1</p> <p>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.</p>	
<p>3.d.2</p> <p>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 people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.</p> <p>Note: See criteria 4.k relating to required treatment planning services for veterans.</p>	

<p>3.d.3</p> <p>The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan.</p> <p>Note: See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.</p>	
<p>SECTION 4: SCOPE OF SERVICES General Service Provisions</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>4.a.1</p> <p>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.</p> <p>The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.</p>	<p>4.a.1</p> <p>The following service enhancements will also be required in Rhode Island:</p> <p>Assertive Community Treatment, i.e.,</p> <ul style="list-style-type: none"> • ACT I (High Intensity) • ACT II (Lower Intensity) • ACT YA (Young Adults)
<p>4.a.2</p> <p>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 a needed specialty service is</p>	<p>4.a.2</p> <p>Each CCBHC shall have the capacity to directly provide mental health and substance use disorder treatment services to people with serious mental illness and serious emotional disorders, as well as developmentally</p>

unavailable through the CCBHC or DCO entities.	appropriate mental health and substance use care for children and youth, separate from any DCO relationship.
<p>4.a.3</p> <p>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.</p>	
<p>4.a.4</p> <p>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.</p>	
<p>SECTION 4: SCOPE OF SERVICES</p> <p>Person-Centered and Family-Centered Care</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>4.b.1</p> <p>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.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.</p>	

<p>4.b.2</p> <p>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.</p>	
<p>SECTION 4: SCOPE OF SERVICES Crisis Behavioral Health Services</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>4.c.1</p> <p>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.¹⁹</p> <p>★ 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.²⁰</p> <p>PAMA requires provision of these three crisis behavioral health services, whether</p>	<p>4.c.1</p> <p>The CCBHC shall provide:</p> <ul style="list-style-type: none"> • 24-hour staffed hotline; • 24-hour mobile crisis teams • 2 person mobile crisis response; AND • Qualified Mental Health Professionals (QMHPs) to provide clinic-based and mobile crisis intervention services. <p>The CCBHC is <u>required</u> to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.</p>

¹⁹ For questions about this process, please email ccbhc@samhsa.hhs.gov

²⁰ For questions about this process, please email ccbhc@samhsa.hhs.gov

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)²¹ systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality 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.²²
- **Crisis receiving/stabilization:** The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and

Children’s mobile crisis services shall meet DCYF emergency services certification requirements.

²¹ Air traffic control (ATC) serves as a conceptual model for real-time coordination of crisis care and linkage to crisis response services. It may involve real-time connection to GPS-enabled mobile teams, true system-wide access to available beds, and outpatient appointment scheduling through the integrated crisis call center. For more information see National Guidelines for Behavioral Health Crisis Care | SAMHSA.

²² For information on crisis services for children and youth, please see National Guidelines for Child and Youth Behavioral Health Crisis Care (samhsa.gov) and A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth (samhsa.gov)

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 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 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.

SECTION 4: SCOPE OF SERVICES
Screening, Assessment, and Diagnosis

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>4.d.1</p> <p>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.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning.</p>	
<p>4.d.2</p> <p>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.</p>	

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:

1. Preliminary diagnoses.
2. The source of referral.
3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved.
4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services.
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications.
6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful.
7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications.
8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors.
9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence.
10. Assessment of need for medical care (with referral and follow-up as required).
11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services.
12. 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:

1. 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.
2. 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.
3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
4. Pregnancy and/or parenting status.
5. 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.
6. Relevant medical history and major health conditions that impact current psychological status.
7. 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.
8. 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).
9. Basic cognitive screening for cognitive impairment.
10. 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.

<ol style="list-style-type: none"> 11. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. 12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services). 13. 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. 14. 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. 15. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions. 	
<p>4.d.5</p> <p>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.</p> <ul style="list-style-type: none"> ★ 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. 	<p>4.d.5</p> <p>Each CCBHC shall provide Traumatic Brain Injury Screening using the OBISS+ (Online Brain Injury Screening and Support System) as part of the comprehensive evaluation.</p> <p>Each CCBHC shall utilize the PHQ-9 assessment to screen all adults, and the PHQ-9M to screen all adolescents (age 12-18 years of age) for depression. For clients in the Healthy Transitions Program, providers may opt to use either version – clinical discretion is allowed. With that said, the State does encourage use of the PHQ-9M as it includes some additional questions which could be of clinical value.</p>
<p>4.d.6</p> <p>The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief</p>	

<p>motivational interviewing techniques to facilitate engagement.</p>	
<p>4.d.7</p> <p>The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.</p>	
<p>4.d.8</p> <p>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 immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1.</p>	
<p>SECTION 4: SCOPE OF SERVICES Person-Centered and Family-Centered Treatment Planning</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>4.e.1</p> <p>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.</p> <p>Note: See program requirement 3 related to coordination of care and treatment</p>	

<p><i>planning.</i></p>	
<p>4.e.2</p> <p>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 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.</p>	
<p>4.e.3</p> <p>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.</p>	
<p>4.e.4</p> <p>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.</p>	
<p>4.e.5</p> <p>The treatment plan is comprehensive, addressing all services required, including</p>	

<p>recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.</p>	
<p>4.e.6</p> <p>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).</p>	
<p>4.e.7</p> <p>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.</p> <p>★ 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. 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).</p>	
<p>SECTION 4: SCOPE OF SERVICES</p> <p>Outpatient Mental Health and Substance Use Services</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>

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.

- ★ 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-

4.f.1

See Addendum 6 for a full list of Rhode Island required Evidence Based Practices (EBPs).

<p>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.</p>	
<p>4.f.2</p> <p>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)²³ to improve service outcomes.</p>	
<p>4.f.3</p> <p>Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.</p>	

²³ Measurement-based care (MBC) is the systematic use of patient-reported information to inform clinical care and shared decision-making among clinicians and patients and to individualize ongoing treatment plans: Measurement-Based Mental Health Care (va.gov).

SECTION 4: SCOPE OF SERVICES
Outpatient Clinic Primary Care Screening and Monitoring

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>4.g.1</p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>4.g.1</p> <p>Rhode Island enhanced screening requirement includes:</p> <ul style="list-style-type: none"> • Tobacco Use
<p>4.g.2</p> <p>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:</p> <ul style="list-style-type: none"> • Identifying people receiving services with chronic diseases. • Ensuring that people receiving services are asked about physical health 	

<p>symptoms; and</p> <ul style="list-style-type: none"> Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g <p>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.</p>	
<p>4.g.3</p> <p>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:</p> <ol style="list-style-type: none"> 1. Ensuring individuals have access to primary care services. 2. Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions. 3. Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and 4. Promoting a healthy behavior lifestyle. <p>Note: <i>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.</i></p>	

<p>Note: See also program requirement 3 regarding coordination of services and treatment planning.</p> <ul style="list-style-type: none"> ★ 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. 	
<p>SECTION 4: SCOPE OF SERVICES Targeted Case Management Services²⁴</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>4.h.1</p> <p>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.</p> <ul style="list-style-type: none"> ★ Based upon the needs of the population served, states should specify the scope of 	<p>4.h.1</p> <p>Each CCBHC is required to provide, either directly or via a DCO, ACT services to high acuity adults and transition aged youth (i.e., ACT-I, ACT-II, or ACT-YA).</p>

²⁴ CCBHC targeted case management services are separate from and do not follow state targeted case management rules under the Medicaid state plan or waivers.

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

SECTION 4: SCOPE OF SERVICES
Psychiatric Rehabilitation Services

Federal Criteria Requirements

Rhode Island Additional Requirements

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 include services and recovery support 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 managers, paying bills, and interacting with neighbors or coworkers.²⁵ 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 psychoeducation; and
- Find and maintain safe and stable housing.

²⁵ For more information, see Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov).

<p>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.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning</p> <ul style="list-style-type: none"> ★ 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. 	
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SECTION 4: SCOPE OF SERVICES
Peer Supports, Peer Counseling, and Family/Caregiver Supports

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>4.j.1</p> <p>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 respites²⁶; 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;</p>	<p>4.j.1</p> <p>Each CCBHC shall be Certified by BHDDH to provide Peer Based Recovery Support Services (PBRSS).</p>

²⁶ For more information, see National Guidelines for Behavioral Health Crisis Care

<p>and family-to-family caregiver support.</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning.</p> <p>★ Certifying states should specify the scope of peer and family services they will require based upon the needs of the population served.</p>	
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SECTION 4: SCOPE OF SERVICES

Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>4.k.1</p> <p>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</p> <p>Note: See program requirement 3 regarding coordination of services and treatment planning.</p>	
<p>4.k.2.</p> <p>All individuals inquiring about services are asked whether they have ever served in the</p>	

<p>U.S. military.</p> <p>Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:</p> <ol style="list-style-type: none"> 1. 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. 2. 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. 3. 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 nonnetwork. <p>Veterans: 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).</p> <p>Note: <i>See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.</i></p>	
<p>4.k.3</p> <p>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</p>	<p>4.k.3</p> <p>Each CCBHC shall have an identified Veterans Coordinator role who is trained as a Veterans Service Officer by NACVSO (the National Association of County Veterans</p>

<p>and other components of health care for all veterans.</p>	<p>Services Officers).</p>
<p>4.k.4.</p> <p>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:</p> <ol style="list-style-type: none"> 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.²⁷ 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 	

²⁷ These services must still meet the basic CCBHC requirements to review and update every 6 months in criterion 2.b.2.

<p>making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).</p> <p>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.</p>	
<p>4.k.5</p> <p>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:</p> <ul style="list-style-type: none"> • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility 	

<ul style="list-style-type: none"> • Respect²⁸ <p>As implemented in VHA recovery, the recovery principles also include the following:</p> <ul style="list-style-type: none"> • Privacy • Security • Honor <p>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.</p>	
<p>4.k.6</p> <p>All behavioral health care is provided with cultural competence.</p> <ol style="list-style-type: none"> 1. 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. 2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity. 	
<p>4.k.7.</p> <p>There is a behavioral health treatment plan for all veterans receiving behavioral health services.</p> <ol style="list-style-type: none"> 1. The treatment plan²⁹ includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. 2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself. 	

²⁸ See SAMHSA's Working Definition of Recovery.

²⁹ If the treatment plan section of the electronic health record does not include fields for capturing diagnosis, it shall be captured in other areas of the electronic health record.

<p>3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.</p> <p>4. The plan is recovery oriented, attentive to the veteran’s values and preferences, and evidence-based regarding what constitutes effective and safe treatments.</p> <p>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.</p>	
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SECTION 5: QUALITY AND OTHER REPORTING
Data Collection, Reporting and Tracking

Federal Criteria Requirements	Rhode Island Additional Requirements
<p>5.a.1</p> <p>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 services; (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.</p> <p>Note: See criteria 3.b for requirements regarding health information systems.</p>	<p>5.a.1</p> <p>As part of the reporting requirements for Rhode Island, CCBHCs shall submit a complete and updated CCBHC Staffing Template at a regular cadence, as determined by the CCBHC Interagency Team, to demonstrate ongoing staffing levels relative to approved staffing plans as specified in certification.</p> <p>Providers are required to participate in the statewide Health Information Exchange (HIE) to support data sharing, care coordination, and quality reporting for the CCBHC program. Providers must work to establish the requisite interfaces to contribute data and the client consent processes to enable this exchange in Demonstration Year 2 and fully participate in the HIE in Demonstration Year 3.</p>

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-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 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

<p>participate in other evaluation-related data collection activities as requested.</p>	
<p>5.a.4</p> <p>★ 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.</p> <p><i>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.</i></p>	
<p>SECTION 5: QUALITY AND OTHER REPORTING Continuous Quality Improvement</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>5.b.1</p> <p>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, 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.</p>	

<p>5.b.2</p> <p>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 (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan</p>	
<p>5.b.3</p> <p>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.</p>	
<p>SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION General Requirements of Organizational Authority and Finances</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>6.a.1.</p> <p>The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria:</p> <ul style="list-style-type: none"> • 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 	

<ul style="list-style-type: none"> • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.) • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). <p>Note: <i>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.</i></p>	
<p>6.a.2</p> <p>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.</p>	
<p>6.a.3</p> <p>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 (CAP) is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.</p>	
<p>SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION</p> <p>Governance</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>

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 making.³⁰ 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

6.b.1

CCBHCs shall adopt one of the following approaches to secure 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 health and/or substance use disorders, and their family members. This governing board can function as the Advisory Council as described in Addendum 8.

Option 2: Development of an Advisory Council that reports to the board, as described in Addendum 8.

³⁰ For more information regarding meaningful participation, see Participation Guidelines for Individuals with Lived Experience and Family | SAMHSA.

<p>3. Fiscal and budgetary decisions 4. Governance (human resource planning, leadership recruitment and selection, etc.)</p> <p>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.</p>	
<p>6.b.2</p> <p>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.</p> <p>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.</p> <p>★ 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.</p>	
<p>6.b.3</p> <p>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</p>	

<p>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.</p>	
<p>6.b.4</p> <p>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.</p>	
<p>SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION</p> <p>Accreditation</p>	
<p>Federal Criteria Requirements</p>	<p>Rhode Island Additional Requirements</p>
<p>6.c.1</p> <p>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.</p>	

<p>6.c.2</p> <p>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.</p> <ul style="list-style-type: none"> ★ 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 standards for the certification process and assures adherence to the CCBHC Certification Criteria. 	<p>6.c.2</p> <p>EOHHS will determine the recertification timeline in compliance with SAMSHA standards that recertification occurs no more than every three years. CCBHC certification is valid for a period of two years from the date of issuance, contingent upon continued provider compliance with all RI CCBHC certification requirements. Providers who wish to retain their certification status beyond two years shall undergo a reapplication process before their current certification expires.</p>
<p>6.c.3</p> <p>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.</p>	

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 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 health 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 CCBHC'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 Utilization Review 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.

17. Develop standards and protocols for primary care screening and monitoring requirements with input and feedback from primary care physicians and informed by the community needs assessment.

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, they should be knowledgeable about contemporary therapeutic and rehabilitative modalities necessary to work with the population served by the program. The medical/clinical director or chief medical officer, regardless of place of residence, shall maintain a physical presence at the CCBHC location(s) to ensure the quality of the medical/behavioral component of care.

ADDENDUM 2: Accreditation Bodies and Standards, Relevant Endorsements and Certifications for Behavioral Health Services

The following accreditation standards, endorsements, and certifications will be considered by the State to evaluate a provider's compliance with a CCBHC standard.

Commission on Accreditation of Rehabilitation Facilities Behavioral Health Accreditation (CARF)

- CARF Certified Community Behavioral Health Clinic (CCBHC)
- 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)

- COA Certified Community Behavioral Health Clinic (CCBHC)
- 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 (PRS)

The Joint Commission (TJC)

- Certified Community Behavioral Health Clinic (CCBHC)
- 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, certified, and/or credentialed 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, a DCO will need to be an enrolled Medicaid provider to provide an applicable Medicaid covered core CCBHC service.
3. The CCBHC will attest that the DCO has at least three years' experience providing a particular service type or treatment modality unless written approval is obtained from the CCBHC Interagency Team.
4. The CCBHC will provide an attestation acknowledging and affirming responsibility for oversight and accountability of all services delivered by all contracted DCOs.
5. Prior to operating as a CCBHC, a formal written agreement (i.e., an executed 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.
6. The CCBHC will provide a plan in sufficient detail to the CCBHC Interagency Team on how it will monitor DCO compliance with the agreement and provide the results of this monitoring activity to EOHHS as directed. The DCO agreement will include the following provisions:
 - a. Describes 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. Describes the specific steps that will be implemented by the CCBHC and DCO to ensure appropriate collaboration across the two organizations.
 - d. Articulates 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. Articulates 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)
 - f. Articulates the CCBHC retains the responsibility for care coordination.

- g. Requires a copy of the proposed DCO staffing pattern detailing the positions, required credentials for each position, and indicates whether the position(s) are currently filled or vacant. (1.a.1 & 1. a.2) and (2.a.6)
- h. Articulates the individual's freedom to choose their provider (3.a.6)
- i. If the DCO provides crisis services to adults, children, and youth, they shall provide:
 - i. Evidence that clinical staff include QMHPs who are available to conduct any assessment that may result in involuntary hospitalization.
 - ii. Copy of their 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).
 - iii. Compliance with payment rules.
 - iv. Compliance with shadow claim submission requirements.
 - v. Adherence to payment arrangements between the CCBHC and DCO for services rendered by the DCO on behalf of the CCBHC.
 - vi. Collection and maintenance of all documentation necessary for CCBHC data collection and reporting as required.
- j. In addition, a DCO that provides crisis services to children and youth specifically shall also provide:
 - i. Copy of their Certification of Mental Health Emergency Service Intervention for Children, Youth and Families (Regulation 214-RICR-40-00-6) or evidence of a pending certification application.
- k. Requires CCBHC training plans address training of DCO staff.
- l. Requires DCO clinical staff be trained in relevant EBPs and that the CCBHC monitors the DCO's use of EBPs including training, coaching, and fidelity compliance.
- m. Requires DCO staff be appropriately licensed, certified, registered, and credentialed as required by state and federal statute and regulation (1.b.1)
- n. Requires the DCO service(s) must be trauma-informed, person-centered, recovery-based, and culturally appropriate.
- o. Requires the DCO provided service(s) for CCBHC consumers meet the same quality standards as those required of the CCBHC (4.a.4).
- p. Requires the persons receiving services from the DCO to have access to the CCBHC's grievance procedures. (4.a.3).
- q. Requires the DCO collects and maintains all documentation necessary for CCBHC data collection and reporting as required by BHDDH, DCYF, EOHHS, and the agreement between the CCBHC and the Managed Care Organizations (MCOs). (5.a.3).
- r. If a CCBHC and DCO relationship is materially altered during the course of a CCBHC program year (i.e., an arrangement is terminated, or service responsibilities change) EOHHS must be notified within ten days as this has oversight and compliance implications. The CCBHC shall also inform their MCO partners of the termination of any DCO arrangements within ten days.
- s. Assure that a new DCO relationship only goes into effect with the start of a CCBHC program year.
- t. The CCBHC must provide oversight of all services performed by a DCO, consistent with all requirements included in the RI CCBHC Certification Standards.

ADDENDUM 4: Staff Qualifications for CCBHC Billing

CCBHC SERVICE	MEDICAID QUALIFIED PROVIDER (within the scope of practice)
Crisis Services	<ul style="list-style-type: none"> • Licensed Independent Practitioner • Qualified Mental Health Professional (QMHP) • Master’s Degree w/ license to provide relevant BH service. • Master’s degree without license with 1 year post master’s degree full time BH experience • Licensed RN w/ ANCC certification as a psychiatric and mental health nurse or licensed RN with 1 year post RN full time BH experience • Clinical Interns • Clinical Supervisors • Unlicensed CCBHC Personnel* • Certified Peer Recovery Specialist • Supervisor/manager <p>Note: <i>Only licensed individuals listed above and QMHPs are qualified to conduct the assessment service.</i></p> <p>* Unlicensed CCBHC personnel also must work under the direct supervision of a licensed professional or QMHP. Unlicensed staff must meet these qualifications, which some or all EMTs might meet:</p> <ul style="list-style-type: none"> • B.A. or B.S. degree in social work, psychology, or related field and have a minimum of two (2) years of experience in a human services profession. • Certified in First Aid/CPR and as a Community Responder • A minimum of four (4) years employment in the human services field may be substituted for a bachelor’s degree.
Outpatient Mental Health and Substance Use Services	<ul style="list-style-type: none"> • Physician • Licensed Independent Practitioner (Psychologist, LICSW, LMHC, LMFT) • Licensed Clinical Social Worker (LCSW) • Licensed Marriage and Family Therapist - Associates (LMFT-A) • Licensed Mental Health Counselor - Associate (LMHC-A) • Master’s degree without license with 1 year post master’s degree full time BH experience • Licensed RN w/ ANCC certification as a psychiatric and mental health nurse • Licensed RN with 1 year post RN full time BH experience • Clinical Interns

	<ul style="list-style-type: none"> • Clinical Supervisors • Supervisor/manager • Licensed Drug Counselor • Certified Alcohol and Drug Counselors • Case Manager
Psychiatric Rehabilitation Services	<ul style="list-style-type: none"> • Clinical Interns • Clinical Supervisors • Supervisor/manager • Community Psychiatric Supports and Treatment (CPST) Specialist
Targeted Case Management	<ul style="list-style-type: none"> • Associates-Degree • Registered Nurse • CPST Specialist • Case Manager
Peer Support Services	<ul style="list-style-type: none"> • Certified Peer Recovery Specialist
Assertive Community Treatment (ACT)	<ul style="list-style-type: none"> • Licensed Independent Practitioner • Registered Nurse • Licensed Clinician • Psychiatrist • Substance Use Disorder Specialist • CPST Specialist • Case Manager • Certified Peer Recovery Specialist • Vocational Specialist • Clinical Interns • Clinical Supervisors • Supervisor/manager
High Acuity Children Services	<ul style="list-style-type: none"> • Program Manager/Director • Psychiatrist • Registered Nurse • Licensed Independent Practitioner (Psychologist, LICSW, LMHC, LMFT) • Licensed Clinical Social Worker (LCSW) • Licensed Marriage and Family Therapist - Associates (LMFT-A) • Licensed Mental Health Counselor - Associate (LMHC-A) • Master's degree without license with 1 year post master's degree full

	<p>time BH experience</p> <ul style="list-style-type: none"> • Case Manager • CPST Specialist • Vocational Specialist • Family Support Partner • Youth Support Partner
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CCBHCs must ensure the following in terms of staffing and service provision:

1. The CCBHC directly provides, or contracts with a DCO to provide, or has a referral relationship with an organization that provides, Standard Adult, Adolescent, and Women & Children Substance Use Disorder Treatment Program services including Medication Assisted Treatment (MAT).
2. The CCBHC provides certified peer recovery specialists to assist individuals to move 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 (PBRSS).
3. 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.
4. The CCBHC has individuals trained to provide Medication 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 (OTP) to allow for consumer choice and access to methadone.
5. The CCBHC must be able to access professional treatment for individuals suffering the effects of trauma by employing or contracting with professionals with expertise in the treatment of trauma.
6. 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 individuals when the CCBHC does not have the necessary expertise in-house.

ADDENDUM 5: Populations of Focus Diagnostic and Assessment Criteria

High Acuity Adults

1. An individual is in the High Acuity Adult Population if they are age 18 years or older **AND** have a DLA score of four (4) or less **AND/OR** and I/DD waiver **AND**:
 - a. 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.
2. If an individual does not meet the above criteria, but you believe they should be in the “High Acuity Adult” population instead of the “Standard” population, you will need to submit a High Acuity Adult Population Exception Request to BHDDH.
 - a. CCBHCs may submit a High Acuity Adult Population Exception request to BHDDH for any individuals who meet the below criteria:
 - They have been discharged from an inpatient psychiatric unit in the past 30 days; **OR**
 - They have been released from incarceration within the past 30 days; **OR**
 - They are currently unhoused; **OR**
 - They have been unhoused within the last 30 days; **OR**
 - They are eligible for the I/DD waiver services, **AND** they do not have one of the qualifying diagnoses listed above; **OR**
 - b. 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 unhoused in the past six months.
 - They are at risk of being unhoused (i.e., are unstably housed).
 - They have been charged with a crime in the past six months.
 - They are at risk of becoming involved in the 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).
3. An individual is in the High Acuity Adult Population if they are transition-aged individuals between the ages of 15 and 26 years, **AND**:
 - a. Experienced a first episode psychosis or early onset of serious mental illness with high prevalence of co-occurring substance use disorders; **OR**
 - b. Have or are at imminent risk of developing a serious mental health condition; **OR**
 - c. Experience any of the following conditions: unemployed, or in school; currently unhoused or at risk of being unhoused; had recent contact with the justice system; at risk of hospitalization.

Please note: *Individuals in a residential setting are not eligible for High Acuity services. Individuals with autism spectrum disorder are eligible only by exception.*

4. Individuals in the High Acuity Adult population must be re-evaluated utilizing the DLA every 90 days per Medicaid requirements. To remain in the High Acuity Adult population, an individual must meet the DLA requirement for this population or have an approved and valid High Acuity Population Exception Request from BHDDH.

High Acuity Children and Youth

1. An individual is in the High Acuity Children and Youth population if they are under the age of 18 years and 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 standard 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 unhoused or have been unhoused 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. They have an Autism Spectrum Disorder, **AND** any secondary behavioral health diagnosis; **OR**
 - b. 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 within the CANS Child Risk Behavior domain or received at least one score of 3 or scores of 2 within the CANS Child Needs domain. The complete CANS is expected to be done within 30 days and updated yearly when applicable.

Note: *Children aged 0-4 will require exception forms until the 0-4 CANS is available.*
 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 may not have 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. A High Acuity Child Population Exception Request may be submitted to DCYF for review and approval.

Substance Use Disorder

1. An individual is in the Substance Use Disorder (SUD) Population if 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.

Standard Population

1. An individual is in the Standard Population if they are not included in the High Acuity Adult, High Acuity Child, **OR** SUD population.

ADDENDUM 6: Required Training, Programs, Evidence-Based Clinical Practices, and Fidelity

Clinical Staff: Individuals who are licensed professionals, trained to provide therapeutic services and conduct assessments, requiring formal education and licensure. Examples: LCSW, RN.

Direct Service Staff: Individuals who work directly with clients but may not have the clinical qualifications to diagnose or provide therapy. They provide hands-on support and assist with implementation of treatment plans. Examples: Case Managers, Peers.

CCBHC REQUIRED EVIDENCED BASED PRACTICES WITH FIDELITY			
EBP	Population	Training	Fidelity Requirement
Assertive Community Treatment (ACT)	Adults (18 and older) and Transition Age Youth (15 – 26 yrs)	All clinical & direct care staff providing team-based services	Fidelity will be required yearly based on the TMACT Fidelity Scale.
Individual Placement and Supports (IPS)	Adults (18 and older) and Transition Age Youth (15-26 yrs)	All clinical & direct care staff providing supported employment services	Fidelity will be required yearly based on a BHDDH modified IPS Fidelity Scale.
Seven Challenges	Adolescents (12 – 17 yrs)	All clinical & direct care staff providing Seven Challenges to adolescents	Fidelity is provided by Seven Challenges LLC yearly and will be required to be reported to the State.
Mobile Response and Stabilization Services (MRSS)	Children *shall be provided to children up to age 18, with option to provide to individuals up to age 21 based on medical necessity	All Mobile Crisis response staff	Fidelity will be required to be reported to the state yearly utilizing the MRSS Fidelity Tool (Version 11/2023); and the Child and Adolescent Behavioral Health Center of Excellence/Center for Innovative Practices – Ohio.
Zero Suicide (ZS)	All Populations	All organizational staff	Providers to: <ul style="list-style-type: none"> • Determine logistics of implementation of Zero Suicide in DY 2. • Begin training and implementation of key protocols and procedures in DY 3. • Additional fidelity requirements are forthcoming. Full implementation typically takes more than 2 years.

CCBHCS SHALL HAVE STAFF TRAINED TO PROVIDE THE BELOW REQUIRED EVIDENCE BASED PRACTICES:

Motivational Interviewing (MI)
Cognitive Behavioral Therapy (CBT)
Dialectical Behavioral Therapy (DBT)
Family Psychoeducation (FPE)
Housing First
12 Step
Medication Assisted Treatment (MAT)
Screening, Brief Intervention and Referral to Treatment (SBIRT)
Trauma Informed Care/Approach

*The State has removed set thresholds for the percentage of CCBHC staff who must be fully trained in each EBP by Demonstration Year, acknowledging that it is not clinically necessary for all staff to receive these trainings, just those providing relevant services and supports.

***State Monitoring:** Provider must provide State with documentation to demonstrate compliance with requirement, upon request. Examples of requested documentation include: staff training certificates and/or logs, and training protocols. At this juncture, the State will not be requiring the application of any specific fidelity tools for these EBPs.

CCBHC REQUIRED ANNUAL TRAININGS	
Training	Requirements
Person/Family Centered/Recovery-Oriented Care	Required of all clinical & direct service staff
Recovery Oriented Treatment Planning	Required of all clinical & direct service staff
Care for Co-Occurring Mental Health and Substance Use Disorders	Required of all clinical & direct service staff
Policy and Procedure for Integration with Primary Care	Required of all clinical & direct service staff
Risk Assessment	Required of all clinical & direct service staff
Suicide and Overdose Prevention and Response	Required of all clinical & direct service staff
Roles of Family and Peer	Required of all clinical & direct service staff
Cultural Competency	Required of all staff
Military and Veterans’ Culture Training	Required of all staff
De-escalation Training	Required of all staff
Policy and Procedure for Continuity of Operations/Disasters	Required of all staff

*All Trainings shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

ADDENDUM 7: Mandatory Treatment Models By Population of Focus

HIGH ACUITY ADULT POPULATION

Assertive Community Treatment (ACT)

Services for Complex Serious and Persistent Mental Illness (SPMI) shall be provided by an Assertive Community Treatment team (ACT) for individuals eligible to be attributed to the “High Acuity Adult” population and with a **DLA score of 4 or less**. Clinical discretion may be applied to determine whether an individual with a DLA score of 4 or less should be assigned to an ACT – I (high intensity) or ACT – II (lower intensity) Team based on their presenting needs.

The goal of ACT services is to help individuals become independent and integrate into the community as they experience recovery.

ACT services require that:

- Core services include integrated treatment, clinical treatment, rehabilitative and supportive services such as: crisis intervention; psychiatric medication; psychosocial rehab; mental health and/or SUD evidenced based treatment; case management services; care coordination; health home services; and social skills and interpersonal relationship training, as needed related to client intensity.

Flexibility:

Both ACT – I and ACT – II team staffing requirements include “FLEX” positions. These positions should be utilized to fill the specific needs of the team population. You can fill these “FLEX” positions with a Community Psychiatric Support Treatment provider (CPST), Case Manager, Clinician, Substance Use Specialist, Vocational Specialist, or a Certified Peer Recovery Specialist depending on your team needs.

Certified Peers:

Certified Peers can be utilized WITHIN your team composition as a “FLEX” position or you can staff your Certified Peer position outside of the team composition (e.g., GOP, Outreach and Engagement, etc.) and assign at minimum 50% of their time to providing support to a specific team or split among teams.

Medical Assistant:

You may assign a medical assistant to support any of your teams, however this position should be listed under “Admin” for the purposes of the CCBHC Staffing Workbook and Cost Report, and is not included in the core composition of your teams.

ACT: Service Intensity, Determining Level of Need, and Staffing Requirements

1. ACT – I (High Intensity)

This level of service is needed when an individual's care requires a multidisciplinary team approach to providing comprehensive treatment, support, and rehabilitation services. ACT – I (High Intensity) **teams shall provide eight (8) or more contacts per month. At least four (4) contacts must be provided in-person with the individual.** Contacts must be qualifying events, as defined in the RI CCBHC Billing Manual.

ACT – I (High Intensity) operations require:

- a. Ten (10) hours of team active operation during weekdays and 4 hours per day on weekends and holidays.
- b. On-call worker from ACT Team 24/7 for client emergencies to triage with crisis workers.

Treatment considerations for individuals who are appropriate for ACT – I (High Intensity) may include:

- a. Requirement of team-based services for minimum 6 months.
- b. Individuals in crisis or recent crisis episode.
- c. Individuals with multiple hospitalizations or incarcerations.
- d. Individuals with poor engagement in treatment.
- e. Court ordered individuals.

An individual receiving ACT – I (high intensity) services with whom the team is having difficulty engaging should not be moved to ACT – II because they **are not meeting the eight (8) visit minimum ACT – I standard.** The ACT Team is expected to use assertive engagement techniques and employ diligent efforts to provide ACT – I (high intensity) level of services.

ACT – I (High Intensity) Staffing Requirement

ACT – I (High Intensity)	Team Census 100
Position	Required (FTE)
Team Lead <i>(LICSW, LCSW, LMHC, LMFT, LCDP, RN)</i>	1
Registered Nurse*	3
Clinician <i>(Principal Counselor, Counselor, LICSW, LCSW, LMHC, LMHC-A, LMFT, LMFT-A)</i>	1
Substance Use Disorder Specialist <i>(LCDP, CADC, Principal Counselor, Counselor, LICSW, LCSW, LMHC, LMFT)</i>	1
Vocational Specialist <i>(Bachelor's degree)</i>	1
CPST or Case Manager <i>(Associate degree or BHDDH approved certification/curriculum)</i>	3
FLEX STAFF	2
Total Staff (Max) and Ratio	12 FTE 1:8 (Census of 100)
MD/APRN	0.75

***RN Variance Guidance:** For a team composition requiring more than 1 FTE RN, a variance may be requested for 1 FTE LPN in lieu 1 FTE RN. An RN is required for appropriate supervision over the LPN.

2. ACT – II

This level of service is required for individuals who may not require the ACT – I (High Intensity) level of support, or may no longer need the ACT – I (High Intensity) level of support, and would benefit from the team-based approach. **ACT – II teams shall provide five (5) or more contacts per month. At least three (3) contacts must be provided in-person with the individual.** Contacts must be qualifying events, as defined in the RI CCBHC Billing Manual.

ACT – II operations require:

- a. Eight (8) hours of team active operation during weekdays.
- b. No weekend or holiday operation requirements.
- c. No on-call operation requirements.

Treatment considerations for individuals who are appropriate for step down to ACT – II may include:

- a. No acute psychiatric episodes requiring ER Visit or Inpatient Psychiatric Hospitalization within the past 6 months.
- b. No arrests or incarceration within the past 6 months.
- c. Making progress with ACT goals requiring fewer individual contacts per month.
- d. Improved community integration as reflected in progress notes and the treatment plan.
- e. Improved or stable housing as reflected in progress notes and the treatment plan.
- f. Sustained employment and meeting employment and educational goals as reflected in progress notes and the treatment plan.
- g. Improved activities of daily life (ADLs) as reflected in progress note and the treatment plan.

The ACT team will utilize clinical discretion to determine when an individual requires an increase in level of service from ACT – II to ACT – I (High Intensity), e.g., major psychiatric crisis, psychiatric hospitalization(s), inability to safely manage symptoms in the community, presenting a risk of danger to self or others, etc.

Individuals on ACT – II receiving increased or decreased contacts for monitoring will be reviewed during the daily team meeting until the team has determined appropriate next steps for the individual. Next steps may include reducing visits in preparation for discharge or stepping-up and individual to ACT – I (High Intensity) as appropriate. As such, when the team is in the process of discharge planning with individuals on ACT – II, the team may conduct fewer than 80% of service contacts in the community to prepare the individual for a setting in which the individual may be required to attend office-based services such as in a clinic. The team must document the intention of increased office visits as a part of discharge planning and reflect this planning in the client's treatment plan.

ACT – II Staffing Requirement

ACT – II	Team Census 200
Position	Required (FTE)
Team Lead <i>(LICSW, LCSW, LMHC, LMFT, LCDP, RN)</i>	1
Registered Nurse*	3
Clinician <i>(Principal Counselor, Counselor, LICSW, LCSW, LMHC, LMHC-A, LMFT, LMFT-A)</i>	2
Substance Use Disorder Specialist <i>(LCDP, CADC, Principal Counselor, Counselor, LICSW, LCSW, LMHC, LMFT)</i>	1
Vocational Specialist** <i>(Bachelor's degree)</i>	2
CPST or Case Manager <i>(Associate degree or BHDDH approved certification/curriculum)</i>	4
FLEX STAFF	.5
Total Staff (Max) and Ratio	13.5 FTE 1:14 (Census of 200)
MD/APRN	0.75

*** RN Variance Guidance:** for a team composition requiring more than 1 FTE RN, a variance may be requested for 1 FTE LPN in lieu 1 FTE RN. An RN is required for appropriate supervision over the LPN.

****Vocational Specialist Variance Guidance:** for a team composition requiring more than 1 FTE Vocational Specialist, a variance may be requested for 1 FTE of a CPST (Associates degree) or Case Manager (Associates degree, and/or BHDDH approved case management curriculum) with IPS training, to provide dedicated rehab support. A Bachelors level Vocational Specialist is required on the team for appropriate supervision over the CPST and/or Case Manager.

3. ACT – YA (Young Adult)

This level of service is needed for individuals who are 15-26 years old, with a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) that impairs functioning in the community, have continuous high service needs, who lack engagement in and whose needs have not been met in traditional outpatient services. ACT – YA (Young Adult) is a program that will use assertive and intentional engagement strategies to work with individuals who may have needs that are unable to be met within general outpatient services.

ACT – YA teams shall provide eight (8) or more contacts per month. At least four (4) contacts must be provided in-person with the individual. Contacts must be qualifying events, as defined in the RI CCBHC Billing Manual.

ACT – YA operations require:

- a. Ten (10) hours of team active operation during weekdays and 4 hours per day on weekends and holidays.
- b. On-call worker from ACT Team 24/7 for client emergencies to triage with crisis workers.

The primary focus is on early identification and intervention of substance use disorders and/or for mental illness which may include first episode psychosis. Individuals served by this team are individuals who have avoided or not responded to traditional outpatient mental health and psychiatric rehabilitation services.

Treatment considerations for individuals who are appropriate for ACT (Young Adult) may include:

- a. Youth who have 2 or more inpatient psychiatric hospitalizations in 12 months.
- b. Youth who have 4 or more psychiatric ER visits in the 12 months.
- c. Youth returning to the community from an inpatient or residential setting.
- d. Youth who have high risk of justice involvement.
- e. Youth at risk of requiring a more restrictive living situation without increased community services.
- f. Youth who lack engagement in and whose needs have not been met in tradition outpatient services.
- g. Youth who need assistance developing a productive vocational or education plan.
- h. Youth with limited family or social support networks.

ACT – YA Staffing Requirement

ACT-YA (Young Adults, Age 15-26)	Team Census 50
Position	Required (FTE)
Team Lead <i>(LICSW, LCSW, LMHC, LMFT, LCDP, RN)</i>	1
Registered Nurse	1
Clinician <i>(Principal Counselor, Counselor, LICSW, LCSW, LMHC, LMHC-A, LMFT, LMFT-A)</i>	2
Substance Use Disorder Specialist <i>(LCDP, CADC, Principal Counselor, Counselor, LICSW, LCSW, LMHC, LMFT)</i>	1
Vocational Specialist <i>(Bachelor's degree)</i>	1
CPST or Case Manager <i>(Associate degree or BHDDH approved certification/curriculum)</i>	1
Total Staff (Max) and Ratio	6 FTE 1:8 (Census of 50)
MD/APRN	0.25

HIGH ACUITY CHILDREN/YOUTH POPULATION

High Acuity Services and supports shall be made available to children and youth up to age 18 who meet eligibility for high acuity services per the RI CCBHC Certification Standards. 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, skill building, and improving parent/caregiver and child/youth functioning through the development of targeted knowledge and skills.

The goal of High Acuity Services is to stabilize children and youth at home and in the community who are at risk of being admitted to more intensive programs (e.g., inpatient hospital programs, residential treatment centers), or to support children and youth transitioning from such facilities back into the community. These services are designed with an emphasis on family involvement, empowering caregivers, and addressing key issues related to the child/youth's behavioral health challenges. The long-term aim is to prepare the child/youth for a transition to less intensive, longer-term outpatient treatment to achieve sustainable positive outcomes.

Services are typically provided 2-3 times per week, with an average treatment duration of 12-16 weeks. The number of service hours may vary depending on the specific High Acuity program and the needs of the children/youth it serves. However, services are expected to be delivered more frequently than in standard outpatient treatment, with a minimum of 10 hours per month. These programs should offer evening and/or weekend hours to accommodate family schedules.

CCBHC High Acuity Children Program Requirements

All programs shall provide or have access to:

1. **Assessment, Evaluation and Treatment Planning:** Comprehensive assessments are conducted by behavioral health professionals to evaluate the child/youth's emotional, psychological, and behavioral needs. This may include clinical interviews, observations, screenings, and gathering input from family members/caregivers, and other individuals involved in the child/youth's life. Assessment and evaluation are essential components in forming treatment planning, as they provide a detailed understanding of the child/youth needs, strengths, challenges, and goals.
2. **Crisis Intervention:** Immediate and intensive support for children/youth in acute crisis situations, such as those involving self-harm, aggression, or suicidal ideation. Crisis intervention often involves a combination of therapeutic techniques, safety planning, and coordination with emergency services.
3. **Individual Therapy:** Specialized therapeutic approaches such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), or trauma-informed therapies are used to address the child/youth's specific behavioral and emotional needs. Children/youth who have experienced significant trauma, specialized services focused on trauma recovery, such as trauma-focused cognitive behavioral therapy (TF-CBT), are encouraged to be incorporated into the treatment plan.

4. Family Therapy and Support: Given the significant role that family dynamics play in a child/youth's mental health; family therapy is often a core component. This can help families understand the child/youth's behavior, improve communication, and develop strategies to support the child/youth's treatment.
5. Group Therapy: Group therapy for children is a therapeutic approach where children/youth participate in structured sessions led by a trained therapist in a group setting with peers facing similar challenges or issues. The goal is to provide a supportive environment where children/youth can learn social skills, improve emotional regulation, and develop coping strategies.
6. Behavioral Interventions: These are structured approaches designed to teach children/youth new coping strategies and ways to manage their behavior. Techniques may include reinforcement systems, skill-building activities, and social skills training.
7. Targeted Case Management: TCM activities support individuals maintaining recovery and access to essential services in areas such as healthcare, social support, legal, education, housing, and employment. Key activities include connecting clients to community and recovery services, enhancing service coordination, offering transitional care after inpatient stays, assisting with complex service systems, advocating for necessary resources, providing benefits counseling, and delivering on-site de-escalation and skill development when other services are unavailable. TCM ensures that services align with the individual's treatment plan, addressing their wellness and recovery goals. Follow-up and monitoring involve communication with the client, family, service providers, and other involved parties.
8. Psychiatric Services: Medication management and consultation with child and adolescent psychiatrists to address any underlying psychiatric conditions (such as depression, anxiety, or mood disorders) that may require pharmacological intervention.
9. Multidisciplinary Team Collaboration: High acuity services often involve a team of professionals, including psychiatrists, psychologists, clinicians, nurses, case managers, community psychiatric support and treatment staff (CPST), youth and family partners, other specialists who work together to develop and implement a comprehensive treatment plan.
10. School and Community Coordination: Coordination with schools, state agencies, and other community services (e.g., child welfare, juvenile justice, primary care/ pediatricians, childcare providers, family home visitors) ensures that the child/youth's care is holistic and extends into the environments where they live, learn, and receive other care.
11. Discharge Planning and Aftercare: Transition planning helps prepare the child/youth and family after the High Acuity services end. This may involve transfers or referrals to less intensive outpatient services, as well as other external community supports and resources.
12. Intensive Outpatient Programs (IOP): These programs provide more intensive care than traditional High Acuity outpatient treatment but do not require overnight stays. IOPs typically involve multiple sessions per week, combining individual therapy, group therapy, and family therapy.

Service Delivery Requirements

1. Services are provided for a minimum of 10 hours monthly, primarily in the home with some occurring in community-based settings as designated in the treatment plan.
2. In keeping with Rhode Island CCBHC standards, providers must maintain an on-call system that allows those receiving High Acuity children services access to clinical staff 24 hours per day/7 days per week/365 days a year when experiencing a crisis. If an in-person mobile crisis response is required, providers will maintain an hour 1 response as required by CCBHCs.
3. Staff shall coordinate treatment planning and aftercare with the child or youth's primary care physician, internal or external outpatient providers, other community-based providers, involved state agencies (e.g., DCYF, court officials, Rhode Island Training school), educational systems, parents/guardians, additional family, and/or significant people in the child/youth's life as applicable.
4. Medication management through the CCBHC shall be made available, when needed. Otherwise, service delivery shall be coordinated with the prescribing physician.
5. Translation and interpretation services are required when staff who speak the primary language of the child/youth and/or the primary language of the parent/caregiver are not available. Children/youth are not to be used to translate or interpret for their parent(s)/caregiver(s).

Staffing Requirements

High acuity children's behavioral health services require specialized staffing to address the complex needs of children and adolescents experiencing severe emotional, psychological, or behavioral challenges. The staffing components in such services typically include a multi-disciplinary team, with each member contributing their expertise to provide comprehensive care. A collaborative, interdisciplinary approach is essential, with all team members communicating and working together to develop and implement individualized care plans.

Below are the key staffing components commonly found in high-acuity children's behavioral health services:

Program Manager/Director:

- Provides Clinical Leadership and oversees daily operations, coordinates the services provided, ensures quality standards are maintained, provides supervision, and manages staffing resources.

Psychiatrists:

- Provide psychiatric evaluations, diagnosis, and medication management.
- Monitor the progress of treatment and adjust care plans as needed.
- Work closely with other team members to address the psychiatric needs of the children/youth.

Nurses:

- Assist with medication administration, physical health monitoring, and health assessments.

- Provide support in managing co-occurring medical and psychiatric conditions.
- Offer health education to children/youth and families.

Psychologists/Therapists/Clinicians:

- Conduct assessments, complete and monitor treatment plans and develop safety plans as needed.
- Develop therapeutic interventions for children/youth and families and monitor/supervise interventions and treatment delivered by non-licensed clinicians, case managers, CPSTs, and Family and/or Youth Partners.
- Specialize in understanding the emotional, cognitive, and behavioral aspects of children’s mental health.
- Provide individual, group, or family therapy, with an emphasis on addressing trauma, coping skills, and behavioral management.
- Specialize in behavior modification techniques and help children/youth develop adaptive coping strategies.

Case Managers:

- Work with families to ensure children/youth’s needs are being met within the home and community.
- Collaborate with other internal and external providers to ensure coordinated care and treatment for the client.
- Responsible for the coordination of services, including medical, psychological, and social care.
- Ensure that children/youth and families have access to the resources they need, and that related treatment goals are met.

CPSTs (Community Psychiatric Supports and Treatment):

- Assist children/youth with managing their daily routines, including family interactions, school or work responsibilities, and social relationships. They often support children/youth and youth in navigating challenges at home, school, or in the community.
- Help children/youth develop practical life skills such as problem-solving, decision-making, social skills, and coping mechanisms to manage their mental health challenges effectively.
- Work with family members to offer education about mental health conditions and effective strategies for supporting the child/youth. This includes improving communication and fostering a supportive home environment.

Vocational Specialists:

- Offer educational support, ensuring that children/youth in care continue their academic development and can achieve educational and vocational goals.
- Work closely with school systems to maintain educational continuity.
- Address behavioral challenges that may be affecting learning.

Family Partners and Youth Partners:

- Provide mentorship and guidance to children/youth and families, offering emotional support and coping strategies.
- Act as advocates for children/youth and families, ensuring their voices are heard in treatment planning and decision-making.
 - *Family Partners*

- Work closely with families to educate them about their child/youth's diagnosis, treatment options, and resources. They can assist families in identifying and accessing community resources (e.g. support groups). They support families during level of care transitions; by ensuring they have the necessary support in place to manage the change. In addition, Family Partners help advocate for the child/youth and family and help navigate systems (e.g., schools, social services).
- Are self-identified parents or caregivers of a child or youth with special needs, including behavioral health needs, and/or a child involved in the child welfare or juvenile justice systems OR professional experience of at least two years working with children/youth with special needs OR equivalently qualified by education in the human services field.
- Partners must be 21 years of age with a minimum of a high school diploma or GED and are required to be supervised by a licensed behavioral health professional who is available to provide support and consultation.
- *Youth Partners*
 - Play a key role in supporting and empowering children/youth who are receiving mental health or substance use services.
 - Youth Partners provide structured, one-to-one mentoring sessions between the Youth Partner and the child/youth, designed to support a specific goal on the child/youth's behavioral health treatment plan. The service takes place in the locations most conducive to the child/youth's acquisition of skills, including the child/youth's home and a wide variety of community sites.
 - Youth Partners must be 21 years of age; and have a high school diploma or equivalent with 2 years of experience working with children/youth OR a relevant Associate's degree with 1 year of experience working with children/youth OR a Bachelor's degree in a relevant field.

Staffing Considerations

1. High-acuity children's services require staff with specialized training in managing complex behavioral health issues. Ongoing training and professional development are essential for ensuring that staff remain equipped with the latest knowledge and skills to effectively support children/youth's needs and provide high-quality care.
2. Staff must hold the necessary credentials for their roles and work under the supervision of licensed professionals to effectively support children/youth with acute needs. The provider ensures that all staff delivering services are provided regularly scheduled weekly supervision by an independently licensed, master's level clinician or above.
 - a. In addition, any staff working in the High Acuity programs must have one year of direct, relevant experience with the targeted population (e.g., substance abuse, developmental disabilities, sexual abuse, and post-traumatic stress disorder).
 - b. If a staff member does not possess the required experience, a waiver request must be submitted to DCYF and be approved to provide services.
3. Staffing should reflect the cultural and linguistic needs of the community it serves.
4. Maintaining appropriate staffing ratios is crucial to ensure that children/youth receive the

necessary attention and care. For high-acuity children's services, the typical ratio is 1 clinician to 8-10 children/youth. However, exceptions may be made for providers who implement specific models that require a lower staff-to-child ratio.

STANDARD POPULATION

Adults and children in the Standard Population are eligible to receive services as needed to help manage individuals through short term acute needs and ongoing management for behavioral health issues. 'As needed' services include targeted case management services, psychiatric rehabilitation services, peer support services, outreach and engagement and access to Evidence Based Practices. Adults and children in the Standard Population have access to both office-based and community-based services based on individual needs and treatment plans.

A DLA score or CANS score is not required for the Standard Population.

Children's general outpatient behavioral health services typically involve a range of components designed to assess, treat, and support children/youth with emotional, behavioral, developmental, and mental health treatment needs. Key elements of this treatment must align with RI CCBHC Certification Standards and include, but are not limited to:

1. Assessment, Evaluation, Treatment Planning
2. Individual/Family Therapy/Group Therapy
3. Medication Management
4. Care Coordination
5. Family and Youth Support

One of the key requirements of CCBHCs is providing crisis support 24 hours a day, 7 days a week, 365 days a year. CCBHCs must ensure that children/youth and their families/caregivers have access to immediate assistance in times of mental health or substance use crises, including those receiving General Outpatient services.

Children receiving general out-patient services shall also have access to Evidence Based Practices (e.g. CBT, TF-CBT, Family Psychoeducation) and culturally competent care. Translation and interpretation services are necessary when staff fluent in the child's primary language or the primary language of the parent/caregiver are unavailable. Children and youth should never be asked to translate or interpret for their parents or caregivers. Additionally, family members or other informal supports should not serve as translators or interpreters in treatment settings.

Treatment is typically scheduled on a weekly or bi-weekly basis and is aimed at helping children/youth improve their emotional well-being and functioning at home and in the community. Treatment modality and frequency are informed by the person/family centered treatment planning process and should be flexible to meet the needs of the child/youth and their family/caregivers. Services should be offered in a setting that is best for the child/youth and their family/caregivers, and not restricted to clinic/office-based services only.

For General Outpatient children's services, the typical therapy caseload is 1 clinician to 20-35 children.

ADDENDUM 8: CCBHC Community/Consumer Advisory Council

The requirements of the Community/Consumer Advisory Council (“Council”) and/or Governing Boards serving as the Council are listed below:

1. Each CCBHC shall develop a Community Advisory Council (“Council”)
 - a. For Governing Boards that meet the fifty-one percent (51%) standard in **Criteria 6.b.1, Option 1** of the RI CCBHC Certification Standards, those boards have the option of functioning as that Council or creating a separate Council(s).
 - b. If the fifty-one percent (51%) standard is not met, the organization must create a separate Council.
 - c. The bylaw of all CCBHC governing boards would be amended to reflect this requirement and the duties and responsibilities listed below.
 - d. The Governing Board would establish protocols for complying with **Criteria 6.b.1, Option 2** of the RI CCBHC Certification Standards by incorporating input and representation from the Council and from individuals with lived experience and family members into the CCBHC’s governance, policies, plans, and budget.
2. 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.
3. The CCBHCs would have the option of developing separate Councils for children, youth, and families and another for adults, for each CCBHC.
4. 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.
5. The CCBHC will assign the necessary behavioral health planning and administrative position(s) to support and assist the functioning of the Council.
6. The Council shall:
 - 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.

7. The Council shall 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, unhoused service providers and local educational authorities are strongly encouraged.
8. 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 shall reflect the review and discussion on the Council recommendations, as further detailed in **1c** above.
9. The CCBHC will post an annual summary of the recommendations of the Council on the CCBHC website.
10. Additional guidance and requirements for the Council and related functions may be issued by EOHHS in partnership with BHDDH and DCYF from time to time to support, direct, and clarify the mission and functions of the Council.
11. The Council would be required to meet at least twice before the end of the first Demonstration Year as a CCBHC (e.g., By September 30, 2025).

ADDENDUM 9: 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 at most every three (3) years. 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 at most every three (3) years.
8. Input with regard to:
 - a. cultural, linguistic, physical health, and behavioral health treatment needs.
 - b. evidence-based practices and behavioral health crisis services.
 - c. access and availability of CCBHC services including days, times, and locations, and telehealth options; and
 - d. potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.
9. Input should come from the following entities if they are in the CCBHC service area:

- a. 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.
 - b. Health centers (including FQHCs in the service area).
 - c. Local health departments (Note: these departments also develop community needs assessments that may be helpful).
 - d. Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics.
 - e. One (1) or more Department of Veterans Affairs facilities.
 - f. Representatives from local K-12 school systems; and
 - g. Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.
10. 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:
- a. Organizations operated by people with lived experience of mental health and substance use conditions.
 - b. Other mental health and SUD treatment providers in the community.
 - c. Residential programs.
 - d. Juvenile justice agencies and facilities.
 - e. Criminal justice agencies and facilities.
 - f. Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers as applicable.
 - g. Child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service; and
 - h. Crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines.
 - i. Specialty providers of medications for treatment of opioid and alcohol use disorders.
 - j. Peer-run and operated service providers.
 - k. Homeless shelters and housing agencies.
 - l. Employment services systems.
 - m. Services for older adults, such as Area Agencies on Aging.
 - n. Aging and Disability Resource Centers; and
 - o. Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food, and transportation programs).