

RI CCBHC Provider Manual



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I. INTRODUCTION

Document History

The State of Rhode Island Certified Community Behavioral Health Clinic (CCBHC) Interagency Team, comprised of the Rhode Island Executive Office of Health and Human Services (EOHHS), the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), and the Department of Children, Youth, and Families (DCYF) have participated in the preparation of this Provider Manual to provide operational guidance with respect to the implementation of the CCBHC core services.

The team anticipates that this document will be updated and refined over the course of the CCBHC program to incorporate provider feedback and to accommodate any program modifications required by the Centers of Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the State.

| Version Number | Date | Summary of Changes |
|----------------|--------------------|---|
| 1.0 | September 17, 2024 | CCBHC Provider Manual for Program Year 1. |
| 2.0 | September 16, 2025 | Insertion of updated Certification Standards and Requirements for Program Year 2. |
| | | |
| | | |

Alignment with State and Federal Guidelines

The CCBHC Provider Manual is aligned with the certification requirements set forth by the CMS and SAMHSA. Additionally, it reflects State-specific regulations and guidelines established by the Rhode Island (RI) EOHHS, BHDDH, and DCYF. This alignment ensures that all operational and clinical practices within RI's CCBHCs are consistent with national standards while being tailored to meet local needs. Providers are expected to adhere to the guidelines outlined in this manual to deliver high-quality, compliant services. CCBHCs must also comply with the policies and procedures set forth in the following documents:

| Document | Content Emphasis | Current Version |
|--|---|-----------------|
| RI CCBHC Certification Standards | Foundational criteria, standards, and ongoing compliance required for CCBHC certification. | 2025 |
| RI CCBHC MCO Operations Manual | Contracting guidelines, program requirements, processes, and system readiness for MCOs working with CCBHCs. | 2025 |

| Document | Content Emphasis | Current Version |
|---|---|-----------------|
| RI CCBHC Quality Manual | Guidelines for quality measures, reporting responsibilities, and Quality Bonus Payment methodology. | 2025 |
| RI CCBHC Billing Manual | Service definitions, payment methodologies, and processes for financial reconciliation. | 2025 |

II. INTENDED PURPOSE

The purpose of this Provider Manual is to serve as a comprehensive guide for CCBHCs operating in RI. It outlines the operational standards, clinical guidelines, and compliance requirements necessary for delivering high-quality, integrated behavioral health services. The manual is designed to support providers, clinical staff, and program managers in implementing the CCBHC model.

A. Mission, Vision, Core Principles

1. Mission Statement

The mission of RI CCBHCs is to provide equitable, high-quality, person-centered behavioral health care that addresses the comprehensive needs of individuals and families. We are committed to fostering wellness, promoting recovery, and ensuring access to integrated, culturally responsive services across the lifespan, empowering all Rhode Islanders to achieve their full potential within their communities.

2. Vision Statement

RI CCBHCs envision a future where all individuals and families have seamless access to holistic, integrated care that nurtures mental, physical, and emotional well-being. We strive to create resilient, inclusive communities where every person can thrive, supported by a robust, collaborative behavioral health system.

3. Core Principles

Services within the CCBHC model are guided by the following core values and principles to enhance the behavioral health system in RI:

- **Integrated Care:** A comprehensive array of behavioral health services is offered, ensuring individuals and families receive all necessary care in collaboration with other providers and services.
- **Person and Family-Centered Care:** Person and family centered care puts clients at the center of the planning process. This method involves a collaborative and strengths-

based approach that relies on understanding the preferences and abilities of the individual seeking treatment and their support systems in order to tailor a personal plan for success.

- **Recovery-Oriented:** Services support a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
- **Cultural and Linguistic Competency:** Services are responsive and respectful to the cultural and linguistic needs, health practices, and beliefs of different population groups. This includes recognizing and addressing the impact of historical and current experiences of oppression on engagement and care.
- **Evidence-Based:** The model utilizes evidence-based and evidence-informed practices, ensuring that services are effective, and staff are committed to these approaches through continuous education.
- **Trauma-Informed:** Care incorporates an understanding of the impact of trauma on individuals and families, aiming to be sensitive, supportive, and avoid re-traumatization. Services prioritize physical and emotional safety, trustworthiness, choice, collaboration and empowerment.
- **Coordination and Collaboration:** Emphasizes clear communication, coordination, and seamless care of the individual. Integration of physical and behavioral health needs is central, supporting partnerships among individuals, families, and providers.
- **Accessible and Available:** Services are delivered in the community, adapting to the specific needs and preferences of individuals and families. Care is provided in the least restrictive settings, leveraging community resources and support networks.
- **Data-Driven:** Data is used to monitor outcomes, performance, and adherence to the model. This informs best practices and service delivery, with an overall goal of sustainability and broad health and recovery metrics.

B. Rhode Island CCBHC Landscape

CCBHCs shall provide these services in a manner that is appropriate for the population 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 pay¹. 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. These populations are referred to as “populations of focus” and are established by the federal

¹ CCBHCs will procure insurance information from clients and bill for provided services via established protocols with Medicaid, Medicare, or other payers. If a client is uninsured, the CCBHC will pursue payment via a sliding fee schedule which conforms with the requirements outlined in federal CCBHC certification criteria 2.d.3.

government.

CCBHCs are certified to provide services within a pre-determined geographic service area known as a “service area”. Rhode Islanders may elect to seek services at any of the CCBHCs located throughout the State; they are not restricted to the designated CCBHC in the service area in which they reside. This flexibility is designed to ensure greater accessibility and client choice. With this said, an individual may only be attributed to one CCBHC per month and providers shall coordinate on transfers of care to ensure no disruption to critical services.

CCBHCs receive Medicaid reimbursement through established Prospective Payment System (PPS) rates. These rates are based on the anticipated costs of CCBHCs’ provision of qualifying services – either directly or via partner organizations known as Designated Collaborating Organizations (DCOs). These services align with the behavioral health needs of the population and priority consumer populations within the service area as defined by the [RI CCBHC Certification Standards](#).

C. Community Needs Assessment Process

The Community Needs Assessment (CNA) is a critical component of the CCBHC model. This systematic approach is designed to identify the behavioral health needs of the community served by each CCBHC and to ensure that the clinic's services are aligned with those needs. The CNA, reviewed and updated every 3 years, informs each clinic’s staffing and service needs for the population the CCBHC serves.

Table 1. Required Elements of the CCBHC Community Needs Assessment

| # | Element |
|---|--|
| 1 | Service area description and sites where CCBHC services are offered. |
| 2 | Prevalence of mental health and substance use conditions and related needs in the service area. |
| 3 | Economic factors and social determinants of health affecting access to care in the service area. |
| 4 | Cultures and languages of populations in the service area. |
| 5 | Identification of underserved populations. |
| 6 | Description of how the CCBHC’s staffing plan will address needs assessment findings. |
| 7 | Plan to update the needs assessment at least every three years. |
| 8 | Input from people with lived experience and key community partners on community needs, CCBHC services, access to care, and barriers to care. |

Source: SAMHSA CCBHC Certification Criteria, Appendix A (March 2023)

D. Designated Collaborating Organizations (DCOs)

CCBHCs are integral to the provision of comprehensive and coordinated behavioral health services. A Designated Collaborating Organization (DCO) is an external entity that a CCBHC contracts with to deliver a core service that the CCBHC itself does not directly provide; or to expand its service capacity and offerings. DCOs are more than just care coordination and referral partners. DCOs deliver services under the CCBHC’s direction and are typically directly compensated by the CCBHC for the service; with these costs integrated into the CCBHC’s PPS rates. These partnerships are vital to expanding the scope of care, allowing CCBHCs to offer a full continuum of services, including specialized care that may require additional expertise or resources.

CCBHCs must directly provide at least 51% of the encounters across all required services, excluding crisis services. The intent behind this federal requirement is to ensure that the majority of care remains under the direct supervision and delivery of the CCBHC, so the CCBHC maintains a strong and consistent relationship with the patients it serves. The integration of services between the CCBHC and its partner DCOs is essential. This integration includes coordinated treatment plans, secure sharing of relevant information, and alignment of services to ensure a seamless experience for all clients. By maintaining clear communication and collaboration, CCBHCs can ensure that clients receive clinically appropriate care, regardless of whether the service is provided directly by the CCBHC or through a DCO.

To comply with state and federal guidelines, CCBHCs must establish formal agreements with their DCOs. These agreements outline the roles, responsibilities, and expectations for both parties, ensuring that services provided by DCOs meet the same standards of care and quality as those delivered directly by the CCBHC. The CCBHC is responsible for monitoring the performance of DCOs, conducting regular audits, and ensuring adherence to evidence-based practices. A brief overview of DCO partnership requirements is outlined in the table below; additional details can be found in the [RI CCBHC Certification Standards](#).

Table 2. Overview of DCO Partnership Requirements

| Topic | DCO Partnership Requirements |
|----------------------------|--|
| Formal Agreements | <ul style="list-style-type: none">• CCBHCs and DCOs should clearly define the roles and responsibilities of each party, including service provision, coordination, and communication protocols.• CCBHCs should ensure that DCOs comply with all applicable State and federal regulations. |
| Service Integration | <ul style="list-style-type: none">• CCBHCs and DCOs should utilize compatible Electronic Health Records (EHR) systems to securely share client data and coordinate care effectively. |
| Quality Monitoring | <ul style="list-style-type: none">• CCBHCs should conduct regular audits, review performance data, and ensure DCO adherence to evidence-based practices. |

| Topic | DCO Partnership Requirements |
|---|--|
| | <ul style="list-style-type: none"> • CCBHCs should address quality issues that arise with DCO-provided services, including corrective actions plans if necessary. |
| Compliance and Reporting | <ul style="list-style-type: none"> • DCOs shall comply with the same reporting requirements as the CCBHC, including data submission to the BHOLD system and adherence to confidentiality regulations such as HIPAA. • CCBHCs shall provide necessary support or training to DCO partners to facilitate compliance. • DCOs shall be licensed, certified, and/or credentialed to provide a Medicaid reimbursable service. • DCO staff who have contact with CCBHC clients and/or their families are subject to the same training requirements as the CCBHC staff for the service they are providing. |
| Service Continuity and Accessibility | <ul style="list-style-type: none"> • DCOs shall maintain appropriate staffing levels. • DCOs shall ensure timely service delivery. • DCOs shall provide services in a manner that is culturally and linguistically appropriate for the populations served. |
| Client Communication | <ul style="list-style-type: none"> • CCBHCs shall ensure that clients are fully informed about which services they will receive from a DCO, and how these services are coordinated with the care provided directly by the CCBHC. • CCBHCs shall ensure clients have clear information on how to access DCO services and whom to contact for support. |

Additional details can be found in the [CCBHC-DCO Oversight Checklist](#).

III. ORGANIZATIONAL STRUCTURE AND STAFFING

A. Leadership and Governance

Governance Structure

- **Board of Directors:** The CCBHC shall have a governing body, such as a Board of Directors, that is responsible for overseeing the CCBHC's operations, ensuring compliance with CCBHC certification standards, and providing strategic direction. The Board should include members with diverse backgrounds, including individuals with experience in healthcare, finance, law, and community representation.
- **Executive Leadership:** The CCBHC should have an executive leadership team, typically including roles such as the CEO, COO, and CFO, who are responsible for the day-to-day management of the clinic, financial oversight, and ensuring that the organization meets its operational and strategic goals.

- **Clinical Leadership:** The CCBHC must appoint a Medical Director to oversee all clinical services (please see [RI CCBHC Certification Standards](#) for additional information on requirements for the Medical Director position). The Medical Director ensures that clinical practices align with evidence-based guidelines and coordinates care across the clinic.
- **Community/Consumer Advisory Council:** The CCBHC must have an advisory council and/or a Governing Board that meets the requirements of a CCBHC advisory council that reports to the Board of Directors, in order to secure meaningful participation in the development of CCBHC policies, processes, programs and services (please see [RI CCBHC Certification Standards](#) for additional information on requirements for the Advisory Council).

Accountability and Reporting

- **Internal Reporting:** Establish regular reporting mechanisms for operational, clinical, and financial performance. This includes monthly reports to the Board of Directors and Executive Leadership team to discuss progress and challenges.
- **External Reporting:** Define the roles responsible for ensuring compliance with external reporting requirements to entities such as CMS, SAMHSA, EOHHS, BHDDH, and DCYF.

B. Staffing Requirements

CCBHC staffing is governed by strict requirements to ensure that all necessary services are delivered effectively and efficiently. Each CCBHC shall employ a multidisciplinary team of professionals, ensuring that all aspects of behavioral health care are covered.

CCBHCs shall have personnel trained in providing services to children, adolescents, adults, and families. This may include child psychologists, pediatric nurses, and family therapists. Staff working with these populations must have training in family-centered care and trauma-informed approaches.

CCBHCs shall have a designated Substance Use Disorder (SUD) Subject Matter Expert (SME) to oversee and advise on SUD services. The requirement of a SUD SME is to ensure integration, collaboration, and parity between behavioral health and SUD services within the CCBHC.

All clinical staff shall be licensed and credentialed according to Rhode Island State law, ensuring they operate within the scope of their professional practice. Any requests for variance in staffing composition (e.g. position and/or credentials) where specified by the State, must be submitted in writing to the BHDDH or DCYF Licensing Unit for review and approval.

CCBHCs shall also provide ongoing professional development and training to their staff. This includes annual training in key areas such as cultural competence, trauma-informed care,

person/family centered care, recovery-oriented treatment planning, crisis de-escalation and evidence-based practices. Continuing education credits (CEUs) shall be supported by the CCBHC to ensure that all staff maintain their licenses and certifications.

Staffing levels shall be sufficient to ensure that all clients receive timely and effective care. Workforce development is integral to maintaining high standards of care. CCBHCs must conduct regular competency assessments through performance evaluations, peer reviews, and direct observation. If a staff member is found lacking in certain competencies, the CCBHC shall provide additional training, supervision, and/or mentorship. Evidence of ongoing coaching and evaluation is required for all CCBHCs.

In the event of staffing shortages, CCBHCs shall have State approved contingency plans in place. These plans may include cross-training existing staff to cover multiple roles or utilizing temporary and contract staff to ensure continuous service delivery. Emergency staffing plans should also be established, detailing how services will be maintained during emergencies, such as natural disasters or pandemics. These plans might include the use of telehealth services and remote work arrangements.

CCBHCs shall submit monthly staffing reports to the State, detailing current staffing levels, hiring progress, and any changes in client census. These reports help the State to monitor whether CCBHCs are meeting their staffing requirements and allow for timely interventions if substantive gaps are identified.

Please refer to the [RI CCBHC Certification Standards](#), as well as applicable Behavioral Health Organization (BHO) licensing regulations for more information on required staffing positions, staffing credentials and qualifications, and staff to client ratios for team-based services (e.g. Assertive Community Treatment, or ACT). Please also refer to the [RI CCBHC Certification Standards](#) for a defined list of Qualified Medicaid Providers who are allowed to bill for CCBHC services.

C. Care Coordination Partnerships

To ensure comprehensive and coordinated care, CCBHCs in Rhode Island must establish formal agreements with various agencies and entities across the State's behavioral health continuum of care. Care coordination partnerships differ from DCO partnerships in that they typically reflect more diverse scopes of services (e.g., beyond the core CCBHC ones) and typically do not involve direct payment by the CCBHC. These agreements must include specific protocols that outline the roles, responsibilities, and coordination strategies necessary to provide integrated care across the lifespan. Care coordination agreements are required to include at minimum, details on how referrals, discharges, tracking, information sharing, and reporting for performance measures (if indicated) will be operationalized. Agreements must also include key

contacts from each agency, and a defined timeframe for which these agreements will be review, evaluated, and refined as needed by both agencies.

In RI, CCBHCs are required to establish care coordination agreements with the following providers at minimum:

- The following providers within each CCBHC’s designated service area:
 - Hospital Emergency Room (ER);
 - Urgent Care;
 - Primary Care Provider;
 - Police/ Emergency Medical Services (EMS);
 - Family Care Community Partnerships (FCCP) providers;
- The following hospitals:
 - Butler Hospital;
 - Bradley Hospital;
 - Hasbro Children Hospital;
 - Eleanor Slater Hospital;
 - Rhode Island State Psychiatric Hospital;
- A federally qualified health center (FQHC);
- The Veterans Administration (VA);
- The Rhode Island Department of Corrections (DOC);
- BH LINK;
- 988;
- Accountable Entities (AEs);
- An opioid treatment (OTP/Methadone) provider;
- A Home Stabilization Service (HSS) provider;
- A provider specialized in support and services for adults and children with intellectual and development disabilities (I/DD); and
- An agency with SSI/SSDI Outreach, Access, and Recovery (SOAR) trained individuals who can support these applications (unless the CCBHC has this resource in-house).

These partnership agreements and protocols ensure that CCBHCs in Rhode Island provide comprehensive, coordinated care that addresses the full range of client needs, promoting overall wellness and recovery. CCBHCs are encouraged to enhance their existing partnerships and build additional care coordination agreements with other organizations operating within their service areas such as schools, peer-operated programs, social service agencies, and justice system programs.

Additional information on care coordination agreements can be found within the [RI CCBHC Certification Standards](#).

IV. REQUIRED SERVICES AND CLINICAL OPERATIONS

A. Availability and Accessibility of Services

Each CCBHC shall be open a minimum of 50 hours per week and shall have Open Access hours:

- 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

B. CCBHC Service Overview

Table 3. Overview of CCBHC Required Services

| Service | Definition | Service Components | Eligibility | Limitations/ Exclusions |
|--|--|---|--|--|
| A. Crisis Behavioral Health Services | Immediate, short- term interventions to stabilize individuals experiencing a mental health or substance use crisis. | <ul style="list-style-type: none"> • 24-hour staffed crisis hotline • 24-hr mobile crisis team with 2-person response • Crisis stabilization services | Individuals in acute mental health or substance use crisis | Not intended for non-urgent cases or routine care. |
| B. Screening Assessment & Diagnosis | Systematic evaluation of an individual's mental health and substance use to identify support needs and to establish a diagnosis. | <ul style="list-style-type: none"> • Required screenings including for traumatic brain injuries (TBI) • Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach • Initial evaluation | All individuals seeking services at the CCBHC | Certain specialized assessments may be limited to specific populations or diagnoses. |

| Service | Definition | Service Components | Eligibility | Limitations/ Exclusions |
|---|--|--|--|---|
| | | <ul style="list-style-type: none"> • Comprehensive assessment • Risk assessment • Diagnostic evaluation | | |
| C. Person and Family-Centered Treatment Planning | Collaborative process between clients and providers to create a tailored plan of care based on individual needs and goals. | <ul style="list-style-type: none"> • Individualized treatment plan • Individual and family participation • Crisis Plan and/or Advanced Directives • Specialty consultation • Progress monitoring and updates | All individuals receiving CCBHC services | Not applicable for certain acute care services where treatment is brief and focused. |
| D. Outpatient Mental Health and Substance Use Services | <p>Structured mental health services provided in a non- residential setting to support ongoing recovery and management of mental illness.</p> <p>Comprehensive care for individuals with substance use disorders, including treatment, counseling, and recovery support.</p> | <ul style="list-style-type: none"> • Individual therapy and/or group therapy • Medication management • Psychoeducation • Medication Assisted Treatment (MAT) • Relapse prevention • Support groups • Developmentally and age-appropriate evidence-based practices and model • Specialty consultation | <p>Individuals with diagnosed mental health conditions requiring ongoing support.</p> <p>Individuals with a diagnosed substance use disorder, particularly those with moderate to severe conditions.</p> | <p>Services may be limited to certain conditions or exclude certain therapies not covered by Medicaid.</p> <p>Not suitable for individuals needing inpatient detoxification or residential treatment.</p> |

| Service | Definition | Service Components | Eligibility | Limitations/ Exclusions |
|---|--|--|--|--|
| E. Outpatient Clinic Primary Care Screening and Monitoring of Key Health Indicators and Health Risks | Integration of physical and behavioral healthcare by screening and monitoring clients' primary health indicators and risks. | <ul style="list-style-type: none"> • HIV and viral hepatitis screening • Other primary care key health indicator screenings • Monitoring of key health indicators • Connection and collaboration with primary care and specialty health providers • Promotion of healthy behaviors | All clients receiving services at the CCBHC, particularly those with known health risks. | Not a substitute for comprehensive primary care services; referrals to primary care providers are required for abnormal results. |
| F. Targeted Case Management | Intensive level of support and coordination of services and resources for individuals with complex needs or serious mental health and substance use conditions, ensuring access to comprehensive care. | <ul style="list-style-type: none"> • Care coordination • Referral to community resources • Assistance with transitions of care • Enrollment in ACT-I, ACT-II, ACT-YA, high acuity children's services, and/or SUD treatment services as appropriate • High risk supportive services | Individuals with multiple service needs, including those with SMI and/or co-occurring disorders. | May exclude individuals whose needs can be met with minimal intervention. |

| Service | Definition | Service Components | Eligibility | Limitations/ Exclusions |
|---|---|--|--|--|
| G. Psychiatric Rehabilitation Services | Services aimed at helping individuals with serious mental illness to develop skills necessary for independent living and community integration. | <ul style="list-style-type: none"> • Skill development • Vocational support • Social skills training • Rehabilitation counseling • Supported Employment • Individual/Family Psychoeducation • Housing support | Individuals with severe mental illness requiring assistance with daily living and vocational skills. | Limited to individuals with chronic mental illness; not suitable for those without functional impairments. |
| H. Peer & Family Support and Counselor Services | Support services provided by individuals with lived experience of mental illness or substance use, focusing on recovery and empowerment. | <ul style="list-style-type: none"> • Peer-led groups • Recovery coaching • Family supports • Youth Supports • Peer education • Service navigation | Individuals and families seeking additional support from peers who have similar experiences. | Peer support is supplementary and not a replacement for clinical care. |
| I. Intensive, Community-Based Behavioral Healthcare for Members of the Armed Forces and Veterans | Comprehensive, community-based services tailored to the unique needs of veterans and service members, focusing on trauma and recovery. | <ul style="list-style-type: none"> • Trauma-informed care • Case management • Veterans' Health Administration (VHA) and benefit enrollment assistance • Coordination of care | Veterans and active-duty service members and their family with behavioral health needs. | Services may be restricted to those with a military background; not available to civilians. |

C. Crisis Behavioral Health Services

Crisis Behavioral Health Services can be provided directly by the CCBHC or through a DCO that meets State and federal standards. The CCBHC and/or DCO must also meet all established BHDDH and DCYF emergency services regulation and licensing standards where appropriate.

1. Definition

Activities which are designed to provide a rapid response to address an acute psychiatric and/or substance use crisis. Crisis services must be available 24/7/365. Assessments must be culturally and linguistically appropriate and trauma informed. Services must include access to crisis prevention, intervention, treatment, and post-intervention stabilization services, that address mental health and/or substance use crises.

2. Core Components

- **Mobile Crisis Teams:** Teams must respond within one hour (or within two hours in rural areas) and include an appropriately credentialed Qualified Mental Health Professional (QMHP) as well a second responder (for more information about staffing requirements see the [RI CCBHC Certification Standards](#)). In RI, CCBHCs must respond to child and youth crises using the Mobile Response and Stabilization Services (MRSS) model.
- **24 Hour Crisis Hotline:** Each CCBHC is required to provide an emergency service crisis line which is answered by a live voice 24 hours per day, 7 days per week, 365 days per year to ensure access to appropriate triage, crisis response, and stabilization services. The answering service or provider must have the capacity to ensure accessibility for callers who speak a language other than English. The caller must have telephone access to a clinician within 15 minutes of the initial call to discuss the crisis and to develop a follow-up service plan based on the client's expressed needs.
- **Crisis Stabilization Services:** CCBHC are required to provide timely crisis stabilization services and post crisis follow-up care.

3. Specific Requirements

- **Screening and Assessment:** Use standardized, validated tools and brief motivational interviewing where appropriate.
- **Substance Use Disorder Services:** Must be capable of addressing crises related to substance use and provide necessary detox services.
- **Naloxone Access:** Ensure access to naloxone for overdose reversal.
- **Prevention Services:** Develop individualized crisis prevention plans and ensure follow-up care.
- **Stabilization Services:** Offer de-escalation, medication management, counseling, case management and peer support, with appropriate referrals as needed.

- **Law Enforcement Protocols:** Establish protocols for the role of law enforcement in crisis situations.

4. Eligibility

Any individual identified as needing crisis services is eligible to receive them.

5. Limitations/Exclusions

Specific limitations or exclusions are outlined in the [RI CCBHC Billing Manual](#).

6. Provider Qualifications/Licensure

Please see the [RI CCBHC Certification Standards](#) for required provider qualifications for delivery of crisis services and State regulations pertaining to QMHP's and child emergency services.

7. Staff Training Requirements

Training must align with Rhode Island Behavioral Health Organization (BHO) licensing, DCYF Emergency Service requirements, and [RI CCBHC Certification Standards](#). Note, staff training should focus on trauma-informed care, and staff must complete "Community First Responder" Naloxone Training to ensure appropriate response for substance use crisis.

8. Staffing Ratios/Case Limits

Mobile crisis teams must include a minimum of two-person teams for mobile crisis response, as specified in the [SAMHSA Behavioral Health Crisis Care Best Practice Toolkit](#) and [RI CCBHC Certification Standards](#).

D. Screening, Assessment, and Diagnosis

Screening, Assessment, and Diagnosis services can be provided directly by the CCBHC or through a DCO.

1. Definition

These services are intended to determine the appropriateness of admission, diagnose behavioral health conditions, and inform the development of a person and family-centered treatment plan. Services must be responsive to the recipient's needs, culturally and linguistically appropriate, and trauma informed.

2. Core Components

- **Culturally Responsive Practices:** Implement best practices for culturally responsive screening and assessment for both children/families and adults.
- **Unified Process:** Screening, assessment, and diagnosis should be a unified process that can be conducted in-person or via telehealth/telemedicine if necessary.

- **Intake Interview/Preliminary Screening:** Includes gathering demographic information, identifying immediate needs, and determining the need for further assessment or treatment.
- **Assessment:** Must include diagnostic impressions, client history, and an evaluation of the client's psychological, social, cognitive, and developmental functioning.
- **Comprehensive Diagnostic Treatment Planning Evaluation:** To be completed within 60 days of the first service request or 30 days after admission, whichever is sooner. Must include a detailed psychosocial evaluation, behavioral health history, and screening for various health indicators.

3. Specific Requirements

- **Standardized Screening Tools:** CCBHCs are required to use evidence-based screening tools for the early identification of mental health and substance use disorders. These tools must be administered during intake and at regular intervals thereafter.
- **Comprehensive Assessments:** Assessments should be completed by appropriately credentialed staff and must include a full evaluation of the client's mental health, physical health, substance use, and social determinants of health. These assessments form the basis for individualized treatment planning.
- **Diagnostic Evaluations:** CCBHCs must provide diagnostic evaluations that meet the standards outlined by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-10). These evaluations should be used to accurately diagnose and guide treatment interventions.
- **Demographic Information:** Gather information such as race, ethnicity, preferred language, sexual and gender identity, family composition, veteran status, and disability status in a culturally sensitive manner.
- **Health Indicators:** Screen for tobacco use, alcohol use, depression, suicide risk, and social determinants of health.

4. Eligibility

Any individual who contacts the CCBHC will be screened. The CCBHC will conduct an assessment to determine the individual's specific needs and the appropriate level of care.

5. Limitations/Exclusions

There are no specific limitations or exclusions for screening, assessment, or diagnosis.

6. Provider Qualifications/Licensure

- **Screening:** Can be conducted by appropriately trained and credentialed staff.
- **Assessment & Diagnosis:** Must be conducted by appropriately credentialed staff in keeping with their scope of practice as defined in RI regulations.
- **Treatment Planning:** Must be conducted by appropriately credentialed staff in keeping

with their scope of practice as defined in RI regulations.

7. Staff Training Requirements

Staff must follow training requirements outlined in the [RI CCBHC Certification Standards](#) and the [CCBHC EBP and Fidelity Resource Guide](#).

8. Staffing Ratios/Case Limits

There are no specific staffing ratio or case limit requirements for screening, assessment, and diagnosis services.

E. Person-Centered and Family-Centered Treatment Planning

Person-Centered and Family-Centered Treatment Planning can be provided directly by the CCBHC or through a DCO.

1. Definition

Treatment planning is a collaborative process directed by the individual receiving care and involving family/caregivers if the individual is a minor or upon request if the individual is an adult. The plan should be developed at a time and location convenient for the individual and their family, focusing on their needs, goals, preferences, and desired outcomes. The plan must be updated as needed and endorsed by the individual.

2. Core Components

- **Culturally Responsive Practices:** Implement practices in treatment planning considering the individual's and family's beliefs, values, and cultural background.
- **Treatment Plan Development:** The plan should be completed by a licensed clinician or under their supervision, involving the individual, their family, and other natural supports. The plan must be signed by the provider, the individual (or their guardian), and any involved caregivers.
- **Treatment Planning Process:** The process supports the individual's prevention, medical, and behavioral health needs, using a strengths-based approach to develop goals. Individuals must have the opportunity to direct the process, request revisions, and access support to understand and participate fully.

3. Specific Requirements

- **Plan Components:** For adults, the plan shall include unique needs, DSM/ICD diagnoses, goals, interventions, and timelines. For children, the plan shall also consider family strengths, goals, and culture, with clear evidence of family involvement.
- **Progress Monitoring:** The plan must be reviewed regularly, no less frequently than every 180 days for adults and every 90 days for children, with updates made based on changes in

the individual's status or treatment goals.

- **Progress Notes:** Providers shall document each service provided to the individual, summarize progress, and recommend changes to the treatment plan as needed.

4. Eligibility

Any member screened and determined to need behavioral health services is eligible for treatment planning services.

5. Limitations/Exclusions

See the [RI CCBHC Billing Manual](#) for specific limitations or exclusions.

6. Provider Qualifications/Licensure

Please see the [RI CCBHC Certification Standards](#) for provider qualifications.

7. Staff Training Requirements

Staff must follow training requirements outlined in the [RI CCBHC Certification Standards](#) and the [CCBHC EBP and Fidelity Resource Guide](#).

8. Staffing Ratios/Case Limits

There are no specific staffing ratio or case limit requirements for this service.

F. Outpatient Mental Health and Substance Use Services

Outpatient Mental Health and Substance Use Services can be provided directly by the CCBHC or through a DCO.

1. Definition

These services are designed to treat an individual's mental health and/or substance use disorder in a manner consistent with their cultural context, identity, and life stage. Treatment is determined by the screening, assessment, and diagnosis process and guided by the individual and family centered treatment plan. Services must incorporate evidence-based practices tailored to the needs of the individual and be age appropriate (e.g., tailored for a child, adolescent, transition-age youth, adult, or an older adult).

2. Core Components (for Adult & Children Populations)

- **Medication Services:** Includes psychotropic medication treatment, injectable medication administration, and medication education. Must be provided by the appropriate licensed or credentialed provider based on their scope of practice
- **Medication Assisted Treatment (MAT):** Uses medication combined with counseling and behavioral therapies to treat severe addictions.
- **Psychotherapy Services/Counseling:** Includes individual, family, and group therapy

aimed at alleviating symptoms, promoting personal growth, and supporting developmental milestones.

- **ASAM Outpatient Services:** Outpatient services for substance use disorder should adhere to the ASAM criteria with the inclusion of ASAM Withdrawal Management, Levels 1 and 2 as needed based on evaluation and level of care required, and as is directed in protocols and procedures developed by the CCBHC Medical Director.

The CCBHC directly, or through a DCO, provides SUD treatment and services as described in the American Society for Addiction Medicine Levels 1 and 2. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of substance use disorder treatment, the CCBHC makes them available through referral or other formal arrangement with other providers.

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.

3. Provider Qualifications & Licensure

- All CCBHCs are required to be a designated “Recovery Friendly Workplace” by BHDDH.
- Please see the [RI CCBHC Certification Standards](#) for individual provider qualifications.

4. Staff Training Requirements

Staff must follow training requirements outlined in the [RI CCBHC Certification Standards](#) and the [CCBHC EBP and Fidelity Resource Guide](#).

5. Staffing Ratios/Case Limits

Refer to [RI CCBHC Certification Standards](#) for information on program specific staffing ratios and case limits

G. Outpatient Clinic Primary Care Screening and Monitoring of Key Health Indicators and Health Risk

Outpatient Clinic Primary Care Screening and Monitoring of Key Health Indicators and Health Risk can be provided directly by the CCBHC or through a DCO.

1. Definition

Primary care screening and health monitoring involves the ongoing review of key health indicators and health risk. Prevention is a key component of these services.

2. Core Components

The CCBHC Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations for the following conditions:

- HIV and Viral Hepatitis
- Primary care screening pursuant to CCBHC Program Requirement 5. Quality and Other Reporting and Appendix B.
- Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director, and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population.

3. Specific Requirements

- **Monitoring Services:** Includes ensuring access to primary care, coordinating periodic lab tests and health measurements, tracking attendance at health appointments, and promoting healthy lifestyle behaviors.
- **Documentation:** Must be recorded if a person refuses to provide access to primary care screening and monitoring information.
- **Protocols Established by the CCBHC Medical Director:**
 - Must conform to US Preventive Services Task Force screening recommendations.
 - Include identifying individuals with chronic diseases, ensuring physical symptoms are assessed, and establishing systems for lab sample collection and analysis.
 - CCBHC must coordinate with primary care providers (PCPs) to ensure screenings are conducted.

4. Admissions/Eligibility Criteria

- **Communicable Disease Risk Assessment:** Conducted prior to admission to ensure the individual is free from serious communicable diseases. If no physical exam has been done within a year prior to admission, the patient must either be assessed for the need for a physical exam or referred for one.

5. Limitations/Exclusions

- **Service Availability:** These services are available to all persons receiving CCBHC services.

6. Provider Qualifications

Please see the [RI CCBHC Certification Standards](#) for provider qualifications.

7. Staffing Ratios/Case Limits

There are no specific staffing ratio or case limit requirements for this service.

H. Targeted Case Management

Targeted Case Management can be provided directly by the CCBHC or through a DCO.

1. Definition

CCBHC Targeted Case Management services are designed to help individuals sustain recovery and access necessary medical, social, legal, educational, housing, vocational, and other services and supports. These services provide an intensive level of support, particularly for individuals at high risk of suicide or overdose, those in transition from residential treatment, hospitals, jails, or experiencing homelessness, and those with complex mental health or substance use conditions.

2. Core Components

- **General Support:**
 - Referral to community, social, and recovery support services.
 - Support for improved community service linkages.
 - Transitional care, including follow-up from inpatient or other settings into the community.
 - Assistance in navigating complex health care, housing, and social services systems.
 - Advocacy for needed services.
 - Benefits counseling.
- **Children/Family-Specific Support:**
 - Ensuring family and child have voice and choice.
 - Assisting with family engagement and building natural supports.
 - Connecting families to culturally relevant community-based resources and supports.
 - Supporting emergency protocols with families.
 - Providing educational support.
 - Child-centered treatment planning and implementation.

3. Admissions/Eligibility Criteria

Targeted case management services are available to any service recipient in need of such service.

4. Limitations/Exclusions

Targeted Case Management Services are built into high acuity programs for adults (e.g. ACT-I, ACT-II, and ACT-YA) and children and youth, as well as in select SUD treatment programs. It does not need to be provided separately for clients receiving these services.

5. Provider Qualifications

Please see the [RI CCBHC Certification Standards](#) for provider qualifications.

6. Staff Training Requirements

Staff must follow training requirements outlined in the [RI CCBHC Certification Standards](#) and the [CCBHC EBP and Fidelity Resource Guide](#).

7. Staffing Ratios/Case Limits

Staffing ratios should align with the individualized service provided. For instance, if an individual is referred for ACT services, the staffing ratio must comply with ACT staffing requirements. Specific staffing ratios for ACT-I, ACT-II, and ACT-YA are detailed in [RI CCBHC Certification Standards](#).

I. Psychiatric Rehabilitation Services

Psychiatric Rehabilitation Services (PRS) can be provided directly by the CCBHC or through a DCO.

1. Definition

PRS provide recovery supports and other services 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.

2. Core Components

CCBHCs must provide PRS, as appropriate, to children, youth, and adults including:

- Community psychiatric supportive treatment services.
- PRS assessments, treatment planning, and care coordination.
- Community psychosocial rehabilitation services.
- Independent living services (activities of daily living).
- Social and interpersonal relationships and supported leisure time activities (structuring of time).
- Supportive educational services (including English as a second language support).
- Individual placement and support (IPS) services as an evidence-based supported employment practice.

3. Additional Services

- Supported education and other educational services.
- Achieving social inclusion and community connectedness.
- Medication education, self-management, and family/caregiver psychoeducation.
- Finding and maintaining safe and stable housing.
- Training in personal care skills.

- Community integration services.
- Cognitive remediation.
- Engagement in substance use disorder, mutual help groups, and community supports.
- Assistance with navigating healthcare systems.
- Recovery support services, such as Illness Management & Recovery, financial management, and dietary and wellness education.

4. Admissions/Eligibility Criteria

The individual's person-centered treatment plan should include the need for PRS and outline the related service components for both adults and children.

5. Limitations/Exclusions

There are no specific limitations or exclusions for this service, although PRS may be provided as part of another service, such as ACT-I or ACT-II services.

6. Provider Qualifications

Please see the [RI CCBHC Certification Standards](#) for provider qualifications.

7. Staff Training Requirements

Required training includes Motivational Interviewing (MI) and Individual Placement and Services (IPS). Staff must follow training requirements outlined in the [RI CCBHC Certification Standards](#) and the [CCBHC EBP and Fidelity Resource Guide](#).

8. Staffing Ratios/Case Limits

There are no specific staffing ratio or case limit requirements for this service.

J. Peer, Family Support and Counselor Services

Peer and Family Support and Counselor Services can be provided directly by the CCBHC or through a DCO.

1. Definition

Peer family support focuses on empowering and informing families caring for individuals with mental health or substance use conditions. Peer family support providers (Certified Peer Recovery Specialists, Youth Partners and Family Partners) may offer support through groups, phone calls, or individual meetings, drawing on their own experiences.

Counselor services encompass a range of behavioral health treatments focusing on mental health and substance use disorders. These services are delivered through a collaborative

process between a certified/licensed counselor and individuals, families, couples, or groups, aimed at achieving mutually determined treatment goals and fostering recovery. Counselors utilize various techniques to help clients develop coping skills, identify stressors, and preserve or restore mental health. Core duties include assessment, treatment planning, referral, service coordination, counseling, and client education.

Peer-Based Recovery Support Services (PBRSS) are delivered by Certified Peer Recovery Specialists (CPRS) credentialed by the RI Certification Board (RICB). These services are intended to support individuals with mental health challenges, mental illness, and/or substance use disorders in stabilizing and maintaining their stability in the community. CPRS use their personal experiences to serve as role models, teachers, and guides, encouraging and empowering individuals to succeed in their recovery and lead healthy, fulfilling lives. Peer support may be provided in various community settings, including homes, shelters, workplaces, schools, and social spaces.

2. Core Components

Individual Peer-Based Recovery Support Services:

- Youth/young adult peer support.
- Recovery coaching.
- Peer navigators for transitions between treatment programs or levels of care.
- Mutual support and self-help groups.
- Peer support for older adults.
- Peer education and leadership development.

Family/Caregiver Support Services:

- Community resources education.
- Navigation support.
- Behavioral health and crisis support.
- Parent/caregiver training and education.
- Family-to-family caregiver support.

Structured Group Services:

- Curriculum-based groups.
- Group recreational activities.

3. Roles and Responsibilities

Peer support staff should have personal experience with child welfare, behavioral health, or juvenile justice systems and be knowledgeable about community resources and supports. They serve as mentors, teachers, and guides, encouraging and empowering

families to succeed in health and wellness, facilitating communication with agencies, and ensuring family needs are addressed. Peers also provide education on confidentiality, mandated reporting, and identifying additional supports as needed.

For Children: Peer support services are aimed at promoting health and wellness, reducing the severity of disabilities, improving function, and supporting long-term health and wellness. Peers help children, youth, and their families engage in treatment, advocate for services, and make informed decisions to achieve successful outcomes.

4. Admissions/Eligibility Criteria

Individuals qualify if they self-identify as experiencing mental illness, substance use, or co-occurring disorders and wish to receive peer support, or if their comprehensive, person-centered treatment plan indicates a need for peer supports.

5. Limitations/Exclusions

There are no specific limitations or exclusions if the admissions/eligibility criteria are met.

6. Provider Qualifications

- The CCBHC employs Certified Peer Recovery Specialists with a credential issued by the RI Certification Board.
- The CCBHC must employ Family Partners and Youth Partners with credentials that align with the RI CCBHC Certification Standards.
- Non-credentialed peers may provide outreach and engagement services.
- Providers must be certified by RI BHDDH to provide PBRSS.

7. Staff Training Requirements

- CPRS must be supervised by a Certified Peer Recovery Specialist Supervisor or a CPRS who has completed BHDDH-approved Peer Supervisor Training.
- Motivational Interviewing training is recommended to enhance service delivery.

8. Staffing Ratios/Case Limits

- One CPRS Supervisor can supervise up to 10 full-time CPRS (1 supervisor to 10 staff).
- One CPRS can facilitate a group of up to 10 individuals (1 CPRS to 10 clients).

K. Intensive, Community-Based Behavioral Healthcare for Members of the Armed Forces and Veterans

Intensive, Community-Based Behavioral Healthcare for Members of the Armed Forces and Veterans can be provided directly by the CCBHC or through a DCO.

1. Definition

CCBHCs are responsible for providing intensive, community-based behavioral healthcare for active-duty members of the U.S. Armed Forces, veterans, and their family members, especially those located far from Military Treatment Facilities (MTFs) or Veteran Administration (VA) medical facilities. Care provided to veterans must be consistent with the Veterans Health Administration (VHA) guidelines, including the Uniform Mental Health Services Handbook. Services should be integrated, coordinated, and recovery-oriented, emphasizing privacy, security, and honor.

2. Core Components

Consistency with VHA Guidelines: Service components must align with the VHA Uniform Mental Health Services Handbook and VA/DoD Clinical Practice Guidelines.

Initial Contact Protocol:

- Individuals must be asked if they or a loved one has ever served in the U.S. military at the initial point of contact.
- **Current/Active-Duty Service Members:** Use their servicing MTF, with referrals managed by their MTF Primary Care Managers (PCMs).
- **Veterans:** Assist with enrollment in VHA services or provide services through the CCBHC if VHA services are declined or unavailable.

Treatment Plan Requirements:

- Include the veteran's diagnoses and consider evidence-based interventions.
- Monitor outcomes and set milestones for reevaluation.
- Focus on symptom management, functioning improvement, and relapse prevention.
- Ensure the plan is recovery-oriented, respects the veteran's values, and is evidence-based.
- Develop the plan with input from the veteran and, if applicable, their family, requiring the veteran's verbal consent.

Veterans Coordinators:

Every CCBHC is required to have a Veterans Coordinator to help coordinate care, ensure regular contact, and give feedback into the treatment plan. This coordinator meets regularly with the RI Office of Veterans Services to enhance coordination and care of all veterans and/or active-duty service members (ADSM). Veterans Coordinators are required to have appropriate training to assist veterans, ADSM, and/or their families in accessing and/or applying to VHA benefits.

3. Admissions/Eligibility Criteria

Eligible individuals include:

- Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility.
- Veterans living 40 miles or more (driving distance) from a VA medical facility.

- Veterans who decline or are ineligible for VHA services.
- Veterans who require services above and beyond what the VHA can provide.

4. Limitations/Exclusions

Refer to the eligibility criteria above.

5. Provider Qualifications

Please see the [RI CCBHC Certification Standards](#) for provider qualifications.

6. Staff Training Requirements

- Non-veteran staff must receive training on military and veterans' culture to understand their unique experiences and contributions.
- Providers must follow the service-specific training requirements relevant to the services delivered.

7. Staffing Ratios/Case Limits

There are no specific staffing ratios or case limit requirements for this service.

V. ATTRIBUTION

CCBHCs must provide the full range of mental health and substance use treatment services to all Rhode Islanders seeking behavioral healthcare, regardless of diagnosis, symptom severity, age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay. CCBHCs must ensure equity in service delivery, focusing on priority populations defined by the State, including BIPOC, individuals with co-occurring behavioral health needs and I/DD, older adults, transition-age youth, LGBTQ+ individuals, justice-involved individuals, people without stable housing, and those from under-resourced communities.

Services must be suitable for individuals across the lifespan and cover all levels of illness severity, including:

- Adults with severe persistent mental illness (SPMI) and serious mental illness (SMI)
- Children and youth with serious emotional disorders (SED)
- Adults and youth with substance use disorder (SUD), including opioid use disorder (OUD)
- Individuals with co-occurring disorders (COD)
- Members of the Armed Forces and Veterans
- General outpatient populations, including court-ordered counseling for driving under the influence (DUI)

A. Overview of Populations

There are four designated CCBHC populations in RI:

1. **High Acuity Adult:** Individuals with serious mental health conditions, a high risk of hospitalization, and/or other significant needs such as co-occurring disorders, or who are at high risk due to other factors like homelessness or justice system involvement. This may include individuals who are eligible for intellectual and development disability (I/DD) waiver services with co-occurring behavioral health concerns and also transition-aged youth (ages 15-26 years). Individuals must have a DLA score of 4 or less with an eligible diagnosis. If the criteria above are not met, a High Acuity Adult Population Exception Request may be submitted to BHDDH for review and approval.
2. **High Acuity Children and Youth:** Children and youth with serious emotional disturbance or significant behavioral health needs. Includes children with history of trauma, or involvement in multiple systems. Individuals must have an eligible diagnosis and a functional assessment score that demonstrates the need for High Acuity services based on criteria established by DCYF. If the criteria above are not met, a High Acuity Child Population Exception Request may be submitted to DCYF for review and approval.
3. **Substance Use Disorder:** Individuals with an eligible primary diagnosis of substance use disorder, particularly those with complex needs.
4. **Standard:** Individuals who do not meet the criteria for any of the above populations.

B. Level of Care Evaluations and Re-evaluations

Providers must use one of the State approved functional assessment tools listed below to evaluate any client who they believe requires more than standard care. The functional assessment score, along with other clinical criteria, will help determine the appropriate CCBHC program/population designation for the client. Providers will enter this information into the Gainwell Eligibility System Portal (commonly known as the "Provider Portal").

In other words:

- For any client who a provider deems requires a standard level of care, i.e. is appropriate to categorize within the CCBHC 'Standard' population – a functional assessment is not required.
- For any client who a provider deems requires more than a standard level of care, i.e. is appropriate to categorize within the CCBHC 'High Acuity Adult', 'High Acuity Child', or 'Substance Use Disorder (SUD)' population – a functional assessment is is required and must be conducted.

Initial Functional Assessment

Providers must use one of the functional assessment tools listed below to evaluate the level of need for any client who they deem requires more than a standard level of care.

- **Daily Living Activities (DLA)** assessment for high acuity adults and any transition-age youth (between the ages of 15 and 26 years) who may be in need of high acuity services;
- **Ohio Scales for Youth (OHIO)** for high acuity children age 5 years or older in CCBHC Program Year 1 and the **Child and Adolescent Needs and Strengths (CANS)** assessment beginning in CCBHC Program Year 2; and
- **American Society of Addiction Medicine (ASAM)** criteria assessment for clients with a primary substance use disorder (SUD).

Providers will use these assessments in tandem with other criteria as defined in **Addendums 5 and 11 of the RI CCBHC Certification Standards** in order to assign a client to the CCBHC High Acuity Adult, High Acuity Child, or SUD populations.

The score thresholds are as follows:

| CCBHC Population | Assessment Score |
|-------------------|--|
| High Acuity Adult | <ul style="list-style-type: none"> • DLA score of 4 or less |
| High Acuity Child | <ul style="list-style-type: none"> • Program Year 1 <ul style="list-style-type: none"> ○ OHIO: Score of 37 or higher on the Problem Severity scale <u>or</u> 34 or lower on the Functional scale. • Program Year 2 <ul style="list-style-type: none"> ○ CANS: At least one score of 3 or two scores of 2 within the Child Risk Behavior domain <u>or</u> at least one score of 3 or two scores of 2 within the Child Needs domain. |
| SUD | <ul style="list-style-type: none"> • An ASAM assessment must be conducted in Program Year 2, however there is no score threshold for eligibility. |

Note: For any client who does not meet the aforementioned score thresholds, but for whom a provider believes requires a high acuity versus standard level of care –

- **For adults and transition-age youth:** Providers should complete a [CCBHC High Acuity Adult Population Exception Request Form](#) and submit to BHDDH (bhddh.exceptions@bhddh.ri.gov) via secure email for review.
- **For children over the age of 5 years:** Providers should complete a [CCBHC High Acuity Child Population Exception Request Form](#) and submit to DCYF (DCYF.CCBHC@dcyf.ri.gov) via secure email for review.
- **For any child under the age of 5 years:** Providers should complete a [CCBHC High Acuity Child Population Exception Request Form](#) and submit to DCYF (DCYF.CCBHC@dcyf.ri.gov) via secure email for review, until the Rhode Island CANS tool for children aged 0 – 4 years is available.

Reevaluation of Level of Care Every 90 Days

Providers must reevaluate each high acuity adult’s, high acuity child’s, and SUD client’s level of care **every 90 days** from the date of their last functional assessment, **or sooner** if a change in acuity is observed (e.g., with a new hospital admission or significant life event) within the 90 days, to determine

the appropriate level of service intensity (i.e., Standard, High Acuity Adult, High Acuity Child, or SUD) for the client. Shifts in level of need are anticipated over time for most clients.

Transition from Use of OHIO to CANS Assessment for High Acuity Children

- **Children Already Engaged in High Acuity Services as of October 1, 2025:**
 - The previous functional assessment (OHIO Scales) score remains valid.
 - However, the CANS Level of Needs (LONS) Assessment must be used to reassess eligibility at, or within 90 days of their last assessment date.
- **New Clients as of October 1, 2025:**
 - The CANS LON is required for any child or youth newly entering a high acuity children’s program on or after October 1, 2025.

Additional Notes

- The CANS LON score must be documented. See below for further instructions.
- In Program Year 2, a complete CANS assessment is *recommended* to be completed within 30 days of intake and updated annually.
- **Children Aged 0 – 4 Years:** Until the Rhode Island CANS tool for children aged 0 – 4 years is available, providers must submit a [CCBHC High Acuity Child Population Exception Request Form](#) for any child in this age group who the CCBHC believes requires a high acuity level of care.

Implementation of Use of ASAM Assessment for SUD Clients

- **Clients Already Enrolled in the CCBHC SUD Population as of October 1, 2025:**
 - The client’s current enrollment in this CCBHC population remains valid. No update to their Provider Portal record is required.
 - However, an ASAM assessment must be conducted for the client within 90 days (i.e., by December 30, 2025) or sooner, and the resultant score must be documented in the client’s EHR record and/or care plan.
- **New Clients as of October 1, 2025:**
 - The ASAM assessment must be conducted prior to enrollment for any new client entering into the SUD program on or after October 1, 2025.

For Reference:

- See [RI CCBHC Billing Manual](#) for instructions on how to submit the functional assessment scores to the State and to attribute clients via the Provider Portal.

VI. MONITORING

A. Program Review and Auditing

EOHHS, BHDDH, and DCYF will perform regular program audits to ensure compliance with the [RI CCBHC Certification Standards](#) and program requirements on a schedule and in a manner of

their choosing. Program audits may also be triggered by a variety of factors including but not limited to:

- Self-monitoring report findings
- Staffing reports and review processes
- Member grievances and/or complaints

Participating CCBHCs shall make all records, audits, claims, documentation, and other materials available to EOHHS, BHDDH, and DCYF upon request in support of these program audits. Following a CCBHC Program Audit, EOHHS, BHDDH, and/or DCYF will generate a report identifying any findings and recommendations that require a response by the CCBHC site. Depending on findings and recommendations of the program audit report, the State may consider licensing or certification actions, such as Program Corrective Action Plans (PCAP), license suspensions, and license or certification terminations; as well as financial penalties as determined necessary by Program Integrity.

CCBHCs with documented program audit findings who do not submit timely and comprehensive PCAPs may be subject to an immediate licensing action by the department, up to and including a recommendation to EOHHS to decertify as a CCBHC and/or exclude from participation in the Medicaid program, depending upon the scope and nature of the findings. BHDDH, DCYF, and/or EOHHS will review the PCAP, and either seek clarification or additional information from the CCBHC site as needed or issue an approval of the PCAP within 30 days of receipt.

Please refer to the [RI CCBHC Billing Manual](#) for more information on the program financial auditing processes.

B. Reporting Responsibilities and Mechanisms

1. State and Federal Reporting

CCBHCs must submit regular reports to State and federal agencies, including performance data, quality metrics, and financial reports. These reports are essential for demonstrating compliance with certification standards and for maintaining eligibility for funding. A detailed list of State reporting requirements is provided in the following subsection.

2. Data Submission Mechanisms

Reports must be submitted using the specified mechanisms, such as the RI Behavioral Health Online Data (BHOLD) system, which is used by BHDDH for tracking admissions, discharges, diagnoses, and client demographic information. CCBHCs must ensure that all data submissions are accurate, timely, and comply with reporting guidelines. CCBHCs are required to participate in the statewide Health Information Exchange (HIE) to support data sharing, care coordination and quality reporting.

3. Incident Reporting and Management

CCBHCs are required to report critical incidents, such as adverse events, client safety issues, and breaches of confidentiality, to the appropriate authorities. These reports must be submitted promptly and include detailed information about the incident and the actions taken in response. CCBHCs must have protocols in place for managing incidents, including conducting investigations, documenting findings, and implementing corrective actions. These protocols should be regularly reviewed and updated as needed to ensure they remain effective.

4. Clinic-Collected Quality Measures

Please refer to [RI CCBHC Quality Manual](#) for required clinic and State collected quality measures as it pertains to the CCBHC Demonstration Program.

C. Data Management Systems

1. BHOLD System Utilization

Overview of the BHOLD System: The BHOLD (Behavioral Health Online Data) system is a centralized data management platform used by BHDDH to track an individual receiving services demographic information and service utilization, as well as performance outcomes across CCBHCs. The system is integral to managing client data, ensuring accurate reporting, and supporting decision-making processes within the CCBHC model.

Data Collection: CCBHCs must enter client-level data into the BHOLD system, including demographic information, diagnoses and program admissions and discharges. This data is used to monitor service delivery, assess client progress, and fulfill State and federal reporting requirements.

2. Data Entry and Management

CCBHCs are required to follow standardized data entry protocols to ensure consistency and accuracy across all data submitted to the BHOLD system. This includes ensuring that all required fields are completed, and that data is uploaded to BHOLD monthly, if not more frequently.

Data Validation: The BHOLD system includes built-in validation checks to ensure that data entered is accurate and complete. CCBHCs must regularly review and correct any data entry errors identified by the system or BHDDH staff, to maintain the integrity of the data.

Confidentiality and Security: All data entered into the BHOLD system must be handled in compliance with HIPAA regulations and State confidentiality laws. CCBHCs must implement security measures, such as password protection and encryption, to safeguard client information within the system.

3. Electronic Health Records (EHR) and Data Integrity

EHR Adoption: CCBHCs are required to use an Electronic Health Record (EHR) system that is certified by the Office of the National Coordinator for Health Information Technology (ONC). The EHR system must be capable of capturing, storing, and transmitting client health information securely and efficiently.

Interoperability: The EHR system used by CCBHCs must be interoperable with other health information systems, including the BHOLD system, to facilitate seamless data exchange. This interoperability ensures that client data can be shared across providers and care settings, supporting coordinated care.

Data Entry Standards: All client encounters, treatment plans, and outcomes must be documented in the EHR system according to standardized data entry protocols. This includes using standardized coding systems, such as ICD-10 and CPT, to ensure data consistency and accuracy.

D. Provider Reporting Requirements

Providers must follow all reporting requirements established by the State, including but not limited to the following list. Reporting templates can be found on the [EOHHS CCBHC webpage](#).

Reporting requirements are subject to change and will be updated via the issuance of additional State guidance. The current reporting requirements are described below in two categories: (1) Ongoing Reporting Requirements, and (2) Certification Compliance Reporting Requirements.

1. Ongoing Reporting Requirements

| # | Report | Description | Frequency | Deadline * |
|---|-----------------------------------|---|-----------|---------------------------------|
| 1 | BHOLD Reporting | Supports monitoring of state-wide behavioral health services provided. | Monthly | 15 th of every month |
| 2 | CCBHC Shadow Claims Report | Supports monitoring of complete and accurate shadow claims billing practices. | Monthly | 15 th of every month |

| # | Report | Description | Frequency | Deadline * |
|----|--|--|--------------------|---|
| 3 | CCBHC Staffing Workbook | Supports monitoring of compliance with clinical staffing requirements. | Monthly | 2 nd Wednesday of every month |
| 4 | High Acuity Child Program Monitoring Report | Supports monitoring of services for high acuity youth. | Monthly | 15 th of every month |
| 5 | CCBHC Crisis Services Report | Supports monitoring of crisis services, including for example response times, interventions provided, and outcomes. | Monthly | 5 th of every month |
| 6 | CCBHC Financial Monitoring Report | Provides comprehensive and timely insights into overall staffing, service volume, expenses, and revenue and informs cost reporting process. | Quarterly | 45 days after reporting quarter end |
| 7 | CCBHC Outreach Activities Monitoring Report | Supports monitoring of outreach, including to vulnerable populations. | Quarterly | 15 days after reporting quarter end |
| 8 | CCBHC-DCO TPL Payment Report | Supports recoupment of FFS TPL payments to providers. Please see the EOHHS CCBHC Webpage for further detail on the FFS TPL recoupment process. | Quarterly | 45 days after reporting quarter end |
| 9 | CCBHC Quality Measures | Refer to CCBHC Quality Manual for further detail. | Quarterly / Annual | 60 days after reporting period end |
| 10 | CCBHC Year-End Cost Report | Informs fiscal review of CCBHCs and rate-setting for the subsequent year. | Annual | 6 months after reporting demonstration year end |

*Reports are due the following business day if the designated due date lands on a holiday or weekend.

2. Certification Compliance Reporting Requirements

In addition to the ongoing reporting requirements listed above, the State also conducts an annual certification compliance review process before the start of a new Program Year. The State provides a checklist of the documentation and attestations that all CCBHCs must submit to the State to demonstrate compliance with the most up-to-date certification criteria.

VII. EMERGENCY PREPAREDNESS PLANS

CCBHCs must develop and maintain a comprehensive emergency preparedness plan that addresses potential disasters, public health emergencies, and other unforeseen events. The plan should detail the procedures for continuing essential services during an emergency, including staffing contingencies, resource allocation, and communication strategies. All staff must be trained in emergency preparedness, including their specific roles and responsibilities during an emergency. Training should cover scenarios such as natural disasters, pandemics, and active shooter situations, ensuring that staff are equipped to respond effectively. CCBHCs should conduct regular mock drills to test the effectiveness of their emergency preparedness plan. These drills should simulate various emergency scenarios and involve all staff members to ensure readiness. The results of these drills should be used to identify areas for improvement and to refine the emergency plan.

A. Service Continuity

The emergency preparedness plan must include strategies for maintaining continuity of essential services during an emergency. This includes identifying critical services, prioritizing resources, and establishing alternative service delivery methods, such as telehealth or mobile units, if necessary.

Backup Systems: CCBHCs must have backup systems in place to ensure that critical operations, such as electronic health records (EHR) and communication systems, remain functional during an emergency. This may include backup power supplies, off-site data storage, and redundant communication systems.

Community Coordination: CCBHCs should coordinate with local, state, and federal emergency management agencies to align their emergency preparedness efforts with broader community response plans. This coordination helps ensure that CCBHCs are integrated into the community's overall emergency response framework and can access additional resources when needed.

B. Communication Strategies

Internal Communication: CCBHCs must establish clear communication protocols for staff during an emergency. This includes identifying key contacts, establishing communication chains of command, and ensuring that all staff have access to reliable communication tools.

Client Communication: CCBHCs must have strategies in place to communicate with clients during an emergency. This includes providing information on service availability, changes in service delivery, and how to access crisis services. Communication methods may include phone calls, text messages, emails, and social media updates.

Public Communication: CCBHCs should also develop a public communication strategy to keep the broader community informed during an emergency. This may include coordinating with local media, issuing public statements, and updating the CCBHC’s website and social media channels with relevant information.

C. Post-Emergency Recovery

Recovery Planning: After an emergency, CCBHCs must implement a recovery plan that focuses on restoring normal operations, addressing any disruptions in service delivery, and supporting the mental health and well-being of clients and staff. The recovery plan should include a timeline for returning to normal operations and strategies for addressing any long-term impacts of the emergency.

Debriefing and Evaluation: CCBHCs should conduct a debriefing session with staff after an emergency to evaluate the effectiveness of the emergency response. This debriefing should include a review of what worked well, what challenges were encountered, and what improvements can be made to the emergency preparedness plan. The insights gained from this evaluation should be used to refine the emergency plan and inform future training and drills.

Joint Debriefings: After a crisis event, CCBHCs should participate in joint debriefings with EMS and other responding agencies. These debriefings provide an opportunity to review the response, identify what worked well, and discuss areas for improvement. The insights gained from these debriefings should be used to refine response protocols and training programs.

Continuous Quality Improvement: The feedback from post-crisis reviews should be incorporated into the CCBHC’s continuous quality improvement (CQI) processes. This includes making necessary adjustments to protocols, enhancing training programs, and improving communication systems to better support future crisis responses.

VIII. LEGAL AND ETHICAL CONSIDERATIONS

A. Confidentiality and Information Sharing

HIPAA Compliance: CCBHCs must ensure that all information sharing with a DCO, law enforcement, EMS, and community partners complies with the Health Insurance Portability and Accountability Act (HIPAA) and other relevant confidentiality laws. This includes obtaining appropriate client consent for information sharing and ensuring that all shared information is handled securely.

Limits of Confidentiality: Staff must be trained to understand the limits of confidentiality, particularly in situations where there is a duty to warn or when information sharing is necessary to

prevent harm. CCBHCs should have clear protocols in place for when and how to share information in these situations, ensuring that legal and ethical standards are met.

B. Client Rights and Advocacy

Client Autonomy: CCBHCs must respect client autonomy during crisis interventions, ensuring that clients are involved in decision-making to the greatest extent possible. This includes explaining the nature of the crisis intervention, discussing potential outcomes, and obtaining informed consent for any treatments or referrals.

Advocacy and Support: CCBHCs should provide advocacy and support services to clients during and after a crisis. This includes ensuring that clients understand their rights, providing assistance with legal issues related to the crisis (e.g., involuntary hospitalization), and connecting clients with additional resources and supports as needed.

C. Legal Obligations

Civil Court Commitment Procedures: CCBHCs must be familiar with the legal procedures for involuntary commitment as identified under the [Mental Health Law](#) and ensure that staff are trained to follow these procedures when necessary. This includes understanding the criteria for involuntary commitment, completing the necessary legal documentation, and coordinating with the BHDDH legal department. All CCBHCs are required to have a “Facility Status” designation from BHDDH to enable the acceptance of, and provision of services to involuntary clients who are subject to Civil Court Certification orders.

CCBHCs are required to serve all Court ordered clients within their designated service area. For extenuating circumstances, a CCBHC may submit a written request to BHDDH to refer a client to another agency if the CCBHC believes they are unable to serve the client. If BHDDH is of the opinion that the client should not receive services from the CCBHC responsible based on service area, the request will be approved and BHDDH will exercise their authority, as the State Mental Health Authority, and assign the client to another CCBHC. Such transfer shall be made in the sole discretion of BHDDH. BHDDH may consider closest proximity to the client’s residence, as a factor for reassignment. This request shall be made in extenuating circumstances only and not for convenience, preference, or due to a lack of existing services at the CCBHC.

Duty to Warn: CCBHCs must adhere to the legal obligation to warn identified individuals if a client poses a serious risk of harm to them. This duty to warn must be balanced with confidentiality requirements, and CCBHCs should have clear protocols for how to handle such situations, including when and how to involve law enforcement.