CCBHC Certification

Community Partner Meeting

12/13/21

Faulkner CONSULTING GROUP

HEALTH MANAGEMENT ASSOCIATES

Meeting Norms

In order to enable an effective discussion, PLEASE:

- Everyone please put your name and organization IN THE CHAT so we have a record of who is in attendance
- Use the “RAISE YOUR HAND” button
- Introduce yourself, and the name of your organization when you first speak
- Leave space for others to contribute –keep comments brief
- Use the CHAT function to support the dialogue, avoid interruptions
- Email Ellie Rosen @ Ellie.Rosen.CTR@ohhs.ri.gov for longer comments
- This meeting will be recorded for minutes purposes

Agenda for Today

Certified Community Behavioral Health Clinic (CCBHC) & Statewide Mobile Crisis Development	
Starting Point	• Comprehensive BH Study • Prioritized Areas of Opportunity: CCBHC & Mobile Crisis

Recent Efforts	• CCBHC & Mobile Crisis Planning - Implementation Planning
	  • Tailored RI Specific Program Design and Refinements Based on Provider Feedback
	  • Medicaid Payment Models
	  • Fiscal Analysis: Medicaid budget proposal, Supporting federal funds
	• Extensive Community Engagement –
	Advocates, Consumers, and Various Provider Types – to inform implementation plans

Today's Agenda	• Brief Background and Overview of RI's CCBHC and Mobile Crisis Initiative • Schedule for Ongoing Community Partner Engagement for Implementation Planning • Today's Discussion Topic – Certification Standards for RI CCBHCs • Questions and Next Steps • Public Comment

Brief Overview of RI's CCBHC and Mobile Crisis Initiatives

Problem Diagnosis: Major Identified Gaps and Shortages in the Continuum of Care

Gap indicates that there was no evidence in our qualitative or quantitative analysis of the service existing in Rhode Island.
Shortage indicates that while some level of service exists it is not adequate to meet the need of Rhode Islanders with BH/SUD conditions.

Mental Health Services for Adults and Older Adults	Gaps	Mobile Crisis Treatment
	Significant Shortages	Community Step Down Hospital Diversion State Sponsored Institutional Services Nursing Home Residential
	Moderate Shortages	Non-CMHC Outpatient Providers Intensive Outpatient Programs Dual Diagnosis Treatment Crisis/Emergency Care Inpatient Treatment Home Care Homeless Outreach
	Slight Shortage	Licensed Community Mental Health Center tied to accessibility statewide
Substance Use Services for Adults and Older Adults	Gaps	Mobile MAT
	Significant Shortages	Indicated Prevention Correctional SUD Transitional Services Recovery Housing Residential – High & Low Intensity*
	Moderate Shortages	Intensive Outpatient Services Supported Employment

*Between Aug -Dec 2020, between 55-108 people were waiting for residential services.
**Between May-Dec 2020, between 5-31 children and adolescents were waiting for residential svs.

Continuum of Care for BH for Children	Gaps	Community Step Down Transition Age Youth Services Residential Treatment for Eating Disorders**
	Significant Shortages	Universal BH Prevention Services Hospital Diversion State Sponsored Institutional Services Nursing Home Residential/Housing**
	Moderate Shortages	SUD Treatment Enhanced Outpatient Services Home and Community Based Services Mobile Crisis
	Slight Shortage	Emergency Services

Key Message: The gap in inpatient/acute services appears to driven by the lack of crisis intervention and community wrap around support and prevention. Our recommendation is *not* to build additional inpatient capacity, rather to invest resources in better community support to alleviate the bottleneck for the existing inpatient beds.

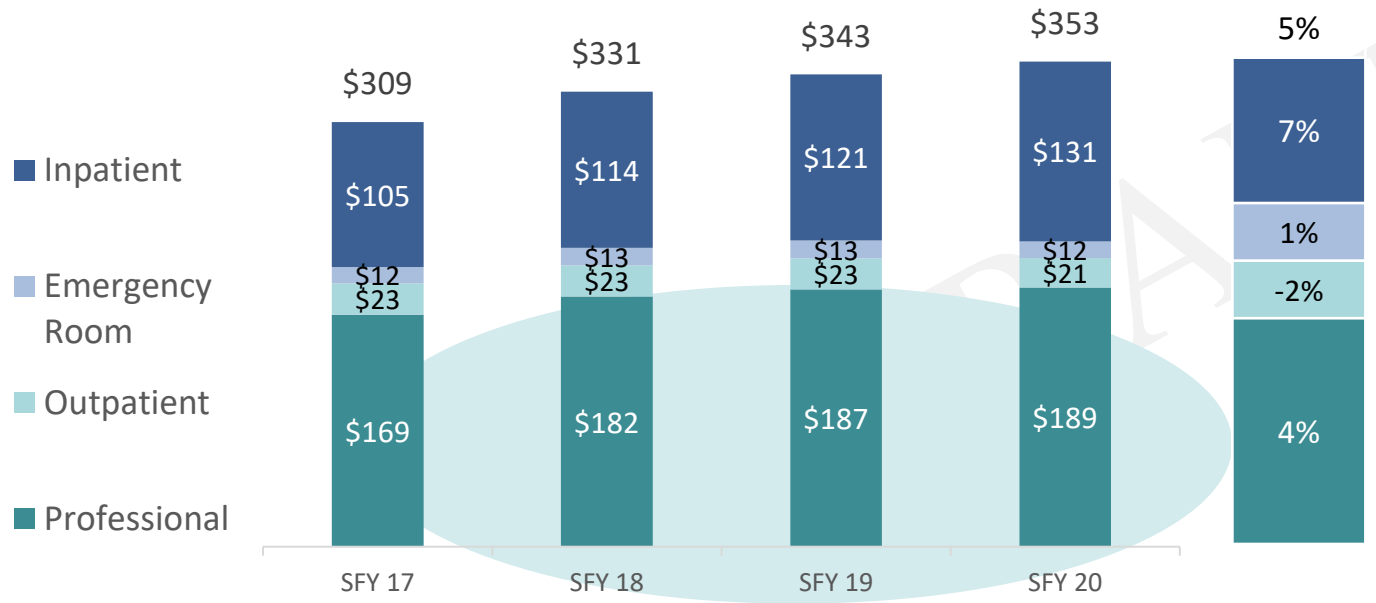
System Concern Due to Gaps
1. Access to children's BH services is significant challenge for RI families, and for RI providers trying to match treatment level need with available capacity.
2. RI'ers often struggle to access residential and hospital levels of care for mental health and substance use.
3. Capacity and access to prescribers within behavioral health treatment services is mixed.
4. Crisis services are difficult to access.
5. Access to counseling and other professional services in the community is mixed.
6. Access to prevention services is inconsistent and under-funded.

Documentation of qualitative and/or quantitative findings related to gaps and shortages are available in Section 4 of this report.

Critical Investments in Community Based BH are needed to support our System of Care

Lack of community based behavioral health infrastructure and capacity leads to shortages, added expenditures in acute/inpatient services

Medicaid BH/SUD Expenditures in Millions, RI, SFY 2017 - 2020



Inpatient/ER % of Total	38%	38%	39%	41%

Key Takeaways:

- Annualized Medicaid BH/SUD Professional Services expenditure growth: 4% - and mostly flat SFY 28-20
- Lack of community based behavioral health infrastructure and capacity leads to shortages, added expenditures in acute/inpatient services
- Medicaid expenditures on BH and SUD services have been steadily shifting away from community-based services and toward inpatient services, inpatient and emergency room spend increased steadily from 38 to 41% of total expenditures over SFY 17-20 – suggesting an opportunity to "rebalance" these expenditures toward lower cost, less restrictive community-based settings.

Source: August 2021 Medicaid members and claims dataset; SFY 2019 full benefit Medicaid members with any claims during the year, excludes LTSS and Other BH/MH expenditures

Confidential working DRAFT under RIGL 38-2-2 (4)(k)

Principles To Drive and Prioritize Policy Considerations

1. **Service delivery should align with community need, grounded in health equity and racial equity:** All systems over the full lifespan should be person-centered and trauma-informed. Providers should meet people where they are and be accessible to all. Access should be streamlined, people should be clear about their options for where to receive care, and people should be able to get their needs met through one comprehensive service from the provider of their choice. Data should be shared across service providers to maximize treatment outcomes while protecting confidentiality. Prioritize pathways of care over episodes of care, integrated across medical and behavioral health care services.

2. **Solutions should actively address systemic racism** as an underlying driver of challenges that manifest with the behavioral health system today.

3. **Prevention is better than treatment. Recovery is possible for everyone.** Investments in prevention are a priority. All services should be part of a recovery-oriented system of care.

4. **Invest in sustainable solutions**, including housing, workforce extenders and data capture, analysis, and sharing infrastructure.

5. **Payment:** Payment should drive to outcomes and access to the right care at the right time. Payment and outcomes should be tied together. Payments should be sufficient to sustain workforce, ensure access to services, and make certain practitioners can practice at the top of their license.

6. **Accountability**: For every person with a BH condition, there should be one provider accountable and one state agency accountable for outcomes, while engaging sister agencies to collaborate as appropriate.

7. **Regulatory Oversight:** Right-size regulatory requirements to ensure regulations tie to meaningful client outcomes and accountability. If a current regulation doesn't directly tie to outcomes or accountability, phase it out. Shift from process to outcome management.

8. **Leverage the existing foundation:** Establish infrastructure efficiently by building on Rhode Island's starting point in a manner consistent with RI's size and scale. Any services created to fill the gaps in existing care continuum should be created in the context of a strategic plan for a full continuum of care.

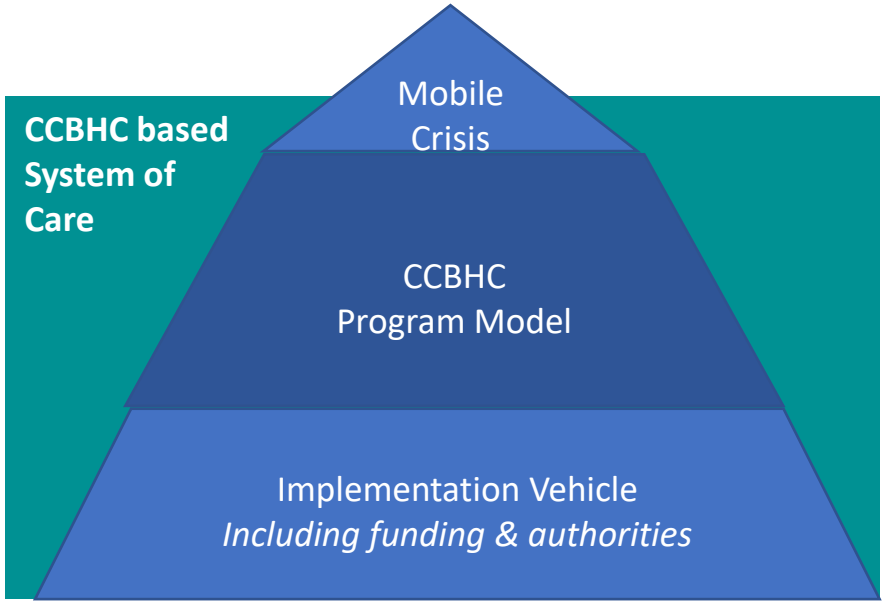
9. **Standardization:** Screening should be universal and frequent; assessments should be standardized utilizing specific tools. Assessment results should track to equitable referrals for services across the continuum of care (risk stratification). Consistent quality measures should be selected and reported by all providers and tied to payment.

Detail of Two Synergistic Policies

To address problems diagnosed through gap analysis with policy solutions that most closely align with the state's principles, team recommends the following two synergistic policies. **These policies are not necessarily stand-alone independent options, but rather mutually reinforcing to address RI's challenges in BH system**:

Design a Single Statewide Mobile Mental Health Crisis System as central part of CCBHC

- Prioritize critical capacity gap identified in Task 1 AND Enable the efficient implementation of CCBHC.
- Reduce need to transport individuals in crisis to inpatient settings of care.
- Integrate the implementation plan with existing efforts to reform the children's mental health system and other BHDDH initiatives in this area.



Program Model Design for CCBHC

Develop a state-specific program model design for a statewide RI CCBHC program.

- RI-specific program model designed to provide comprehensive mental health and substance use disorder services to vulnerable individuals throughout the life cycle.
- Plan will incorporate an approach to payment for outcomes for CCBHC participants.
- Include base requirements (to the extent applicable) and any mods/ additions determined necessary to address RI's unique needs.
- Include programmatic design - required staffing, governance, care coordination, integration elements.

Implementation Vehicle for CCBHC – Funding and Authorities

Determine the best policy vehicle for implementation and associated funding mechanisms.

- Include options for leveraging federal support/participation and approaches to state financing.
- Plan for multiple funding streams and implementation approaches, including both short and long-term financing options and phased approach
- Include specific agency grants, congressional appropriations, state plan amendment, waiver options, and demonstration programs. Explore requirements and timing for various funding options.
- Explore funding for upfront & ongoing CCBHC support for state, plan, and provider partners, including infrastructure investments.

Priority Initiatives: CCBHC & Mobile Crisis

Goals Addressed by CCBHC Model

- Expanded access to evidence-based assessment, treatment, and referral
- Focus on equity issues
- Application of evidence-based, trauma informed, and measurement-based care (foundations for VBP)
- Coverage throughout the state for all ages
- Emphasis on MH/SUD care in one location
- **Required 24/7 mobile crisis services**
- Focus on community-based intervention
- Coordination for all communities accessing the BH system, including people with I/DD
- Maximize federal financial participation in the form of matching funds or other revenue opportunities

Goals Addressed by Mobile Crisis Services Model

- Expanded access to statewide 24/7 mobile crisis services for adults
- Provision of 24/7 mobile crisis services for youth
- Quality standards are identified, formalized, measured and continuously monitored.
- Divert people from the ED
- Mobile crisis access regardless of neighborhood, insurance status, or language capability
- Integrating mental and substance use disorders within the crisis system
- Criminal justice diversion for an appropriate and humane response to individuals in BH crisis
- Ensure connection to follow-up care
- Maximize federal financial participation in the form of matching funds or other revenue opportunities

The Evidence is Compelling

There are multiple studies providing substantive evidence in support of CCBHC and mobile crisis savings opportunities.

Overall CCBHC Model Savings (Inclusive of Mobile Crisis)

Emergency Department

New York Case Study[1]
- 26% decrease in BH ED service monthly cost
- 30% decrease in ED health services monthly cost

Missouri Case Study[1]
- 75% decrease in ED services after Year 1

SAMHSA[2]
- 62% decrease in ED visits for program participants as of Jan 2020 (3-yr program)

Inpatient Hospitalization

New York Case Study[1]
- 27% decrease in BH inpatient service monthly cost
- 20% decrease in inpatient health services monthly cost

Missouri Case Study[1]
- 83% decrease in hospitalizations after Year 1

SAMHSA[2]
- 62% decrease in IP stays for program participants as of Jan 2020 (3-yr program)

Mobile Crisis Savings

ED/IP

NIH Study[3]
- Youth who used a Mobile Crisis service were 22% less likely to have a subsequent BH ED visit

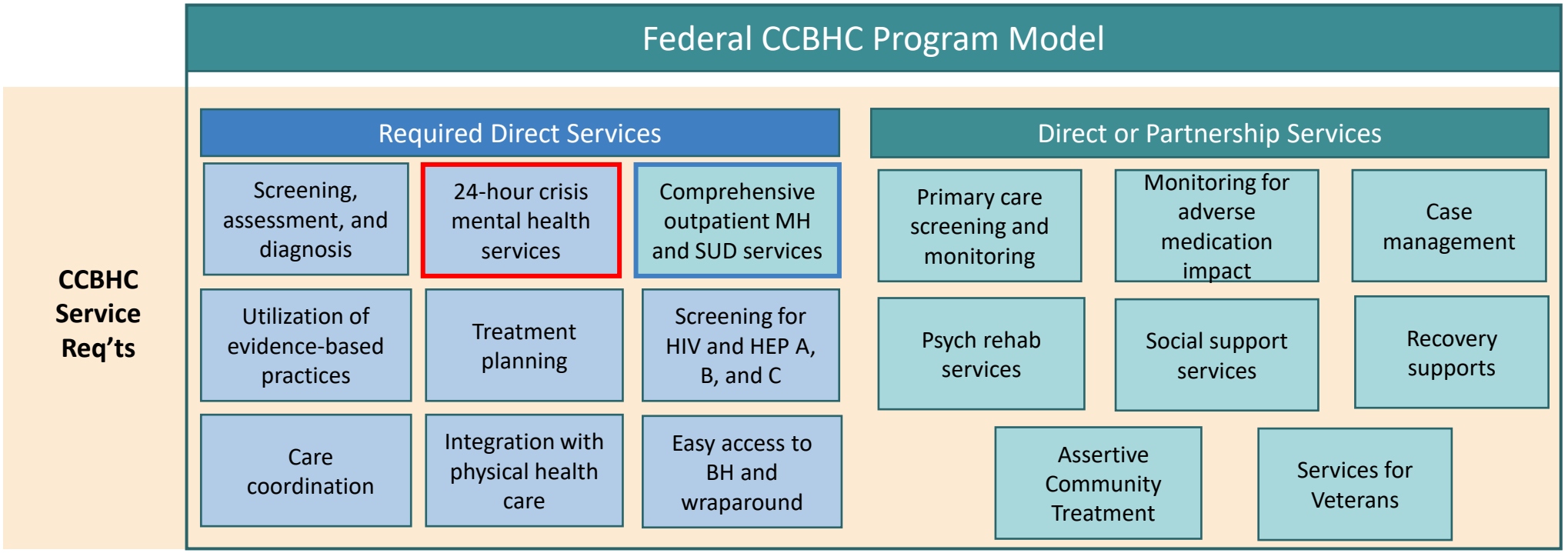
Connecticut Case Study[4]
- Youth who used a Mobile Crisis service were 25% less likely to have a subsequent BH ED visit

Psychiatric Services Journal[5]
- Community-based crisis intervention reduced hospitalization rates by 8 percentage points.

Sources:
[1] Certified Community Behavioral Health Clinics (CCBHC), *The New Model for Mental Health and Addiction Care Gaining Momentum in States*, January 29, 2021, National Council for Behavioral Health
[2] SAMHSA FY 2021 - *Justification of Estimates for Appropriations Committees*
[3] NIH, *Impact of Mobile Crisis Services on Emergency Department Use Among Youths with Behavioral Health Service Needs*, October 2019
[4] Child Health and Development Institute of Connecticut, *Evaluation of Connecticut's Mobile Crisis Intervention Services*, 2018
[5] Psychiatric Services Journal, February 2001 Vol. 52, No. 2

CCBHC Model Overview

The CCBHC Program Model includes the following service requirements – *the intent is to leverage the Federal CCBHC model and tailor it to State specific BH needs and landscape*



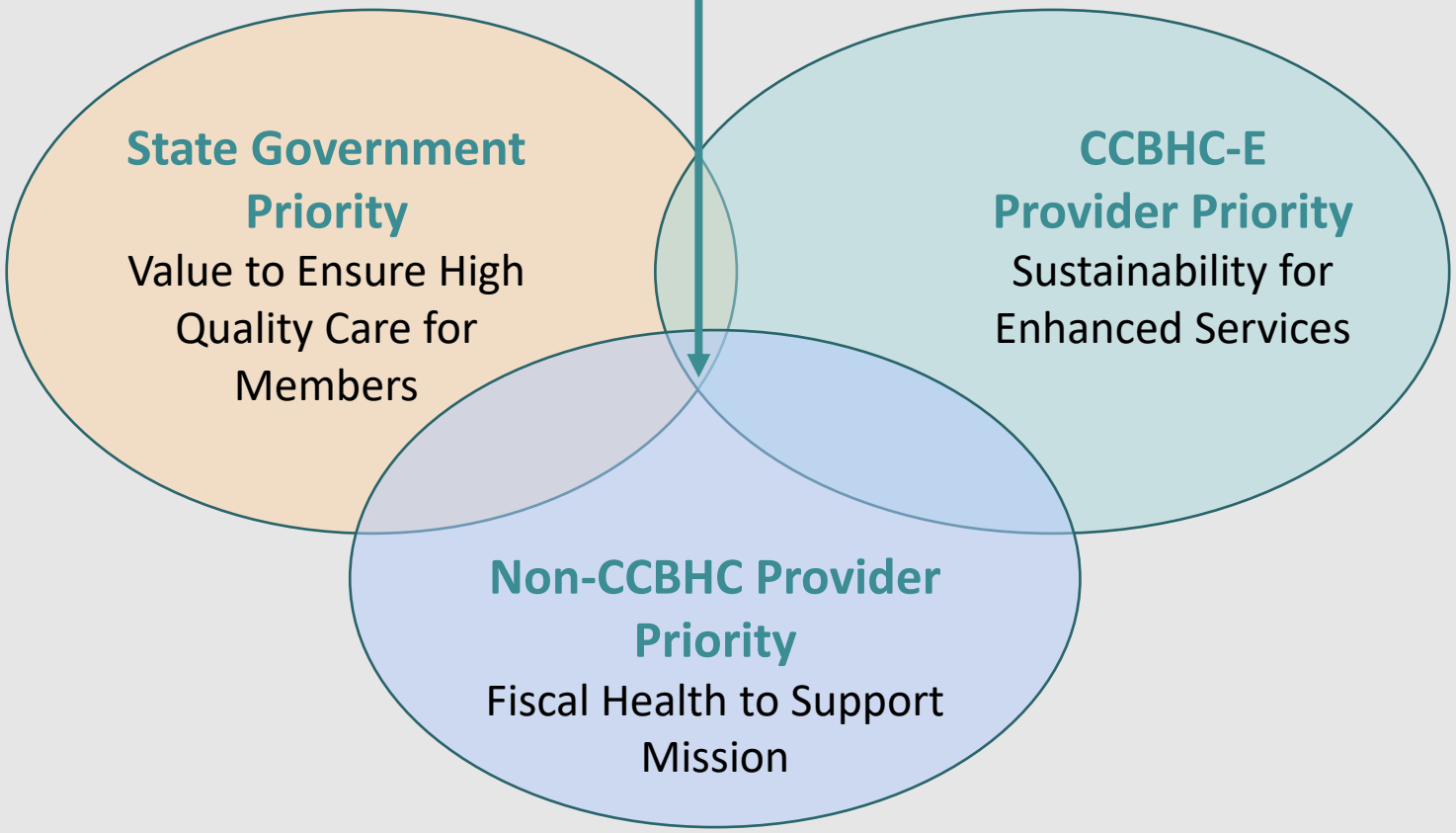
Rhode Island CCBHC Enhancements:

- Medicaid payment model
- DCO vs. Direct service requirements: Allowing for tailored service model and providers for specific populations (i.e. Children/Youth vs. Adults, PWIDD)
- Statewide mobile crisis model

CCBHC Payment Model: Addressing State and Provider Priorities

Payment Model Goal

A state-defined payment model based on historical rates and provider cost data that considers infrastructure and quality performance in alignment with state reform programs that drive the BH system toward value



CCBHC Populations and Services

CCBHCs will provide expanded services to all populations - including children/youth and moderate acuity adults

CCBHC Required Services	ACT	OTP HH	High Acuity Adult *(Current IHH)*	Moderate Acuity Adults	High Need Children/Youth	Moderate Acuity Children/Youth
Comprehensive outpatient MH and SUD services						
Screening, assessment, and diagnosis						
24-hour crisis mental health services						
Utilization of evidence-based practices						
Treatment Planning						
Screen for HIV and HEP A, B, and C	*Services generaly captured by existing Health Home payment + FFS (Except grey highlights)*			**ADDED** *Service Req'ts & Payment*		
Care Coordination						
Integration with physical health care						
Primary care screening and monitoring						
Psych rehab services and social support services						
Assertive Community Treatment						
Monitoring for adverse medication impact						
Services for Veterans						
Case Management						
Recovery Supports (peer and family)						

- Address IHH/ACT "cliff"- encourage expanded services to be provided to all populations – not just complex, IHH/ACT participants
- Include children/youth in the CCBHC care delivery model and funding model
- Fund/support expanded service offerings - specifically 24/7 mobile crisis

Community Partner Requests and Modifications Made

Community/ Provider Request	State Response	Request Accepted?
Prospective, cost-based payment	• PMPM paid prospectively based on attribution, with retrospective reconciliation • PMPM rate developed based on RI-specific costs for a defined service array	✓
Provider specific payment rates based on provider cost reporting	• Provider specific rates based on provider cost reporting create perverse incentives for providers to add cost, with no link to value or outcomes	
Annual rate adjustments	• Annual trend factor added to ensure rates adjust sustainably each year	✓
Full capitation, inclusive of comprehensive outpatient MH & SUD services, with outpatient rate increases	• Incorporated comprehensive OP MH & SUD services in the PMPM • Added a baseline unit cost increase in accordance with Milliman comparative rate development study to address concerns that program impacts would be limited if OP services were underfunded • Enhanced withhold to ensure prepaid PMPM is supported by critical encounter data and reporting	✓
Fund outreach within the CCBHC PMPM	• Added funding for an outreach coordinator (peer) at each CCBHC	✓
Add funding for care management/ care coordination	• Added funding for a daily team huddle as a service enhancement to the CCBHC required service array	✓

Summary of Fiscal Proposal

State Medicaid Budget Request		
Key Elements	Description	Additional Notes

CCBHC Base Rate	• Population specific PMPM
	• Prospective, cost based PMPM
	• Populations:
	  • ACT
	  • High Acuity Adults (IHH)
	  • SUD/High Acuity Adult
	  • OTP HH, Moderate Acuity Adults
	  • High Acuity Children/Youth
	  • Moderate Acuity Children/Youth
		• **Full capitation, inclusive of comprehensive OP MH & SUD services**
		• Most significant service gaps are for Children/Youth and moderate acuity adults

CCBHC Quality Incentive Program	Added quality performance incentive Estimated at 5% of base rate	Anticipate start with Pay for Reporting, shifting to Pay for Performance
Mobile Crisis Payment Rate	**Three components** • Bundled, Tiered Base Rate • Extended Service Rate • Quality Incentives	• Medicaid Only • RFP structure to include infrastructure investment

Additional Program Elements *(seeking additional funding outside state budget request)*
1. CCBHC Incentive Program Phase 1 Provider infrastructure incentive
2. CCBHC Phase 0 Provider Infrastructure Development (DCOs) Grants Culturally sensitive, SUD providers, Children and Youth BH providers
3. Mobile Crisis Infrastructure (Part of RFP, Phase 1) Ramp up for selected Mobile Crisis vendors thru new procurement
4. Mobile Crisis Additional Elements Payment for uninsured/Medicare populations Payment for commercially insured populations
6. Mobile Crisis Statewide Call Center/988

Schedule for Ongoing Community Partner Engagement for Implementation Planning

Community Partner Engagement Implementation Planning
Tentative Schedule

Anticipate one 90 minute meeting every two weeks that is topic specific

Week of	Dec 13	Dec 20	Dec 27	Jan 3	Jan 10	Jan 17	Jan 31	Feb 7	Feb 14	Feb 21	Feb 28	Mar 7	Mar 14	Mar 21	Mar 28
CCBHC Certification Standards	xx														
Mobile Crisis Program Structure					xx										
CCBHC Provider Infrastructure Development Program Requirements: Phase 0							xx								
CCBHC Provider Infrastructure Development Program Requirements: Phase 1									xx						
CCBHC Attribution requirements											xx				
Other/Placeholder													xx		

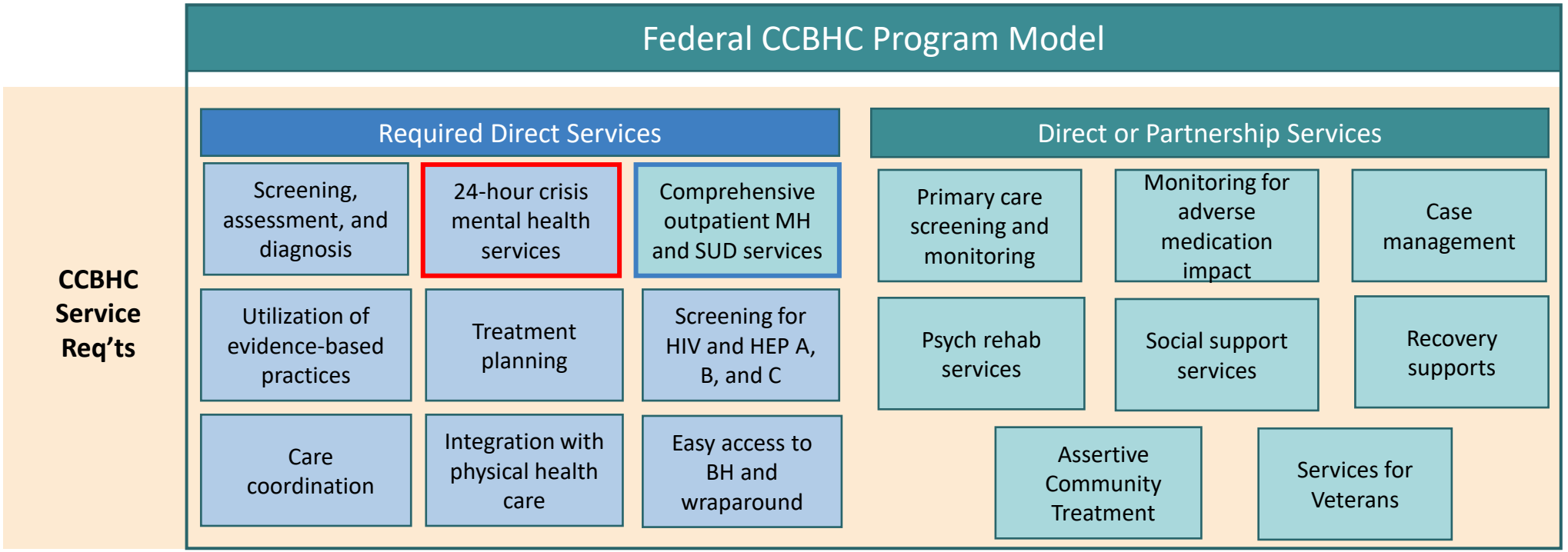
Certification Standards for RI CCBHCs

CCBHC Certification Standards: Key Decision Points

- CCBHC Service Requirements and Rhode Island Specific Enhancements
- CCBHC Provider Application and Eligibility
- Certification Process & Methodology

Starting Point for Certification Standards: Federal Model

The RI CCBHC Program Requirements will start with the federal model, adapted to build on *RI specific **needs and landscape***



Rhode Island CCBHC Attributes:

- Medicaid payment model
- DCO vs. Direct service requirements: Allowing for tailored service model and providers for specific populations (i.e. Children/Youth vs. Adults, PWIDD)
- Statewide mobile crisis model

DRAFT RI Specific Service Enhancements

Critical Enhancements to Federal Certification Standard intended address RI-specific gaps include:

RI Specific Objectives	Potential Standards
Requirement to **treat all ages** (children to adults) **at every level of acuity**, including prevention.	• Lead agency does not have to have comprehensive lifecycle services – DCO may provide some portion of comprehensive life cycle services • Lifecycle Services may not need to be provided in a single location
Strong emphasis on **health equity and racial equity**	• Requirement to **increase provider training in health equity and racial equity**, Specific emphasis on increasing numbers of linguistically and culturally competent providers, including non-licensed providers with lived experience. • Align and build on existing CMHO **Board representation requirements, to ensure representation by consumers/families served in a manner consistent with demographics of the clientele** • Require DCO partnership(s) with at least one CBO that meets certain criteria with respect to demographic representation • Data collection and quality: requirement to build processes to capture race, ethnicity, gender, and SOGI data on the populations they serve (consistent with CMS standards) • Require **participation in Health Equity Zones** or other place-based initiatives
Requirement to provide directly or provide access to **24/7 mobile crisis services**.	• Separate statewide RFP for mobile crisis services • MOU with the mobile crisis vendors
Increased **integration/coordination: of BH and medical services;**	• Require an agreement with regionally located AEs, specifying the care coordination and case management responsibilities of the AE vs. the CCBHC for CCBHC attributed patients • Require Contract with all participating Medicaid Managed Care plans
Increased **integration/coordination of BH and IDD and homeless services.**	• Anticipate a mix of partnership and potential added requirements to support these populations • State may tailor attribution rules to acknowledge complexity of IDD population
Service Enhancements	• Outreach and Team Huddles

DRAFT CCBHC Provider Application and Eligibility

Intent	Options Considered	Proposed Implementation Strategies	Considerations
Best serve the member by: • Building on and enhancing existing provider infrastructure • Retaining a stable network of providers across the state, covering each geography • Creating greater equity opportunity • Not disrupting existing provider-member relationships • Encouraging/enabling multiple players/non-CMHOs to participate • Ensuring minimum standards are met – and that providers are capable of providing the requested services • Supporting consumer choice	**Application** **Procurement** *(one per "region")* **Procurement (up to two per "region")** ** Region to be defined based on population/ service needs*	• Initial **Letter of Intent** to inform selection process for interested entities • Eligible agencies must have provided a **minimum number of BH visits** in prior year *(inclusive of the services provided by DCOs)* • State procures based on determined **region.** Entities **may participate in multiple regions** • Providers who are currently **IHH or ACT providers must participate in CCBHC** program to remain IHH/ACT eligible • Require that the **Board of the CCBHC** is 50%+1 members who have been served by the CCBHC or have a family member who has been served by the CCBHC • Exception for CCBHCs that where BH services represent less than a certain percentage of the total organizational revenue	• Some duplication • Two providers-one month problem • Some churn in the PMPM recipients • Should region = Catchment area? • Relationships with AEs, hospitals, HEZs VA are mandated and vertically integrated, but duplicated

DRAFT Certification Process and Methodology

Intent
Best serve the member by: • Ensuring minimum standards are met – and providers are capable of providing the requested services • Ensuring consistency, reliability, quality assurance, nuance • Aligning with existing CCBHC-E attestation requirements and current provider regulatory requirements • Considering cost and administrative burden on both state and providers • Aligning with best practices as implemented in other states

Key Decision Points	Options Considered	DRAFT Approach for Discussion
Process	Site Visit Desk Audit Hybrid Self Attestation	**Desk audit** (check list with attached documents) **followed by an on-site certification visit**
Methodology	Checklist Chart review HR File review Scenario testing	Chart review HR file review Scenario testing
Certification Timing	Provisional or Permanent Certification	**Preliminary Certification is for a one-year period**. Agencies that receive over X% but less than Y% on their certification audit receive Preliminary Certification **Comprehensive Certification is for a three-year period.** Agencies that receive over Y% on their certification audit receive Comprehensive Certification

Questions and Next Steps

Community Stakeholder Engagement Implementation Planning

- **Continued Implementation Planning - Upcoming Community Partner Discussions**
  - Mobile Crisis Program Structure
  - CCBHC Provider Infrastructure Development Program Requirements: Phase 0
  - CCBHC Provider Infrastructure Development Program Requirements: Phase 1
  - CCBHC Attribution Requirements

- **Draft Implementation Documents**
  - DRAFT Certification Standards
  - Program Requirements for Phase 0/1 Infrastructure funding
  - Mobile Crisis Procurement

Public Comment?

Appendix

Backup: CCBHC Baseline Service Requirements

The proposed CCBHC service requirements vary by population as follows. Service requirements for the three new cohorts are shown.

CCBHC Required Services	Moderate Acuity Adults	High Need Children/ Youth	Moderate Needs Children/ Youth	Staff Type
Comprehensive OP MH and SUD services	**Comprehensive MH/SUD FFS expenditures included in PMPM** (excluding Crisis Intervention, Clubhouse, and MHPRR) + Benchmarked rate increase on underlying FFS rates, based on Milliman comparative rate study			
Screening, assessment, and diagnosis	Included in **PMPM** – based on FFS expenditure history and benchmarked rate increase			
24-hour crisis MH services	Distinct mobile crisis service rate to be established			
Utilization of evidence-based practices	BHDDH will identify a set of BH EBPs that are minimum standard for CCBHCs (i.e. MI, CBT, DBT) and will assess the ability of the CCBHC to provide those EBPs during the certification (and recertification) process. Cost of training incorporated in the CCBHC PMPM.			
Treatment Planning	**Annual** team meetings and a PMPM built up based on expected costs	**Bi-monthly** team meetings and a PMPM built up based on expected costs	**Semi-annual** team meetings and a PMPM built up based on expected costs	Team *(inclusive of RN, Psychiatry/ Prescriber, and Counselor)*
Screen for HIV & HEP A, B, C	**Annual screening** covered by a PMPM built up based on expected costs	**Quarterly screening** covered by a PMPM built up based on expected costs	**Annual screening** covered by a PMPM built up based on expected costs	RN
Care Coordination	**1 monthly contact** with other providers and collaterals	**6 monthly contacts with** other providers and collaterals	**2 monthly contacts** with other providers and collaterals	Counselor
Integration with physical health care	**Semi-annual case conference** with PC re BH/physical interactions	**Monthly case conference** with PC re BH/physical interactions	**Quarterly case conference** with PC re BH/physical interactions	RN
Primary care screening and monitoring	Quarterly capture of a set of vitals (weight, a1c, etc)	Quarterly capture of a set of vitals (weight, a1c, etc)	Quarterly capture of a set of vitals (weight, a1c, etc)	RN
Psych rehab services and social support services	Included in **PMPM** – based on FFS expenditure history and benchmarked rate increase	N/A	N/A	
Assertive Community Treatment	N/A	N/A	N/A	
Monitoring for adverse medication impact	Quarterly capture of a set of vitals (weight, a1c, etc)	Quarterly capture of a set of vitals (weight, a1c, etc)	Quarterly capture of a set of vitals (weight, a1c, etc)	RN
Services for Veterans	Military cultural competency training for (at least) all client-facing staff. Assessed on initial and re-certification. Cost of training incorporated in the CCBHC PMPM.			
Case Management	Minimum of one contact per month from CM with a BA	Minimum of four contacts per month from CM who meets certain educational/ experiential credentials	Bi-monthly contact from CM with a BA	Counselor
Recovery Supports (peer)	Included in **PMPM** – based on FFS expenditure history and benchmarked rate increase	N/A	N/A	
Recovery Supports (family)	Family support group bi-monthly	Available through Cedar Family Centers, EI, Family Home Visiting, and HBTS programs		
Daily Huddle	Care team daily huddle			
Outreach Coordinator	Peer specialist outreach coordinator position			

Sample Certification Documents from Other States/SAMHSA

Sample: Minnesota Desk Audit Tool

Criteria Certification Requirements

Please attach one or multiple documents that includes all of the following responses labeled according to the numbering in the checklists below.

Program Requirement 1: STAFFING

	#	Type	Request
X	1.1	Document	Provide your needs assessment or statement of need for your clinic
☐	1.2	Narrative	What cultural, linguistic and treatment needs of populations in your service area were identified in your needs assessment or statement of need? What staffing needs of populations served by your clinic were identified?
☐	1.3	Plan	Clinic Staffing Plan: Size, composition, licenses/experience levels, appropriateness for populations served, capability to serve all ages, linguistic capability, ability to prescribe buprenorphine, utilization of peer staff and expertise in trauma.
☐	1.4	Narrative	Does your clinic have a psychiatrist as a Medical Director? If not, describe how your clinic is in compliance with federal criteria (1.b.2) and Rule 29 or have a variance in place to satisfy this requirement. Also, verify that your clinic has (or has access to) a medically trained behavioral health care provider who can prescribe medication including buprenorphine and other medications used to treat opioid and alcohol use disorders.
☐	1.5	Narrative	Describe how peer staff are integrated into your clinic's programming. Describe the current status and future plan. Ensure that Certified Peer Specialists, Certified Family Peer Specialists and Certified Recovery Specialist are included in the Clinic Staffing Plan.
☐	1.6	Procedure	Procedure for Staff Skills and Competencies: Assessments used to determine training needs of staff, documentation of each staff person's training received, and documentation that each staff person's licensure and credentials are in good standing. Including how DCOs will follow these policies.

SAMHSA Appendix M Self-Assessment Checklist

This compliance checklist identifies the criteria required for a Certified Community Behavioral Health Clinic (CCBHC) and their designated collaborating organizations (DCOs), which together form the CCBHC.

Program Requirement 1: Staffing

Criteria 1.A. General Staffing Requirements

1.a.1 Needs Assessment and Staffing Plan

_____ The CCBHC has completed a needs assessment.

_____ The CCBHC needs assessment addresses cultural, linguistic, treatment and staffing needs and resources of the area to be served by the CCBHCs and addresses transportation, income, culture, and other barriers.

_____ The CCBHC needs assessment addresses workforce shortages.

_____ Consumers and family members and relevant communities (e.g., ethnic, tribal) were consulted in a meaningful way to complete the needs assessment.

_____ There is recognition of the CCBHC's obligation to update the assessment at least every 3 years.

_____ The staffing plan for the CCBHC reflects the findings of the needs assessment.

_____ The CCBHC bases its requirements for services at the CCBHC, including care coordination, on the needs assessment findings.

Chart Review Sample Elements

The chart details a crisis plan.
All consent to share information forms are signed.
The treatment plan is signed by the consumer and/or the parents/guardians
The names of relatives/friends with whom information can be shared are made explicit and the consumer's signature acknowledging that consent is available.
The treatment plan includes evidence of shared decision-making.
The treatment plan addresses all 9 required CCBHC services.
There is either an advance directive in the chart or a signed decision by the consumer not to create one.
The treatment plan includes a process for monitoring progress toward the consumer's goals.
The treatment plan is based on the evidence-based/best practice assessments done on intake.
The consumer's chart includes data about the consumer's blood pressure.

HR File Review Sample Elements

The Medical Director's personnel file indicates that s/he is a Board-Certified psychiatrist.
The selected personnel files include documentation of the employees' verified educational credentials.
The interpreters' personnel files include documentation of their training to function in a medical setting.
The personnel files indicate compliance with the relevant trainings.

Scenario Test Sample

Your CCBHA is contacted on Sunday by a social worker from a local hospital's inpatient psychiatry unit seeking to arrange follow-up care for a 75-year-old scheduled for discharge by Monday. The patient is a native French speaker whose English is limited. He resides with his daughter. He has been diagnosed with schizophrenia and mild dementia. He has been previously hospitalized for issues related to his diabetes, which has not previously been well managed.

Critical Elements
Culturally and linguistically competent care
Transitional care
Peer support
Family support
Coordination with hospitals
Care management
Integrated care
Advance directive
Post-crisis planning