2023

Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals

Application for Certified Community Behavioral Health Clinic (CCBHC) Provider Status

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INTRODUCTION

Overview

Any applicant seeking certification by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) as a Certified Community Behavioral Health Clinic (CCBHC) provider must use this application. Prospective applicants should first thoroughly review the Certified Community Behavioral Health Clinics State of Rhode Island Certification Guide. Compliance with the 115 criteria or standards is the basis for consideration for certification.

The Protecting Access to Medicare Act (PAMA) § 223 laid the groundwork for the establishment of Certified Community Behavioral Health Clinics (CCBHCs). In accordance with that legislation, in 2015 the Substance Abuse and Mental Health Services Administration (SAMHSA) published Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (the Criteria).

Starting in 2021, EOHHS/RI Medicaid, BHDDH, and DCYF worked with input from a group of community providers and advocates to build a CCBHC proposal to address issues identified in the Rhode Island Behavioral Health System Review. In the State Fiscal Year 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS to submit a State Plan Amendment to CMS to establish CCBHCs in Rhode Island, according to the federal model. It also directed BHDDH to define the criteria to certify the clinics and, working in concert with EOHHS, to determine how many CCBHCs can be certified in State Fiscal Year (SFY) 2024 and the costs for each one.

SAMHSA designated BHDDH as the state mental health authority and the state substance abuse authority. BHDDH administers and oversees the federal block grant and discretionary funding. BHDDH is also charged with the certification of select programs and services that are reimbursed by Medicaid including CCBHCs.

Application Structure and Format

This application is divided into several sections following the six program areas of Rhode Island's CCBHC Certification Standards. We ask that the applicant show compliance with each certification in several ways. Thus, in each section, the application requests:

- **Narratives:** In these sections of the application, we are asking for written descriptions needed to provide context necessary to demonstrate compliance with a given standard. These can include staffing patterns and organizational charts.

- **Documents:** In these sections of the application, we are asking applicants to provide documents. These may include full policy and procedure documents. Requested documents are required for those standards which may vary from provider to provider and are not covered in depth by regulation (licensure) or accreditation.

- **Policy or Procedure Titles**: Instead of full copies, here we require policy citations, which could include numbers, dates of issuance or revision dates, and page numbers (as appropriate) used to demonstrate compliance with standards that are consistent with the ordinary course of business for a licensed or accredited organization providing the behavioral health services required of a CCBHC. The actual policies or procedures may be requested during the application review period, including during the on-site assessment process.

- **Attestations:** Are used for standards where time constraints or other significant barriers may prevent the applicant from being able to produce the other types of documentation needed to demonstrate compliance during the relatively short application period. Ultimately applicants will need to demonstrate compliance with a standard by provision of a document such as a policy or procedure, DCO contract language, or another form of documentation. Please note that the CEO and Board Chair signs an acknowledgement at the end of the application that all materials submitted, including attestations, with the application are truthful. Failure to attest, or inability to produce required documentation may result in inability to certify compliance with the standard referenced in the attestation.

Throughout the document, you will see references to the associated Certified Community Behavioral Health Clinics State of Rhode Island Certification Guide – for instance: (1.a.1) or (2.a.6) – which will provide you with background on the question being asked.

Application Process, Timeline and Submission Instructions

The application is **due on Monday, April 3 by 5:00 PM (ET)**. It is a fillable form that must be completed and submitted electronically to OHHS.CCBHCReadiness@ohhs.ri.gov along with an attached zip file for supporting documentation. It is organized by the required documents in the categories

described above. Requests for supplemental information may be requested by the application review team to clarify or expand on information already provided or omitted.

Please plan to submit this with enough time prior to the deadline to allow for delays in transmission. We will not be able to accept applications after the 5:00 PM (ET) deadline.

Scoring

An interagency review panel will score applications based on documentation of compliance with each referenced certification standard. The interagency review panel will include State employees with experience in clinical behavioral healthcare services, Medicaid, program administration, data/evaluation and compliance monitoring, implementation of evidence-based programs or clinical practices, and other relevant subject matter expertise.

Please note: As the certifying body for CCBHCs, BHDDH sought and received technical assistance from the National Council on Mental Well Being related to application processes and scoring, and reviewed other States' applications including scoring protocols.

APPLICANT INFORMATION

Applicant/Organization Name: _____

Mailing Address: _____

Address 2: _____

City/Town: _____

State/Province: _____

ZIP/Postal Code: _____

Primary Contact Name: _____

Email Address: _____

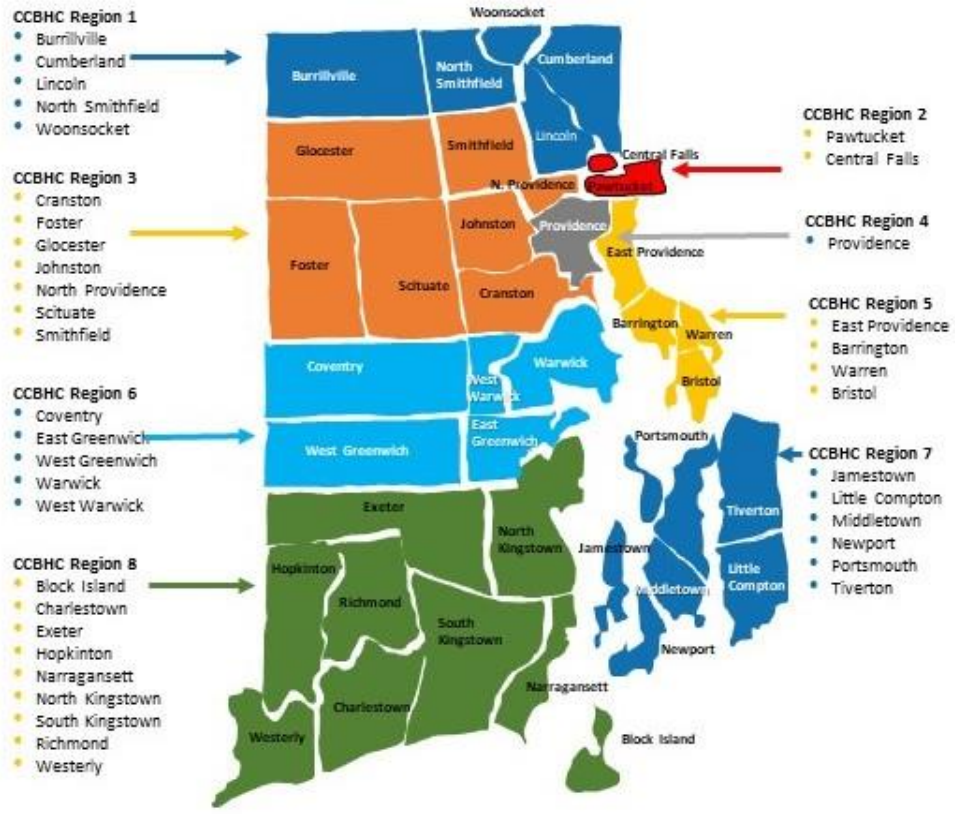
Phone Number: _____

Name of Governing Board Chair: _____

Name of President/Chief Executive Officer: _____

Name of Chief Financial Officer: _____

Potential CCBHCs must submit an application for each CCBHC region the applicant seeks to serve. For which region are you applying with this application? Please check **ONE** box below.



Region 1 ◯ Region 2 ◯ Region 3 ◯ Region 4 ◯

Region 5 ◯ Region 6 ◯ Region 7 ◯ Region 8 ◯

GENERAL APPLICATION INFORMATION

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

1. Be licensed in RI as a behavioral healthcare organization (BHO) and within the scope of its license provides CCBHC required services or have a pending application for BHO licensure or request to add service(s) in process at the time of request for certification as a CCBHC.
2. Be a qualified Medicaid provider **or** be in process at the time of application.
3. Be accredited by a nationally recognized accreditation body (The Joint Commission, Commission on Accreditation of Rehabilitation Facilities or Council on Accreditation) with standards specific to delivery of behavioral healthcare services for mental illness and substance use disorder **or** have a pending application submitted at the time of request for certification as a CCBHC.
4. Have a minimum of 3 years of demonstrated experience providing evidence-based practices for people experiencing serious and persistent mental illness (SPMI), serious mental illness (SMI), **and/or** serious emotional disturbance (SED) **or** individuals with complex or severe substance use disorders, **or** a track record of providing person-centered, recovery oriented and trauma informed care.
5. Demonstrated experience and ability to directly provide the following four services for outpatient behavioral health care.
    a. Crisis behavioral health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
    b. Screening, assessment, and diagnosis, including risk assessment.
    c. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
    d. Outpatient mental health and substance use services.
6. Have submitted an initial Cost Report to the State by the mid-February 2023 deadline.

The following documents will be used to demonstrate compliance with multiple program areas and standards. Therefore, all applicant organizations are required to submit the following:

1. Organization's official mission statement
2. Copy of organizational chart
3. Information requested in the table below including locations of behavioral health service provision, services provided, approximate annual count of individuals served, and when the site was opened. Please add rows to the table as needed.

Address of each location of behavioral health services currently provided (within and outside region/catchment area)	List services provided (e.g., ACT, counseling, case management, IOP) at the location	Annual total count of individuals served at the location	What month and year did the location open?

4. A list of organizations with which the applicant has a Designated Collaborating Organization (DCO) agreement or an agreement that is still being negotiated. In this list, please identify the service(s) the DCO covers, and which agreements are signed, which are pending, and indicate if any of the DCOs listed were listed in the PPS-2 cost report.

PROGRAM REQUIREMENT 1: STAFFING

Application requirements

For Program Requirement #1 – Staffing, please provide your Narrative, Documents, Policy References, and Attestations as described below.

Narrative:

The Narrative should be a separate Word document, not to exceed 10 pages in total for Questions 1 through 7. Please use Calibri or Times New Roman 11-point font, with 1-inch margins. Please title the narrative with the associated program requirement.

1. Please provide:
    a. A summary of your community needs and/or summary of community needs assessment if available, and
    b. A summary of the unique socio-demographic factors of the service area and how these factors are reflected in the applicant's planned outreach and engagement activities, service delivery plans, and
    c. A summary of the applicant's efforts to eliminate health disparities experienced by relevant cultural and linguistic minorities. (1.a.1) and (2.a.6)

2. Please provide a plan of how your CCBHC will address the behavioral health needs of SAMHSA populations of focus and how you propose to increase the number served as compared to the previous year (1.a.1):

    SAMHSA populations of focus. (1.a.1):

    - Adults with Serious and Persistent Mental Illness (SPMI),
    - Children and Youth with Severe Emotional Disorders (SED),
    - Individuals with Substance Use Disorder (SUD),

3. Please check off the priority consumer population the applicant is planning to serve. Then provide a plan of how your CCBHC will address their unique behavioral health needs.

    Priority consumer population, as identified by the State of RI (1.a.1):
    ☐ BIPOC (Black, Indigenous, and People of Color),
    ☐ People with co-occurring Behavioral Health and Intellectual/Developmental Disabilities (BH/IDD),
    ☐ Members of the LGBTQ+ Community,

☐ People who are justice-involved,
☐ Older adults,
☐ People who are unhoused,
☐ Transition age youth,
☐ Members of under-resourced communities (high poverty, low-income areas) and
☐ Other culturally diverse groups, if any.

4. Please explain how your services or programs are organized or coordinated to maximize accessibility and client flow among those services, consistent with the role of the CCBHC as a fixed point of accountability for clinical care. This could include transition between services and/or access to additional services needed and provided by applicant. (1.a.2)

5. Please provide a description of how meaningful access to services, programs and related materials is provided to those with language-based disabilities, those who are hard of hearing or deaf and those who require auxiliary aids to access care. Also please describe commonly spoken languages, other than English, within the CCBHC Service area and provide a detailed description of how translation services are to be provided to consumers by the CCBHC and by the DCO for those services delivered by a DCO. (1.d.2, 1.d.3, 1.d.4)

6. Submit a description of the applicant's orientation and onboarding for new staff. (1.c.1)

Documents:

1. **Signed Medical Director Credentials:** Provide the name of the medical director, credentials, %FTE, and job description that reflects their duties and responsibilities. This document should be signed by the medical director. (Please see Addendum 1 of the of the CCBHC Certification Standards dated December 21, 2022, entitled *CCBHC Medical Director Specific Requirements and Duties* for more information. (1.a.3)
2. **Staffing Plan:** Please include a staffing plan for each service delivered by the CCBHC, and by a partner DCO in compliance with the SAMHSA criteria (1.b.2) and Addendum 4 of the CCBHC State of Rhode Island Certification Guide entitled "Required Staffing".
    a. The plan should detail the description of positions, required credentials for each position and whether the position(s) are currently filled or vacant. (1.b.2)

b. Please include in your staffing plan including a description of the experience and expertise of your (1.a.2):
    i. Clinical staff in providing services to the populations of focus:
        - SPMI
        - SUD
        - SED
    ii. Clinical leadership staff in providing services to the populations of focus:
        - SPMI
        - SUD
        - SED
c. The applicant should identify the Qualified Mental Health Professionals (QMHPs) for both the applicant organization and any proposed DCOs (2.a.7) and their hours of availability.

3. **CLAS Standards:** Submit a copy of the plan to meet the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care that details how the applicant will address the cultural and linguistic treatment needs of the population to be served. (1.c.1).
4. **Training Plan:** Submit a copy of the plan that details how the applicant plans to implement the following CCBHC required trainings, consistent with addendum 6 on the Certification Standards Guide and subject to approval by a member of the CCBHC Review Team (1.c.1, Addendum Six)
    - Person/family centered care training
    - Principles of trauma-informed care
    - Recovery oriented treatment planning
    - Cultural Competency
    - Eight Dimensions of Wellness
    - Crisis De-escalation training
    - ADA compliance
    - Abuse and neglect reporting
    - Disaster planning and infection control
    - The role of Peer Supports, Peer Counseling, and Family/Caregiver Supports
    - Military culture

Policy or Procedure Titles:

Provide the following policy or procedure titles, numbers, issuance or revision dates, and page numbers, as appropriate, concerning the following:

1. Accessing needed specialized behavioral health services from other providers when current clinicians do not have the requisite expertise. (1.b.2)
2. The CCBHC and all DCO services are trauma-informed/responsive, person/family-centered, recovery-based, and culturally appropriate. (1.c.1)
3. Initial trainings for staff relevant to cultural competency (1.c.1), and training about military and veterans' culture (4.k.6)
4. CCBHC and/or DCO protocols for assessing skills and competence of staff providing CCBHC required services (1.c.2)
5. CCBHC and/or DCO policies and procedures must document cultural competency and training requirement completion in personnel records (1.c.3)
6. Competency of staff who will be conducting the trainings. (1.c.4)

Attestations:

Please check the boxes below to attest to the applicant's agreement with the associated statements. If you are unable to attest to the requirement, please provide the reason why and the anticipated date that you will be able to fully demonstrate compliance.

1. ☐ The applicant understands that as a condition of certification as a CCBHC it must commit to completion of a needs assessment within a three (3) year period (1.a.1).

   If the applicant is unable to comply with 1, please explain:

2. Please check all that apply related to the requirement of a comprehensive needs assessment:

   ☐ a. Has completed a needs assessment that is less than three (3) years old since the date of completion

   ☐ b. Has completed a needs assessment that is more than three (3) years old since completion date or the organization has never completed a needs assessment – but will complete a needs assessment in the first year of operation after certification as a CCBHC.

   If the applicant is unable to comply with 2, please explain:

3. ☐ The applicant will maintain relevant and state-required insurance while certified as a CCBHC. I also certify that the applicant shall notify BHDDH of any material changes in insurance coverage during the certification period. (1.a.4)

   If the applicant is unable to comply with 3, please explain:

4. ☐ The applicant's staff members or contractors who provide direct service possess appropriate licenses, certification or credentialling for the CCBHC and the DCO as required. (1.b.1)

   If the applicant is unable to comply with 4, please explain:

PROGRAM REQUIREMENT 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES

Application requirements

For Program Requirement #2 – Availability and Accessibility of Services, please provide your Narrative, Documents, Policy References, and Attestations as described below.

Narrative:

The Narrative should be a separate Word document, not to exceed 3 pages in total for Questions 1 and 2. Please use Calibri or Times New Roman 11-point font, with 1-inch margins. Please title the narrative with the associated program requirement.

1. Provide a description of the applicant's use of telehealth/telemedicine. (2.a.5)
2. Provide a list of the collaborating Emergency Departments (EDs) and a brief description of the collaboration related to compliance with the SAMHSA criteria/standard. (2.c.4).

Documents:

1. Provide the applicant's list of locations for available services/programs, the times that they will be available including evening and weekend hours in the service area for which the applicant is applying, in compliance with SAMHSA criteria/standards (2.a.2) and (2.a.3).
2. Provide the applicant's policies and procedures related to services that are provided outside of the clinic included but not limited to crisis; case management; care coordination; telehealth; outreach and engagement activities, and provision of Individual Placement and Supports, in compliance with SAMHSA criteria/standard (2.a.5).
3. Provide a copy of CCBHC policies and procedures related to outreach and engagement activities that assist clients and families in accessing care to address behavioral health conditions and needs in compliance with SAMHSA criteria/standard (2.a.6).
4. Provide a copy of the applicant's crisis planning procedures that describe how the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations in conjunction with the consumer and their family. (2.c.6)
5. Provide a copy of fee schedules for services for those unable to pay, related procedures for making a sliding fee schedule available which includes guarantees related to no cost sharing for Medicaid beneficiaries. (2.d.2 through 2.d.4)

Policy references:

Provide the following policy or procedure titles, numbers, issuance or revision dates, and page numbers, as appropriate, concerning the following:

1. Providing or arranging the provision of transportation for individuals to access needed services. (2.a.4)
2. A continuity of operations/disaster plan, that includes infection control measures, for any DCO that is not licensed by BHDDH as a BHO (2.a.8).
3. Accessing crisis management services and related topics covered at the time of initial evaluation. (2.c.3)

4. Protocols are in place concerning the involvement of law enforcement designed to reduce delays for initiating services during and following a psychiatric crisis. (2.c.5)

Attestations:

Please check the boxes below to attest to your applicant's agreement with the associated statements. If you are unable to attest to the requirement, please provide the reason why and the anticipated date that you will be able to fully demonstrate compliance.

1. An applicant (or DCO) must have facility status in compliance with the RI Mental Health Law (R.I. Gen. Laws §40.1-5-1, et seq.) to provide court-ordered outpatient services. The applicant:

   ☐ a. **Has facility status** in compliance with the RI Mental Health Law (R.I. Gen. Laws §40.1-5-1, et seq.) to provide court-ordered outpatient services; or

   ☐ b. Does **not have facility status** to provide court-ordered outpatient services under the RI Mental Health Law (R.I. Gen. Laws §40.1-5-1, et seq.) at the time of CCBHC application, but have or will have an appropriate DCO arrangement with an entity that has facility status by July 1, 2023. (2.a.7).

   If the applicant is unable to comply with 1a or 1b, please explain:

2. The applicant will:

   ☐ a. Assess and report the number (#) and percentage (%) of individuals requesting service who were determined to need urgent and routine care. (2.b.1)

   ☐ b. Assess and report the number and percentage of individuals with urgent needs who began receiving required clinical services within 1 business day, and the number and percentage of individuals with routine needs who began receiving required services within 10 business days. (2.b.1)

   ☐ c. Assess and report the mean number of days before comprehensive diagnostic and planning evaluations are completed. (2.b.1) and (2.b.3)

If the applicant is unable to comply with 2a, 2b, or 2c, please explain:

3. ☐ Following the resolution of a crisis, if an individual continues in treatment, the next contact with individual involved will be face-to-face, and the individual's need for services and level of risk will be reassessed. (2.b.1)
   If the applicant is unable to comply with 3, please explain:

4. ☐ Staff will promote collaborative treatment planning by providing PCPs with all relevant assessment, evaluation, and treatment plan information; seeking all relevant treatment and test results from PCPs; and inviting PCPs to participate in treatment planning. (2.b.2)
   If the applicant is unable to comply with 4, please explain:

5. ☐ Update all consumers' comprehensive evaluation with the cooperation of the individual when changes in their status, significant response to treatment, or goal achievement have occurred, and at least every 90 days for individuals with moderate or more serious impairment as determined by an approved functional assessment. (2.b.2).
   If the applicant is unable to comply with 5, please explain:

6. ☐ The applicant is capable of monitoring and reporting length of time from crisis contact to face-to-face intervention as part of its CCBHC application. (2.c.1)

If the applicant is unable to comply with 6, please explain:

7. The applicant will:

☐ a. Clearly describe in its policies and procedures the methods for providing a continuum of crisis prevention, response, and post-intervention services in a manner accessible to the public; AND

☐ b. Provide a link to the website where the information is posted. (2.c.2)

If the applicant is unable to comply with 7a or 7b, please explain:

8. ☐ The applicant has or will have by July 1, 2023, policies or procedures related to how, in conjunction with the consumer, the applicant creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations. (2.c.6)
If the applicant is unable to comply with 8, please explain:

9. ☐ The applicant attests that no one will be denied behavioral health care services, including but not limited to crisis management services, because of an inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1). (2.d.1)
If the applicant is unable to comply with 9, please explain:

10. ☐ Services will not be denied to individuals who do not have a current permanent address. (2.e.1)
If the applicant is unable to comply with 10, please explain:

11. ☐ The applicant is prepared to address the needs of consumers who do not live within the CCBHC catchment or service area. (2.e.2)
If the applicant is unable to comply with 11, please explain:

PROGRAM REQUIREMENT #3: CARE COORDINATION

Application requirements

For Program Requirement #3 – Care Coordination, please provide your Narrative, Documents, Policy References, and Attestations as described below.

Narrative:

The Narrative should be a separate Word document, not to exceed 4 pages in total for Questions 1,2 and 3. Please use Calibri or Times New Roman 11-point font, with 1-inch margins. Please title the narrative with the associated program requirement.

1. Provide information on the applicant's HIT system (3.b.2) and its capability to conduct activities on:
   - population health management
   - quality improvement
   - reducing health disparities
   - Research, and
   - outreach

2. Provide a description of how the applicant's (CCBHC's) HIT system provides for care coordination between the CCBHC and any DCO. Provide a plan for improvements to EHRs within their HIT to improve transitions of care. (3.b.5)
3. Please describe the applicant's strategies to develop, maintain and continually evaluate effective inter-organizational care coordination partnerships. (3.a.1)

Documents:

1. Provide a copy of the applicant's organizational policies, procedures and protocols related to care coordination in compliance with SAMHSA criteria/standards (3.a.1).
2. Provide the applicant's policies and procedures that include a requirement that when an individual is referred to external providers or resources, staff confirm that the appointment was kept. (3.a.3)
3. The applicant is required to have agreements regarding care coordination with the following. Please check off those whom you currently have care coordination agreements and provide the written agreements (3.a.1)

SAMHSA-Required CCBHC Care Coordination Agreements	YES	NO
Federally Qualified Health Center (FQHCs) or Rural Health Clinics (RHCs) serving CCBHC consumers. (3.c.1)		
Other primary care providers (3.c.1)		
Inpatient psychiatric treatment programs (3.c.2)		
Ambulatory and medical detoxification (3.c.2) (3.c.5)		
Post-detoxification step-down services (3.c.2)		
Key community and regional services, supports and providers (3.c.3) (3.c.4)		
Veteran's Administration and other veteran serving organizations (3.c.4)		
Inpatient acute-care hospitals, including emergency departments (3.c.5)		
Hospital outpatient clinics (3.c.5)		
Urgent care centers (3.c.5)		
Residential crisis settings (3.c.5)		
State-Required CCBHC Care Coordination Agreements		
9-8-8 provider		
Family Care Community Partnerships (FCCPs)		
Accountable Entities (AEs)		

a. If no to any of the above, by what date will you have it? Please provide a response for each provider group for which there was a no response to a care coordination request by the applicant.

4. Provide a copy of the applicant's policies and procedures that require that the applicant makes, and documents, reasonable attempts to track admissions and discharges of non-Medicaid consumers to a variety of settings, and to provide appropriate transitions to safe community settings. (3.c.2)

5. Provide copies of the applicant's policies and procedures that require that it makes, and documents, reasonable attempts to follow up within 24 hours following hospital discharge. (3.c.5)

Policy References:

Provide the following policy or procedure titles, numbers, issuance or revision dates, and page numbers, as appropriate, concerning the following:

1. The standard of Care Coordination: (3.a.1, 3.c.2, 3.c.3., 3.c.4 and 3.c.5).
    a. Generic care coordination
    b. involving consumers and family members in treatment planning and care coordination. (3.d.1) and
    c. if care coordination is carried out in keeping with consumer preferences (3. a. 4)
2. Assignment of interdisciplinary team (3.d.2).
3. Crisis planning to include psychiatric advanced directives or wellness recovery action plans. (3.a.4)
4. Obtaining consent and release of information needed for care coordination with other providers not affiliated with the CCBHC. (3. a.5)

Attestation:

Please check the boxes below to attest to the applicant's agreement with the associated statements. If you are unable to attest to the requirement, please provide the reason why and the anticipated date that you will be able to fully demonstrate compliance.

1. ☐ The applicant complies with all federal and state laws and regulations, for adults and/or minors that pertain to confidentiality, health care privacy and security including, but not limited to, HIPAA and 42 CFR Part 2. (3.a.2)

   If the applicant is unable to comply with 1, please explain:

2. ☐ The applicant will work with its DCO(s) to ensure that that the DCO(s) complies(y) with all federal and state laws and regulations for adults and/or minors that pertain to confidentiality, health care privacy and security including, but not limited to, HIPAA and 42 CFR Part 2. (3.b.4)

   If the applicant is unable to comply with 2, please explain:

3. ☐ The applicant's agreements with DCOs include a provision regarding the consumer's freedom to choose their provider with the CCBHC or the DCO. (3.a.6)

   If the applicant is unable to comply with 3, please explain:

4. A formal CCBHC/DCO agreement will be required before the applicant will be permitted to operate as a DCO. This agreement will be reviewed by BHDDH and must meet the CCBHC/DCO requirements listed in Addendum 4 of the CCBHC Certification Standards:

   ☐ The final agreements between the applicant and any DCOs will incorporate all requirements listed in Addendum 4 of the CCBHC Certification Standards entitled *Requirements of Designated Collaborating Organizations*.

   If the applicant is unable to comply with 4, please explain:

5. The applicant:

☐ a. Currently maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture information as required by this program requirement (3b1) and follows the program requirements on health IT system capability requirements (3.b.2) and (3.b.3).

☐ b. Will establish a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system will have the capability to capture information as required by this program requirement (3.b.1) and will be in compliance with the program requirement on health IT system requirements by the following date: 12/31/2023. (3.b.2) and (3.b.3).

If the applicant is unable to comply with 5a or 5b, please explain:

6. The applicant:

☐ a. Has a policy, procedure or protocol requiring that each client record contains the name of the Primary Care Provider (PCP), or that they are assisting an individual in acquiring a PCP, or that the individual refuses to provide the name of their PCP. Insert the policy or procedure number, title, issuance or revision date or page numbers here (3.c.1):

☐ b. Has established protocols to ensure adequate care coordination with other PCPs (including FQHC look-alikes and community health centers) (3.c.1)

☐ c. Does not have a policy or procedure or protocol as described in 5a or 5b but will create such a policy and procedure and provide the policy or procedure number, title, issuance or revision date and page numbers prior to certification.

If the applicant is unable to comply with 6a, 6b, or 6c, please explain:

PROGRAM REQUIREMENT #4: SCOPE OF SERVICES

Application requirements

For Program Requirement #4 – Scope of Services, please provide your Narrative, Documents, Policy References, and Attestations as described below.

Narrative:

The Narrative should be a separate Word document. Please use Calibri or Times New Roman 11-point font, with 1-inch margins. Please title the narrative with the associated program requirement.

1. Describe (not to exceed 10 pages in total for #s 1a through 1e.):

    a. The way that the applicant employs a trauma informed/trauma responsive care approach. (4.d.5 & 4.f.2).

    b. The specific services and frequency of services provided in the community, including mobile crisis response and response to substance use-related crises, such as harm reduction and coordination with 24-hour service providers for substance use-related crises. (4.c.1)

    c. The extent to which the applicant currently addresses or will address, the provision of each of the 9 required services and ACT and HIV/Hepatitis testing. Include in your narrative (4.a.1):
        - the years of experience providing each 9 required services and ACT,
        - the numbers served (separate adult and children) in each category in your most recent one-year period,
        - as well as your capacity to provide these services.

    d. Describe the years of experience of the CCBHC and any proposed DCOs in providing services to the priority consumer populations (1.a.1) please clarify between the CCBHC & proposed DCO.

    e. Describe your current specialty services, structure and processes (4.f.1):
        - Non-high acuity mental health services
        - Substance use disorder treatment
        - Transition age youth (16-25)
        - Children and adolescents (0-15)

2. Use Table 1 below and a narrative (not to exceed 1 page), to describe how the applicant directly provides or will provide ASAM Level1-WM and ASAM level 2-WM services. (4.c.1) and to identify the organizations with whom there are agreements referral relationship to access ASAM Level 3.2 WM (Social Setting Detox) services, and ASAM 3.7 WM (Modified Medical Detox) services. (4.c.1)

Table 1- Description of Organizational Experience and How CCBHC SUD Crisis Services Will be Provided by the Applicant Organization			
Descriptions of ASAM Levels that must be provided by the CCBHC		**Currently Provided**	**Will be Offered**
ASAM Level 1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery.	☐	☐
ASAM Level 2-WM	Moderate withdrawal with all day withdrawal management supports and supervision; at night has supportive family or living situation, likely to complete withdrawal management.	☐	☐
Descriptions of ASAM Levels requiring referral relationships		**Referral organization(s)**	
ASAM Level 3.2-WM (Social Setting Detox)	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery		
ASAM 3.7-WM (Modified Medical Detox)	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring.	_____	

3. Please describe (not to exceed 1 page) the applicant's specific functional assessments and screening tools employed and how brief motivational interviewing techniques are utilized (4.d.7)

4. Please describe (not to exceed 3 pages) the extent to which the applicant *(not DCO)* has **current** experience with implementing **each** of the 15 required Evidence Based Clinical Practices and Programs (listed below). If you do not have experience with an EBP, please indicate this in your narrative. Please describe for **each** EBP the following (4.f.2):

a. the years of experience providing each of the 15 required EBPs
b. The age group (children, adult or both) with whom each of the EBPs listed was implemented,
c. the numbers and percentage of staff who are currently trained in each EBP
d. Historical use of fidelity monitoring including tools utilized

Evidence Based Clinical Practices and Programs

- Motivational Interviewing/Motivational Enhancement Therapy
- Cognitive Behavioral Therapy (CBT) Age/population appropriate
- Dialectical Behavioral Therapy (DBT)
- Family Psychoeducation (FPE)/ Family to Family
- Integrated Dual Disorder Treatment (IDDT)
- Medication Treatment Evaluation and Management (MedTEAM)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Trauma informed care
- Coordinated Specialty Care/ Healthy Transitions (CSC/HT)
- Zero Suicide
- Assertive Community Treatment (ACT)
- Permanent Supported Housing/Housing First
- Individual Placement and Support (IPS)
- Medication Assisted Treatment (MAT)
- 12-Step Facilitation Therapy/Matrix Model

5. Describe (not to exceed 1 page) How the applicant **will** implement the required Evidence Based Practices (EBPs) (4.f.1, 4.f.2) and such elements as:

    a. Your implementation plan for the CCBHC and DCOs, including relevant training, staff development and quality improvement initiatives.
    b. The manner in which fidelity to the required EBPs will be implemented.
    c. The manner in which it will provide ongoing coaching in each of the EBP's.
    d. The manner in which you will evaluate the need for new EBPs or adaptation of existing EBPs.
    e. Please specify which EBPs from table 2 will be delivered by CCBHC and/or DCO.
    f. Please provide a list of currently used EBPs for children and youth and your plan for maintaining or expanding EBPs for children and youth.

6. Describe (not to exceed 2 pages):
    a. How the applicant has been providing and will provide case management services to CCBHC populations of focus, i.e., Adults with Serious and Persistent Mental Illness or Serious Mental Illness; Children with Serious Emotional Disturbance; and Individuals with Severe Substance Use Disorder (1.a.2, 4.h.1)
    b. Please include in your description how the applicant will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports, as well as other requirements that appear in requirement (4.h.1)

Documents:

The applicant will provide:

1. A copy of the proposed staffing pattern for the CCBHC and the Designated Collaborative Organization(s) (DCO), if any, detailing the positions and required credentials for each position and indicate whether the position(s) are currently filled or vacant. (1.a.1 & 1.a.2) and (2.a.6). (4.f.2)

2. A copy of your policy and procedures on monitoring DCO quality and compliance to CCBHC standards (4.a.4)

3. A list of employed or contracted physicians who prescribe buprenorphine or naltrexone for the treatment of opioid use disorder. (4.f.2)

4. The letter from BHDDH on behalf of Medicaid certifying the applicant to provide Peer Based Recovery Support Services (PRBSS) and the names and credentials for Certified Peer Recovery Specialists employed by the applicant

or

provide a plan to become a certified provider for any DCO proposed that is not currently certified to provide PBRSS.

Please note: Applicants that employ peers who do not have a peer recovery specialist credential may provide outreach and engagement services under a DCO relationship with CCBHC. (4.j.1).

5. Protocols for providing for immediate access to services for veterans (4.k.2)

6. The name of the person/persons appointed to work on outreach and engagement activities with the Active-Duty Service Member (ADSM), Veterans and veteran serving organizations. (4.k.3) If not appointed at this time, please specify time frame when the person/persons will be appointed.

Policy Reference:

Provide the following policy or procedure titles, numbers, issuance or revision dates, and page numbers, as appropriate, concerning the following:

1. Existing consumer grievance procedure. (4.a.3) or attest below.

2. Screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions, and process for referral where necessary for screening, assessment or diagnosis. (4.d.1)
    a. Timely screening and assessment (4.d.2)
    b. Use of culturally and linguistically appropriate screening tools. (4.d.8)
    c. Requirement of conducting a brief intervention as part of the screening for unsafe substance use and the referral process for a full assessment and treatment, if applicable. (4.d.9)
3. Person and family centered treatment. (4.e.1)
    a. Integration of prevention, medical and behavioral health needs and delivery of services. (4.e.2)
    b. Requirement on consumer assessment in treatment planning. (4.e.3)
    c. Requirement on capturing consumer's words and ideas in treatment planning. (4.e.4)
    d. Shared decision making in treatment planning (4.e.5)
    e. Requirement regarding the use of consultation. (4.e.6)
    f. Requirement regarding consumer's advance directives. (4.e.7)
    g. Other aspects of consumer, person-centered and family-centered treatment required based upon the needs of the population served. (4.e.8)
4. Use of developmentally appropriate, evidence-based clinical practices and programs. (4.f.3)
5. The treatment approaches used for children and adolescents. (4.f.4)
6. Adherence to related care coordination with the Principal Behavioral Health Provider and any other providers as indicated in criteria. (4.k.4)

Attestations:

Please check the boxes below to attest to the applicant's agreement with the associated statements. If you are unable to attest to the requirement, please provide the reason why and the anticipated date that you will be able to fully demonstrate compliance.

1. ☐ The applicant certifies that consistent with the consumer's freedom of choice, the consumer may choose their provider within the CCBHC or its DCO(s), as further detailed in program requirement (4.a.2).

    If the applicant is unable to comply with 1, please explain:

2. ☐ The applicant will ensure that regarding either CCBHC or DCO services, consumers will have access to CCBHC's existing grievance procedures. (4.a.3)
   If the applicant is unable to comply with 2, please explain:

3. ☐ The applicant attests that DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC. (4.a.4)
   If the applicant is unable to comply with 3, please explain:

4. ☐ The applicant attests that the entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria. (4.a5)
   If the applicant is unable to comply with 4, please explain:

5. ☐ The applicant provides person-centered and family-centered care that recognizes the cultural and other needs of the individuals and includes but is not limited to consumers who are American Indian or Alaska Native (AI/AN), whose preferences may include traditional medicine or approaches. These services can be provided directly or by formal agreement. (4.b.2)
   If the applicant is unable to comply with 5, please explain:

6. ☐ The applicant attests that it is or will be certified under the DCYF Regulation (214-RICR-40.00) and further attest that DCOs providing emergency or mobile crisis services to children and youth will also meet this regulatory requirement. If the applicant is unable to comply with 6, please explain:

7. The applicant will develop and implement revised policies and procedures concerning the following:

☐ a. An initial evaluation and care plan to be completed within 10 days of first contact to meet presenting needs or other immediate or urgent needs, and

☐ b. A full mental health assessment to be conducted within 30 days, and further attestation to completing all the required elements of the evaluation. (4.d.3)

☐ c. A determination is made during initial evaluations regarding whether the individual presently is, or ever has been a member of the U.S. Armed Forces; and this information is regularly reported to BHOLD and included in the individual's electronic health record. (4.d.3)

If the applicant is unable to comply with 7a, 7b, or 7c, please explain:

8. ☐ The applicant certifies that it meets the requirements of evaluation associated with standard 4.d.5, including state requirements.
If the applicant is unable to comply with 8, please explain:

9. The applicant:

☐ a. is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk (4.g.1).

☐ b. Screens all adolescents (13 to 18 years of age) for depression (4.d.6)

☐ c. Screens all adults (19 years of age and older) for depression using the PHQ9 (4.d.6)

☐ d. Evaluates all adults and adolescents who present a suicide risk for major depression (4.d.6)

☐ e. Uses primary care screening for all individuals served (or as explicitly limited to designated populations) for the following: BMI screening and follow up; weight assessment and counseling for nutrition and physical activity for children and youth; tobacco use screening and cessation intervention; unhealthy alcohol and use of SBIRT; diabetes screening; dental care screening; vision care screening; and viral infections including Hep and HIV, alcohol use, blood pressure, A1C levels and LDL levels (as indicated above). (4.d.6)

If the applicant is unable to comply with 9a, 9b, 9c, 9d, or 9e, please explain:

10. The applicant:

☐ a. Provides psychiatric rehabilitation services as described in (4.i.1)

If the applicant is unable to comply with 10, please explain:

11. The applicant:

☐ a. Will follow all SAMHSA criteria related to provision of intensive, community based mental health care for members of the Armed Forces and Veterans.as described in criteria (4.k.1)

☐ b. Is capable of measuring activity including, but not limited to, care coordination, referrals, meetings with VA staff and other veteran serving organizations. (4.k.3)

☐ c. Attests that care for veterans must conform to that definition and to those principles to satisfy the statutory requirement that care for veterans Adheres to guidelines promulgated by the Veterans Health Administration (VHA).

If the applicant is unable to comply with 11a, 11b, or 11c, please explain:

12. The applicant:

☐ a. Certifies that policies and procedures exist that provide for the documentation of all required items listed in standard 4.k.7

or

☐ b. Certifies that if the policy and procedure described in 8a, based on standard 4.k.7, does not exist, a policy/procedure will be created or revised within 6 months of the date of certification and at that time the applicant will provide the title, date of issuance or revision, and page numbers that reflect compliance with this requirement.

If the applicant is unable to comply with 12a or 12b, please explain:

PROGRAM REQUIREMENT #5: QUALITY AND OTHER REPORTING

Application requirements

For Program Requirement #5 – Quality and Other Reporting, please provide your Narrative, Documents, Policy References, and Attestations as described below.

Narrative:

The Narrative should be a separate Word document, not to exceed 2 pages in total for Questions 1 through 4. Please use Calibri or Times New Roman 11-point font, with 1-inch margins. Please title the narrative with the associated program requirement.

1. Please describe the plan applicant has or plans to have, to collect, report, and track encounter, outcome, and quality data including, but not limited, to data capturing:

- consumer characteristics
- staffing
- access to services
- use of services
- screening, prevention and treatment
- care coordination
- other processes of care
- costs
- consumer outcomes including data that may be collected by the DCO

Please note: (see Addenda 3 and 9 of the Certification Standards Guide for additional detail). (5.a.1) and (5.a.3)

2. Please describe how you will ensure that the required monthly data is entered into the Behavioral Health On-Line Data System in a timely and accurate fashion to capture all required quality measures. (5.a.2, Addendum 9)

3. Please describe how the applicant will regularly monitor the compliance with all the attestations provided and compliance with all the policies, procedures and protocols referenced in this application. (5.b.1)

4. Please describe applicant's demonstrated experience in conducting timely Continuous Quality Improvement (CQI) activities and its use of data to improve care coordination, access, and treatment. (5.b.2)

Documents:

The applicant will provide copies of formal agreements (contracts or MOUs) that establishes formal relationships between the applicant and DCO. If no agreement has been established, please provide prospective language that will establish formal relationships between the applicant and prospective DCOs. Formal agreements should include provisions that the DCO:

1. Provide required data to the CCBHC in a timely manner (5.a.3)

2. Obtain appropriate consumer consent for the sharing of information and comply with all federal and state privacy and confidentiality requirements (5.a.3)

3. Provide a copy of the applicant's CQI Plan. (5.b.2)

Attestations:

Please check the boxes below to attest to the applicant's agreement with the associated statements. If you are unable to attest to the requirement, please provide the reason why and the anticipated date that you will be able to fully demonstrate compliance.

1. ☐ The applicant attests that it will collect all required data and submit monthly to the RI Behavioral Health On-Line Data System (BHOLD) and submit a quarterly report (5.a.1 and Addendum 9)

   If the applicant is unable to comply with 1, please explain:

2. The applicant is capable of tracking and reporting data as required by Section 5 of the CCBHC Certification Standards, on or before entering contracts with Managed Care Organizations (MCOs), including but not limited to:

   ☐ a. The CCBHC complies with all the elements of CCBHC Certification Standard 5.a.4 regarding Medicaid claims and encounter data.

   ☐ b. The CCBHC agrees to comply with all the elements of CCBHC Certification Standard 5.a.5 regarding annual cost reports.

   If the applicant is unable to comply with 2a or 2b, please explain:

3. The applicant's CQI plans will be revised to address CCBHC specific activity and requirements including but not limited to:

   ☐ a. The CQI plan includes specific activities and data as listed in section 5.b.1 of the CCBHC Certification Standards.

   ☐ b. The applicant agrees to comply with all elements of the CCBHC Certification Standard 5.b.2 regarding CQI processes and must include:

   - CCBHC consumer suicide deaths or suicide attempts
   - CCBHC consumer 30-day hospital readmissions for psychiatric or substance use reasons
   - urgent appointments not scheduled within 24hr hours
   - fatal and non-fatal overdoses
   - abuse of consumer by CCBHC staff or abuse of staff by CCBHC consumer

- such other events the state, the CCBHC or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

If the applicant is unable to comply with 3a or 3b, please explain:

PROGRAM REQUIREMENT #6: ORGANIZATIONAL AUTHORITY, GOVERNANCE, AND ACCREDITATION

Application requirements

For Program Requirement #6 – Organizational Authority, Governance and Accreditation, please provide your Narrative, Documents, Policy References, and Attestations as described below.

Narrative:

The Narrative should be a separate Word document, not to exceed 1 page in total for Questions 1. Please use Calibri or Times New Roman 11-point font, with 1-inch margins. Please title the narrative with the associated program requirement.

1. Any CCBHC applicant that proposes to serve Washington County must provide evidence that they have reached out to the Narragansett Indian Health Center. (6.a.2) – only required for applicants proposing to serve CCBHC Region 8.

Documents:

1. In the event of any findings, reportable conditions, material weaknesses or if a management letter is issued in connection with the Audit Report, a copy of the corrective action plan to address them is provided with this application. (6.a.3)

Attestations:

Please check the boxes below to attest to the applicant's agreement with the associated statements. If you are unable to attest to the requirement, please provide

the reason why and the anticipated date that you will be able to fully demonstrate compliance.

1. ☐ The applicant attests that an independent financial audit is performed annually (6.a.3)

   If the applicant is unable to comply with 1, please explain:

2. The applicant attests to how it complies with criteria (standards) 6.b.1 through 6.b.4 which describe board structures and governance operating procedures for a CCBHC.

   ☐ a. CCBHC board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders.

   AND,

   ☐ b. The applicant attests that it will comply with the process and structure established in Addendum10 - *CCBHC Standard on Governance and Meaningful/Consumer/Family Participation - Community/Consumer Advisory Council*.

   AND,

   Please select "c" or "d' below and describe how the board incorporates the meaningful participation of families, consumers, or people in recovery from behavioral health conditions. If neither "c" nor "d" applies, please check "e".

   ☐ c. The CCBHC board structure incorporates meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers, either through 51 percent of the board being families, consumers, or people in recovery from behavioral health conditions.

   OR,

☐ d. Through a substantial portion of the governing board members meeting these criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

OR,

☐ e. Please describe how the applicant proposes to meet this standard through the process and structure described in Addendum 10.

If the applicant is unable to comply with 2a and 2b and 2c or 2d or 2e, please explain:

3. The applicant attests Compliance with Criteria (Standard) 6.b.5

☐ a. Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served.

☐ b. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.

If the applicant is unable to comply with 3a or 3b, please explain:

ACKNOWLEDGMENT STATEMENT

Application for Certified Community Behavioral Health Clinic Provider Status

Applicant organization's Name: _____

The organization named above:_____ is applying to become a Rhode Island Certified Community Behavioral Health Clinic (CCBHC). The certification process is conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

The undersigned, who is authorized to sign on behalf of the organization, has read the foregoing application, and agrees that the statements contained within it, including all attestations, and any information and/or documentation submitted as part of or in support of the application, are true and correct. The undersigned, as the authorized representative of the organization, gives assurance of the ability and intention to comply with the laws, regulations, and standards applicable to RI CCBHCs.

It is understood that this organization will be eligible for certification only after it has complied with the requirements of the certification standards issued by BHDDHs, all applicable laws and regulations, and that such certification, if granted, is subject to revocation at any time the organization fails to comply with the certification standards; state or federal law; or state or federal regulations.

It is also understood and agreed that agents of BHDDH are authorized by law and/or regulations to make inspections of premises; review the organization, personnel, and client/consumer records; observe program operations; interview employees and clients/consumers about the program(s); and audit the financial records of this organization to determine compliance with standards or to investigate any complaints.

It is understood that this organization is only authorized to receive the PPS rates if the organization has achieved the status of contingent or full certification. Correspondence from BHDDH will identify any areas where full compliance with a standard has not been demonstrated.

Signature: _____ Date: _____

Printed Name: _____

Chief Executive Officer

Signature: _____ Date: _____

Printed Name: _____

Governing Board Chair

Signature: _____ Date: _____

Printed Name: _____