

RFS 24-77045

Attachment E

Certification Criteria Response Template

Background: The State has defined the requirements for becoming a CCBHC in the Demonstration Program, articulated in this Attachment E. The State is interested in gathering information on providers' readiness for CCBHC to inform its selection of Demonstration Program sites. The State expects selected Demonstration Sites to achieve designation/certification, including meeting the below requirements, by the start of the Demonstration Program which is anticipated to begin in or around July 2024. The below Certification Criteria are the State's initial requirements for CCBHCs and will be continuously, iteratively refined leading into and during the Demonstration Program, in collaboration with stakeholders including all prospective CCBHCs (not just those selected through this RFS).

The State's Certification Criteria are meant to serve as a floor, not a ceiling - the State is interested in learning how Respondents meet the Criteria as a minimum, and how they are going to or plan to go beyond the Criteria to meet needs in their community.

Instructions:

In the table in each Program Requirement section, please enter "yes" or "no" in columns 3 and 4 to indicate your current ability and anticipated future ability to meet the State's requirements for a CCBHC during the Demonstration Program.

At the end of each Program Requirement section, please provide a narrative explaining your current ability to meet the Certification Criteria relative to that Program Requirement. For each criterion in that Program Requirement section, please address:

1. If you currently meet the criterion, how are you doing so?
2. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
3. If you are exceeding the criterion requirements, what are you doing?

Program Requirement 1: General Staffing Requirements

Criterion #	Criterion	Do you currently meet this criterion?	If not, will you be able to meet this criterion by 7/1/24?
1.a.1	<p>As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every 3 years. The community needs assessment should be submitted to DMHA to receive certification.</p> <p>Additional community needs assessment requirements include:</p> <ul style="list-style-type: none"> • Community needs assessment updated every 3 years and submitted with re-certification documentation • Describe population that will be served • Describe how access (including hours and service locations) will be responsive to community need • Identify community partners that the CCBHC engages with or has a Memorandum of Understanding or other Contractual Agreement with • Collect information on disabilities • List ways the CCBHC is currently able to address specific populations or community needs specific to their area • List areas the CCBHC cannot meet due to limited staff, hours, location, or other factors, as well as plans to outsource or contract with a DCO to address these areas • Address what staff positions currently exist and what positions will need to be created and/or filled to meet CCBHC requirements • Survey undocumented population and underserved and historically 	Yes	

	marginalized individuals within the mental health and substance use space		
1.a.2	<p>The CCBHC submits a list of staffing (position and number of staff) in its application for certification. The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.</p> <p><i>Note: See criteria 4.k relating to required staffing of services for veterans.</i></p>	Partial	Yes
1.a.3	<p>The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. The CCBHC must share the CEO and Medical Director information with DMHA as part of the designation/certification process.</p> <p>Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care.</p> <p><i>Note: If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical</i></p>	Yes	

	<i>Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.</i>		
1.a.4	The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.	Yes	
1.b.1	<p>All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.</p> <p>All DCOs that the CCBHC contracts with must be currently certified or designated when applicable in their field of service, such as Addictions Service Provider. The CCBHC must document the relationship with a DCO with an MOU or other contractual arrangement and will inform DMHA as part of the designation/certification process.</p>	Yes	
1.b.2	The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as	Yes	

	<p>reflected in their treatment plans, and as required to meet program requirements of these criteria. The CCBHC must inform DMHA of all staffing information and licensure as part of the designation/certification process.</p> <p>CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA- approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include, but are not limited to, a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses (including LPNs and RNs), (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, (13) community health workers, (14) licensed addiction counselors, and (15) staff who have the time and ability to assist individuals navigating financial needs, housing needs, and service transition needs (ex: navigators, peers). Staff should</p>		
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	<p>reflect the communities identified in the CCBHC's needs assessment in lived experiences, cultures, and identities.</p> <p>The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers.</p> <p>Additional staff requirements include:</p> <ul style="list-style-type: none"> • Navigator position: Staff member with the time and ability to help individuals receiving services navigate the CCBHC process, barriers, and service offerings. The position must align with the services referenced above in Item 15. <p><i>Note: Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies, to the extent possible, to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision.</i></p>		
1.c.1	<p>The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and annually thereafter, the CCBHC must provide training on:</p> <ul style="list-style-type: none"> • Evidence-based practices as defined by the State during demonstration 	Yes	

	<ul style="list-style-type: none"> • Cultural competency and awareness (described below) • Person-centered and family-centered, recovery-oriented planning and services • Trauma-informed care • The clinic's policy and procedures for continuity of operations/disasters • The clinic's policy and procedures for integration and coordination with primary care • Care for co-occurring mental health and substance use disorders • Risk assessment (ex: suicide risk, homicidal risk, etc.) • Suicide and overdose prevention and response, suicide prevention EBPs, policies and procedures for responding after a suicide death, suicide risk assessment training • Safety planning training • The roles of family and other informal supports • The roles of Certified Peer Support Professionals • Confidentiality and privacy requirements <p>Trainings may be provided on-line. Training logs must be kept and made available for QI auditing purposes.</p> <p>Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.</p>		
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	<p>Cultural Awareness is the recognition of one's own cultural influences and understanding how clients' culture, beliefs, and values affect their perceptions, understanding of mental health, and their relationship with their service provider. To provide culturally responsive treatment services, counselors, other clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, and assumptions about others. Providers need to invest in gaining cultural knowledge of the populations that they serve and obtaining specific cultural knowledge as it relates to help-seeking, treatment, and recovery. This dimension also involves competence in clinical skills that ensure delivery of culturally appropriate treatment interventions. This language was inspired by <i>TIP 59: Improving Cultural Competency Quick Guide for Clinicians</i> (https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf).</p> <p><i>Note: See criteria 4.k relating to cultural competency requirements in services for veterans.</i></p>		
1.c.2	<p>The CCBHC regularly assesses the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.</p>	Yes	
1.c.3	<p>The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. CCBHCs are required to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices, as defined by the State during demonstration. Training logs, supervision and ongoing coaching schedules should be documented and described, as stated in the CCBHC continuous quality improvement (CQI) plan. Staff personnel records will be kept and made available for QI auditing purposes.</p>	Yes	

1.c.4	Individuals providing staff training are qualified as evidenced by their education, training, and experience.	Yes	
1.d.1	The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities. The CCBHC is required to provide meaningful access to language services if a need for such services is addressed in the Needs Assessment. The State recommends utilizing the Office of Healthy Opportunity's manual for language access for LEP.	Yes	
1.d.2	<p>The CCBHC is required to have access to interpretation/translation service(s) that are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.</p> <p>The CCBHC is required to have written translations of vital documents for each eligible LEP language group as identified by and in alignment with a State-approved accreditation body.</p>	Yes	
1.d.3	Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).	Yes	
1.d.4	Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the	Yes	

	CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.		
1.d.5	The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors. The CCBHC is required to upload all policies at certification to DMHA's identified location.	Yes	

Program Requirement 1: General Staffing Requirements Narrative

Please provide a narrative explaining your current ability to meet the Certification Criteria in Program Requirement 1. For each criterion, please address:

4. If you currently meet the criterion, how are you doing so?
5. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
6. If you are exceeding the criterion requirements, what are you doing?

1.a.1	The Community Mental Health Needs Assessment for Marion County was completed in 2023 by the Richard M. Fairbanks School of Public Health Center for Health Policy at Indiana University. The Community Needs Assessment helps inform both our clinical service lines and staffing plan. An attachment of the Community Needs Assessment has been provided in compliance with the requirement found in Attachment D 2.4.3.1.
1.a.2	As part of its application to the RFS, Sandra Eskenazi Mental Health Center (Sandra Eskenazi MHC) has provided a list of staff (positions and number of staff currently employed). The Community Mental Health Needs Assessment for Marion County indicated some additional services needed in Marion County. One such service is fidelity to the ACT Model of Care to address the extremely high needs of individuals seeking care and to reduce the need for

	<p>emergency room visits and hospital stays. In addition to the recommendations in the Community Needs Assessment, the State has also noted the need to add required positions for CCBHC-status, such as a Navigator and an inpatient emergency department and psychiatric Liaison. Sandra Eskenazi MHC is strengthening its ability to work with veterans to fully meet these requirements.</p> <p>Currently the Sandra Eskenazi MHC Director of Clinical Services is working with STAR Behavioral Health Providers and the Purdue University Center for Deployment Psychology to achieve certification status under STAR. In part, this includes sending clinicians to Tier One training. STAR will send monthly reports on training and Sandra Eskenazi MHC STAR provider referrals to the Director of Clinical Services. Currently Sandra Eskenazi MHC has limited staff trained in the STAR model for veterans. Marion County is designated as a Health Care Professional Shortage Area by HRSA. To help address staffing shortages, Sandra Eskenazi MHC has developed the John and Kathy Ackerman Mental Health Professional Development Center and has gained the necessary financial support for the next 3-5 years to develop workforce talent in three areas: Master's level Clinicians, Bachelor's level Social Workers, and Peer Recovery Specialists (persons with lived experience). With the assistance of the Ackerman Center, Sandra Eskenazi MHC will be able to hire the additional positions required to offer all CCBHC services by July 1, 2024. Sandra Eskenazi MHC seeks to continue growing its pipelines for Master's, Bachelor's, and Peer Recovery providers. To increase the number of Master's level Clinicians, Bachelor's level Social Workers, and Peer Recovery Specialists, we have established the following training goals for the Ackerman Center over the next three (3) years. These trainees will be able to fill open positions to meet the demands of our community.</p> <ul style="list-style-type: none"> • Master's Level Clinician--45 Students • Bachelor's Level Provider--60 Students • Peer Recovery Specialist--45 person with lived experience <p>Sandra Eskenazi MHC's goal is to hire 20-25% of those trained each year. In the past two years we have hired 75% of our Master's level Clinician trainees, representing 33-45% of our overall Clinician hires for those years.</p>
1.a.3	<p>Ashley Overley MD, a board-certified psychiatrist with fellowship training in public and community psychiatry, serves as the Chief Executive Officer of Sandra Eskenazi MHC. In addition to the CEO, Sandra Eskenazi MHC has a strong senior leadership team. The team is comprised of a Chief Operating Officer, Director of Clinical</p>

	Services, Director of Operations, and Director of Workforce Development Strategy. Additionally, Heather Fretwell MD, a board-certified psychiatrist, provides 0.7 FTE as Sandra Eskenazi MHC's Chief Medical Officer. Sandra Eskenazi MHC has additional administrative support that includes a Quality Improvement Advisor, Clinical Talent Acquisition Consultants, Health Information System Analyst (EMR) and Behavioral Health Regulatory Audit Coordinator.
1.a.4	Sandra Eskenazi MHC is self-insured and maintains appropriate liability and malpractice insurance required.
1.b.1	Sandra Eskenazi MHC is the oldest community mental health center in the state of Indiana, having served the most vulnerable in the Indianapolis community since 1969. Sandra Eskenazi MHC is part of the community and works within the community to ensure that service needs are met. The 2023 Community Needs Assessment of Marion County aligns with whom Sandra Eskenazi MHC treats each day. Sandra Eskenazi MHC maintains its mission to provide flexible service reflective of the needs of the community through integration within Eskenazi Health, the safety-net public hospital system for Marion County/Indianapolis; and through collaboration with Eskenazi Health's largest FQHC system in Marion County. Sandra Eskenazi MHC has one of the longest running opioid treatment programs in the State. Additionally, Sandra Eskenazi MHC has full access to Eskenazi Health's finance, billing, regulatory, limited English proficiency (LEP) services, information security, and other departments to assist in ensuring that it can meet community needs and the requirements of a CCBHC. Sandra Eskenazi MHC will establish a designated collaborating organization (DCO) agreement to meet any needs in the designated service area. DCO will be established with both large and small organization based on the need to support clients in Marion County.
1.b.2	The Sandra Eskenazi MHC staffing plan will meet any requirements of the State behavioral health authority and any accreditation standard required by the state. Currently Sandra Eskenazi MHC is a Certified Community Mental Health Center. Its current CCBHC expansion grant program has been surveyed under Joint Commission CCBHC standards (July 2023). Sandra Eskenazi MHC maintains a core workforce to address the needs of people currently receiving services. In addition, Sandra Eskenazi MHC leverages appropriate telehealth/telemedicine to help alleviate specific staff shortages. In each of its clinics, Sandra Eskenazi MHC employs robust, medically trained behavioral health providers who can prescribe and manage medication including all MOUD treatment options. MOUD treatment options include a state certified opioid treatment program accessible within Sandra Eskenazi MHC. Sandra Eskenazi MHC is a leader in provider training for psychiatric residents. Sandra Eskenazi MHC is a major training site for the Indiana University School of Medicine (IUSM) psychiatry residency program, for nurses

	<p>seeking the advance practice certification, and for IUSM medical student psychiatry rotations. Sandra Eskenazi MHC employs psychiatrists, advance practice practitioners, RNs, LPNs, LCSWs, LMFTs, LMHCs, licensed psychologists, certified peers, staff trained to provide case management, licensed addiction counselors, medical assistants, and staff specially trained in assisting individuals navigating financial needs and housing needs.</p>
1.c.1	<p>Sandra Eskenazi MHC has made workforce development a focus of its organization since 2019 and, as of September, named a director for the John & Kathy Ackerman Mental Health Professional Development Center. The Ackerman Center is the umbrella initiative that coordinates all workforce development efforts, including the Behavioral Health Academy, the Peer Recovery Apprenticeship, and Care Coordinator Pathway. These initiatives are intended to provide ongoing competency and skills development for all staff, from new hires to those with many years of continuous service. The Director of the Ackerman Center works closely with the Director of Clinical Services to ensure that staff training plans and internal trainings meet their intended purpose in developing a competent workforce. Sandra Eskenazi MHC meets all requirements of Criterion 1.c.1 regarding training at new hire orientation and annually thereafter, including veteran's culture. Sandra Eskenazi MHC is committed to ensuring that training is in alignment with SAMHSA's Recovery Model, as well as the National Standards for Culturally and Linguistically Appropriate Services (CLAS).</p>
1.c.2	<p>Sandra Eskenazi MHC has policies in place that address training plans as well as assessment of competency. As a division of Eskenazi Health, Sandra Eskenazi MHC utilizes HealthStream as its record keeping and e-learning delivery system for training. HealthStream is a robust and powerful system that tracks education, facilitates the development/assignment of training, and has an end user portal of hundreds of behavioral health related training modules (several of which qualify for CEUs for licensed professionals).</p>
1.c.3	<p>As stated, Sandra Eskenazi MHC utilizes HealthStream as its education and training portal. As a division of Eskenazi Health, the human resources software Sandra Eskenazi MHC uses is SuccessFactors. Performance appraisals, continuous improvement, and goals are set, evaluated, and scored within SuccessFactors. Since 2016, Sandra Eskenazi MHC has maintained a clinical supervision protocol that provides a standardized clinical supervision tool with the recommended frequency per role and tenure that improves fidelity of EBPs and standards of care while solidifying the competence of our clinicians. Currently, an internal workgroup is reevaluating our clinical supervision protocol utilizing a continuous quality improvement (CQI) plan.</p>

1.c.4	<p>Sandra Eskenazi MHC carefully considers how training is conducted and by whom. Currently, only dedicated training and development facilitators or clinical leaders provide training at Sandra Eskenazi MHC. Additionally, only clinical leaders that are subject matter experts (SMEs) are considered for training responsibilities.</p> <p>Furthermore, for evidence-based practices (EBP) such as Motivational Interviewing or suicide assessment through use of the C-SSRS/SAFE-T, only clinical leaders who have additional training and are on EBP committees may train in those subjects. For example, our Motivational Interviewing Committee has six trainers who are members of the Motivational Interviewing Network of Trainers (MINT), an organization that has a very difficult and strenuous application process.</p> <p>Between 2022 and 2023, Sandra Eskenazi MHC committed \$60,000 in grant funding to contract with the Beck Institute to provide Cognitive Behavioral Therapy (CBT) training to all clinicians and Master's level students. We have learned over our 54 years that the core foundation of high fidelity EBP implementation is good training from the best possible source. We used our work in Motivational Interviewing to inform our decision-making as we believe it is a solid model for EBP training and implementation.</p>
1.d.1	<p>As a division of Eskenazi Health, Sandra Eskenazi MHC has access to the rich and extensive Limited English Proficiency (LEP) services available through the hospital system. These LEP services include video remote interpreters (VRI), over the phone interpretation (OPI), and in-person Spanish medical interpreters available through an interpreter dispatch. Staff have access to other non-English speaking languages through contracted services provided by LUNA, an Indianapolis-based interpretation and translation organization. Additionally, bilingual or multilingual Sandra Eskenazi MHC staff have the opportunity to be evaluated and deemed competent to provide limited translation of the services they provide (though will not be considered interpreters).</p>
1.d.2	<p>As a division of Eskenazi Health, Sandra Eskenazi MHC has access to rich and extensive LEP services, that include VRI, OPI, and in person interpreter services for over 170 languages. For those client care staff who are bilingual or multilingual, they have the option to be assessed for competency in limited translation of the services provided (and will not be deemed interpreters). Regarding translation of printed items, Sandra Eskenazi MHC has access to Eskenazi Health's Translation Services, a division specifically charged with translating documents into non-English languages.</p>

1.d.3	As stated, Sandra Eskenazi MHC has full access to the resources of Eskenazi Health to ensure that those who need additional communication, interpretation and translation support receive them as needed. For hearing impaired clients, a VRI unit is utilized to access a qualified interpreter skilled in American Sign Language (ASL). If someone is not available, there is the ability to request an ASL interpreter from Crossroads Rehabilitation.
1.d.4	Regarding translation of printed items, Sandra Eskenazi MHC has access to Eskenazi Health's Translation Services, a division specifically charged with translating documents into Spanish. Translation services works with various vendors for translations in languages other than Spanish. Primary documents are available on the Eskenazi Health website in Spanish and English.
1.d.5	As a division of Eskenazi Health, Sandra Eskenazi MHC acknowledges and follows the privacy and confidentiality policies established by Eskenazi Health's privacy officer and legal department. Staff are made aware of and have immediate access to these policies. Privacy standards are reviewed every year during hospital annual education.

Program Requirement 2: Availability and Accessibility of Services

Criterion #	Criterion	Do you currently meet this criterion?	If not, will you be able to meet this criterion by 7/1/24?
2.a.1	The CCBHC provides a safe, functional, clean, sanitary, inclusive, and welcoming environment for staff and people receiving services, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses and as required by State contracts. CCBHCs must align with standards provided by a State-approved accreditation body.	Yes	
2.a.2	Informed by the community needs assessment, the CCBHC ensures that all services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including outside of standard business hours, such as some evening and weekend hours. In addition, crisis response services will be available through the CCBHC 24 hours per day, 7 days a week.	Yes	
2.a.3	Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and preferred by the person receiving services and family, in the homes of people receiving services. The preferred location of the person receiving services will be honored when safe. Other additional allowable sites for CCBHC services include but are not limited to group homes and nursing facilities. Services are restricted to those activities not billable or included into a payment structure or per diem by Medicaid.	Yes	
2.a.4	The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate	Yes	

	access to services in alignment with the person-centered and family-centered treatment plan. The CCBHC will assist the person receiving services in navigating transportation access, including but not limited to sharing relevant phone numbers and websites to schedule transportation. The CCBHC will document in the treatment plan and address transportation barriers for the person receiving services, if applicable.		
2.a.5	<p>The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with best practices and the preferences of the person receiving services to support access to all required services. The CCBHC shall adhere to State telehealth guidelines.</p> <p>All listed and related technologies must adhere to the same in-person confidentiality guidelines that are outlined in Criteria 3.a.2.</p>	No	Yes
2.a.6	Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.	Yes	
2.a.7	Services are subject to all state standards for the provision of both voluntary and court- ordered services.	Yes	
2.a.8	The CCBHC develops and maintains a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.	Yes	

	<p>The CCBHC is required to respond to disasters or public calamities as defined by IC 10-14-3-1. The CCBHC will designate a primary and secondary point of contact who can be contacted to coordinate their organization's available staff when planning for or responding to a disaster or mass violence event. The contact information for the primary and secondary point of contact must be shared with DMHA.</p>		
2.b.1	<p>All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in- person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs (routine, urgent, or emergent). That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.</p> <ul style="list-style-type: none"> • The preliminary triage must be completed during the first contact. • Based on preliminary triage, the initial evaluation request is offered within 24 hours for emergent needs, one business day for urgent needs, and within 10 business days for routine needs unless the person receiving services chooses otherwise. • A comprehensive evaluation must occur within 60 days. • For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. <p>The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each</p>	Yes	

	<p>specified in program requirement 4. At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.</p> <p><i>Note: Requirements for these screenings and evaluations are specified in criteria 4.d.</i></p> <p>Please note that the State does not anticipate same or next day access will be achieved by the CCBHC immediately. Required staffing changes (including new and unfilled positions) to ensure same or next day access must be included in the Community Needs Assessment and PPS rate calculations.</p>		
2.b.2	<p>The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals, changes in individual status, changes in level of care, and/or at the request of the person receiving services or their legal guardian. The treatment plan must be reviewed and updated no less frequently than every 90 days, unless the state, federal, or applicable accreditation standards are more stringent.</p>	Yes	

2.b.3	<p>People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided with an appointment within 10 business days of the request, unless the person receiving services chooses otherwise. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with an urgent non-emergency need or hospital discharge, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Open access scheduling is encouraged.</p> <p>Discharge planning from outpatient or emergent care settings (e.g., hospitals, jail-based, residential facilities) is encouraged to occur while the individual is at the respective facility.</p>	Yes	
2.c.1	In accordance with program requirement 4.c and 2.a.2, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week. Crisis management services include but are not limited to mobile crisis teams and Crisis Receiving Stabilization services.	Yes	
2.c.2	<p>A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public. The CCBHC is required to align methods with SAMHSA best practices and state code.</p> <p>Sample postvention services include but are not limited to: local community Local Outreach to Suicide Survivors (LOSS), suicide loss support groups, and Alternatives to Suicide Peer Support Groups.</p>	No	Yes
2.c.3	Individuals who are served by the CCBHC are educated about crisis prevention planning and safety planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and	No	Yes

	other area hotlines and warmlines, and overdose prevention, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis prevention planning. This includes but is not limited to individuals with LEP (limited English proficiency), individuals with disabilities, older adults, and others with dually diagnosed psychiatric and developmental disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).		
2.c.4	In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs), including Acute Psych EDs. Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.	Yes	
2.c.5	<p>Protocols, including those for the involvement of law enforcement and the court system (drug courts, veteran courts, problem solving courts, etc.), are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system while promoting individual and public safety, and complying with applicable state and local laws and regulations. The CCBHC is recommended to have protocols that include the Justice Reinvestment Advisory Council (JRAC) or other local justice advisory groups as a collaboration partner.</p> <p><i>Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.</i></p>	Yes	
2.c.6	Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis prevention plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.	No	Yes

	<p>The crisis prevention plan should include but is not limited to: 988 crisis response system information, evidence of participation of person receiving services, and information and resources about supports (please see criterion 3.a.4 for more details on crisis prevention planning requirements). Once finalized, a copy of the crisis prevention plan should be shared with the person receiving services and their relevant caregiver/support person when possible and with permission.</p> <p>Crisis prevention plans should be completed at initial evaluation to gather information around triggers leading to mental health crisis or substance use crisis, signs of mental health or substance use crisis, coping skills, informal supports, formal supports, and other related topics.</p>		
2.d.1	<p>The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)); and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1). People seeking services should be able to receive behavioral health care and crisis response services regardless of their ability to pay, what service provider they work with, and other personal information including diagnoses, age, and history.</p>	Yes	
2.d.2	<p>The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.</p>	Yes	
2.d.3	<p>The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal</p>	Yes	

	requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.		
2.d.4	The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.	Yes	
2.e.1	The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address.	Yes	
2.e.2	The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking non- crisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience out-of- home placements and adults who are displaced by incarceration or housing instability. In compliance with federal and state policies, the CCBHC must share necessary medical records with the new provider if a person receiving services changes providers and consents to sharing information.	No	Yes

	All listed and related technologies must adhere to the same in-person confidentiality guidelines that are outlined in Criteria 3.a.2.		
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Program Requirement 2: Availability and Accessibility of Services Narrative

Please provide a narrative explaining your current ability to meet the Certification Criteria in Program Requirement 2. For each criterion, please address:

1. If you currently meet the criterion, how are you doing so?
2. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
3. If you are exceeding the criterion requirements, what are you doing?

2.a.1	Sandra Eskenazi MHC and Eskenazi Health have enforced smoke-free campuses for many years. This policy is consistent with our commitment to being leaders in healthcare. Through Eskenazi Health we have on-site clinic security, contracted environmental services, and capital improvements that keep the clinic campuses smoke-free and up to standard.
2.a.2	Sandra Eskenazi MHC has locations across Indianapolis that ensure access to services. All Sandra Eskenazi MHC clinics are open into the evening. The Eskenazi Hospital campus has crisis services available 24/7 with crisis clinicians and psychiatric staff through the Crisis Intervention Unit, the Emergency Department, and Psychiatric Triage (23-hour observation). There is a CCBHC mobile crisis team that operates 24 hours a day, 7 days a week.
2.a.3	Sandra Eskenazi MHC has locations and programs across Indianapolis that ensure access to services. We have behavioral health staff in 20 school locations. The CCBHC provides clinic-based support to clients in group home, transitional, and semi-independent living programs. Sandra Eskenazi MHC prides itself on being a community-based behavioral health center that has teams providing psychiatric rehabilitation services, clinical services, and nursing services in the community where clients live and work.
2.a.4	Sandra Eskenazi MHC can provide transportation services, bus tickets, or vouchers for individuals receiving services. The Crisis Intervention Unit provides cab services. Sandra Eskenazi MHC outpatient programs provide

	<p>bus tickets upon request/need and has access to Eskenazi Health transportation services to assist in transportation between healthcare facilities.</p>
2.a.5	<p>During the pandemic, Sandra Eskenazi MHC implemented telehealth/telemedicine, video conferencing, asynchronous interventions, and improved its use of technologies like WebEx and SharePoint for internal collaboration and coordination. Backed by Eskenazi Health's Information Systems Administration (IS), Sandra Eskenazi MHC has access to resources and supports necessary to provide service delivery via telehealth. However, it should be noted that telehealth is used for near-term problem solving, cancellations, and to substitute visits for no-shows. Protocol for when telehealth options should be provided include:</p> <ul style="list-style-type: none"> • Patient is ill but well enough to participate in telehealth session • Patient's transportation falls through at last minute • Alternate patients identified after initial patient no-shows or cancelled that can attend in that slot via telehealth
2.a.6	<p>Sandra Eskenazi MHC, as a division of Eskenazi Health, is under auspices of The Health & Hospital Corporation of Marion County (HHC). As part of Eskenazi Health and HHC, Sandra Eskenazi MHC is often tasked by the City of Indianapolis/Marion County (as well as by DMHA/State of Indiana) with unique community behavioral health and social work initiatives that often exist outside of traditional community mental health center services. Current examples of initiatives that focus on outreach, engagement, and retention activities for underserved populations are the Mental Health Toolkit, the Assessment and Intervention Center (AIC), Mobile Crisis Assistance Team (MCAT), and the John and Kathy Ackerman Mental Health Professional Development Center. The Community Needs Assessment validated the need for outreach and engagement as nearly 26,000 adults with SMI and 55,000 adults with substance use disorder have not accessed treatment. Initiatives such as the Mental Health Toolkit, AIC, and MCAT get at the heart of addressing that community need.</p> <p>The Mental Health Toolkit's focus is providing outreach and behavioral health information to reduce stigma and increase access to care for communities of color in Indianapolis. Mental Health Toolkit staff use Mental Health First Aid (MHFA) as a modality of training; in fact, the program currently provides funding for individuals in those communities to become MHFA trainers to perpetuate the initiative. Another exciting part of the Mental Health Toolkit initiative is the inclusion of a mental health care coordinator embedded at Wheeler Mission to provide immediate aid for client needs and to assist them in navigating treatment. There has been a 30% reduction in</p>

	<p>ambulance runs to Wheeler Mission since establishing this team member on site. Sandra Eskenazi MHC operates the AIC, a partnership with the City of Indianapolis Office of Public Health and Safety, to link individuals to the right treatment at the right time while reducing potential for incarceration or returning to emergency departments for emergent care. The MCAT team is the co-responder team for Marion County in partnership with the Indianapolis Metropolitan Police Department (IMPD) to ensure that mental health events are handled as such and not as potentially criminal infractions. When law enforcement interactions with a person experiencing mental illness are handled as a mental health event, MCAT is then able to assist in access to care. Lastly, as previously mentioned, Sandra Eskenazi MHC has made workforce development a focus of its organization since 2019, which has culminated in the John & Kathy Ackerman Mental Health Professional Development Center. The Ackerman Center's focus is to increase the number of qualified clinicians and mental health workers who serve often marginalized and underserved populations. By partnering with education institutions or peer-serving organizations like the Indiana Counselor's Association on Alcohol and Drug Abuse (ICAADA), Sandra Eskenazi MHC's intent is to prepare the next generation of mental health workforce in community mental health and CCBHC service delivery.</p>
2.a.7	<p>Sandra Eskenazi MHC is compliant with all state standards regarding voluntary and court-ordered services. EH policy and procedure ensure ongoing compliance, as well as consultation through Eskenazi Health's legal department.</p>
2.a.8	<p>Sandra Eskenazi MHC, in conjunction and collaboration with Eskenazi Health, maintains disaster and business continuity plans. Additionally, Sandra Eskenazi MHC actively participates in state meetings regarding Resilience and Emotional Support Teams (REST) and maintains such a team at Eskenazi Health to ensure our capability to respond to locate acute crises and regional disasters. Policies are maintained for each of the aforementioned.</p>
2.b.1	<p>In preparation to become a CCBHC and to ensure best practice regarding access to care, Sandra Eskenazi MHC began the process of moving its outpatient clinics to same-day access in 2020 and completed that change process in the summer of 2021. The same-day access intake is not a brief triage, but rather a full behavioral health intake with a full comprehensive biopsychosocial assessment, that includes all the bullets listed in 4.d.3 for initial evaluation (e.g., preliminary diagnoses, source of referral, risk assessment, medications, substance/alcohol use) and 4.d.4 for comprehensive evaluation (e.g., reasons for seeking services at the CCBHC, overview of social supports, behavioral health history, relevant medical history). This was a significant undertaking during the pandemic, but a needed one as Sandra Eskenazi MHC was one of the few regional CMHCs to continue to take</p>

	<p>new clients. We truly saw an explosion of new clients coming to our center from all corners of Marion County. This resulted in plans to open a new behavioral health clinic and to expand the OTP in the 2nd quarter of 2024. Both are opening in areas of Marion County where heat mapping of both current clients and of drug overdose deaths indicate high levels of community need. As an integral part of the Eskenazi Health safety net, Sandra Eskenazi MHC wants to safeguard immediate access to care for our community, ensuring that we have the staffing plan and available services to sustain this effort.</p>
2.b.2	<p>Sandra Eskenazi MHC's treatment plans are person- and family-centered. They are updated per policy when clinically relevant (e.g., recent hospitalization or suicidal ideation) or every 90 days or less. The treatment planning and review process is a multi-disciplinary endeavor pulling together psychiatry, psychology, case management, nursing, social work, and skills development.</p>
2.b.3	<p>Through Sandra Eskenazi MHC's same-day access initiative, we ensured that both new and current clients have access to services upon request. Additionally, Sandra Eskenazi MHC implements a morning throughput call that includes crisis services, psychiatric triage, psychiatric acute care, and outpatient services to coordinate discharges from crisis, triage, or acute care services with outpatient services, ensuring that each client is seen as required or requested. To assist with discharge dispositioning and navigation, Sandra Eskenazi MHC created and will hire an inpatient/emergency room liaison to coordinate care between a hospitalization and clinic follow-up. As part of the same-day access process, Sandra Eskenazi MHC also created the ability to provide clinical services upon request, including next-business-day, for urgent non-emergency need or hospital discharge. This is one of the functions of the morning agency throughput call.</p>
2.c.1	<p>Sandra Eskenazi MHC has a Mobile Crisis Recovery Team (MCRT) that serves as the CCBHC mobile crisis team. They are available 24 hours a day, 7 days a week. Crisis services are also available at the Eskenazi Hospital location 24 hours a day, 7 days a week. Clinicians are available in the Emergency Department and the Crisis Intervention Unit to assess individuals in crisis. Last, the Psychiatric Triage is our crisis receiving stabilization unit that provides 23-hour observation, allowing additional time for clinician and physician assessment and disposition planning.</p>
2.c.2	<p>Sandra Eskenazi MHC currently does not have a policy that outlines a continuum of crisis prevention, response, and postvention. This policy will be created and executed before the July 1, 2024 deadline utilizing our internal policy development process.</p>

2.c.3	Clients are provided information at initial visit (intake) regarding available crisis services, such as Sandra Eskenazi MHC's Crisis Intervention Unit. However, no education on crisis prevention or safety planning is provided at the initial visit, as safety planning (informed by Stanley-Brown safety planning) is currently conducted as a postvention activity after a crisis. Crisis planning and education is conducted during our CCBHC SAMHSA Expansion clinic and will be expanded to all clinics in the CCBHC prior to July 1, 2024.
2.c.4	As part of Eskenazi Health, Sandra Eskenazi MHC has a close working relationship with the hospital's Emergency Department, as we provide assessment and consultation through our Crisis Intervention Unit. Additionally, Sandra Eskenazi MHC manages a Psychiatric Triage. The program has guidelines in place for working with the Emergency Department through our Mobile Crisis Recovery Team handbook. Workflows have been developed as well in the Epic electronic health record that both Sandra Eskenazi MHC and the Emergency Department share. Lastly, Sandra Eskenazi MHC conducts a morning agency throughput call between crisis services, psychiatric triage, psychiatric acute care, and outpatient services to coordinate discharges from crisis, triage, or acute care services with outpatient services, ensuring that each client is seen as required or requested. Our Crisis Intervention Unit has strong relationships with other area hospitals and is often contacted for consultation or transfer when Sandra Eskenazi MHC clients appear in their systems. These relationships will be enhanced with the addition of an inpatient/emergency room liaison who can coordinate care among systems upon client hospital discharge.
2.c.5	Sandra Eskenazi MHC collaborates with all specialty courts and participates in the Marion County Re-Entry Coalition. Sandra Eskenazi MHC also participates in PAIR, the Psychiatric Assertive Identification Program that allows those individuals meeting serious mental illness (SMI) criteria to defer incarceration and have charges dismissed through a minimum of twelve months of treatment and case management at Sandra Eskenazi MHC.
2.c.6	Sandra Eskenazi MHC implemented safety planning for crisis situations/high risk behaviors in 2016 based upon the Stanley-Brown Safety Plan. This is written into our suicide assessment policy with supported workflows in the Epic electronic health record. However, safety planning is not routinely conducted with clients at intake. Sandra Eskenazi MHC will implement this before July 1, 2024, as the infrastructure, both in terms of Epic support and clinical workflows, exists and would afford a logical and supported transition to this process.

2.d.1	Sandra Eskenazi MHC has policies and associated workflows in place to ensure (1) access to care regardless of ability to pay, age, history, and other demographics; and (2) availability of a sliding fee schedule to ensure access of care regardless of ability to pay.
2.d.2	Sandra Eskenazi MHC has policies and associated workflows in place regarding the established sliding fee discount program. The sliding fee scale addresses all services provided by the CCBHC and is accessible to individuals and families receiving services. The sliding fee scale is communicated in languages/formats for individuals seeking services who have LEP, literacy barriers, or disabilities.
2.d.3	Sandra Eskenazi MHC worked closely with all relevant Eskenazi Health divisions (finance, billing, compliance, revenue cycle) to ensure that all fee schedules meet all state and federal requirements.
2.d.4	Sandra Eskenazi MHC has policies and associated workflows in place regarding the established sliding fee discount program.
2.e.1	Sandra Eskenazi MHC ensures access to care for all individuals seeking services and has codified this in policy. Sandra Eskenazi MHC is committed to working with those experiencing homelessness and has done so since its existence. Currently Sandra Eskenazi MHC works with the City of Indianapolis in the Continuum of Care and has a dedicated clinical team that works with Permanent Supportive Housing clients seeking Sandra Eskenazi MHC clinic services.
2.e.2	Sandra Eskenazi MHC does not currently have formalized protocols or policy in place to address the needs of individuals who do not live close to the CCBHC. These needed protocols will be written into policy or area specific guidelines (for those areas working with special populations) by July 1, 2024.

Program Requirement 3: Care Coordination

Criterion #	Criterion	Do you currently meet this criterion?	If not, will you be able to meet this criterion by 7/1/24?
3.a.1	<p>Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.</p> <p><i>Note: See criteria 4.k relating to care coordination requirements for veterans.</i></p>	Yes	
3.a.2	<p>The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited at time of treatment plan review and/or as needed.</p> <p><i>Note: CCBHCs are encouraged to explore options for electronic documentation of</i></p>	Yes	

	<i>consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.</i>		
3.a.3	Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports. The CCBHC must follow up with the person receiving services or their parent/guardian to ensure they were able to access services they were referred to, including external referral sources. The CCBHC must document follow-up services in the patient's record.	Yes	
3.a.4	The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis prevention plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline (988), local hotlines, warmlines, mobile crisis, stabilization services, and Recovery Hubs peer recovery supports (211) should a crisis arise when providers are not in their office. Crisis prevention plan specifics are detailed in Criteria 2.c.6.	Partial	Yes
3.a.5	Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care. If the person receiving services is on methadone treatment, the CCBHC	Partial	YES

	must connect with the Opioid Treatment Program (OTP) to adequately provide services.		
3.a.6	Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services and/or their parent/guardian to choose their provider within the CCBHC, with its DCOs, or with any other provider. The CCBHC must include language around freedom of choice, as part of the patient's rights documents. This language shall include that a person receiving services has the freedom to choose their provider and to change their provider, without having to specify a reason.	Yes	
3.a.7	The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.	Yes	
3.b.1	The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The CCBHC must agree to interact with 988 state-owned software for mobile crisis dispatch and Crisis Receiving and Stabilization Services providers and outpatient follow-up referral.	No	Yes
3.b.2	The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.	Yes	

	The CCBHC is expected to share data with the State in accordance with the requirements set forth in its contractual agreement to provide CCBHC services.		
3.b.3	<p>The CCBHC uses technology that has been certified to current criteria¹³ under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities (see footnotes for citations to the required health IT certification criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs:</p> <ul style="list-style-type: none"> -Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible). -At a minimum, support care coordination by sending and receiving summary of care records. -Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice. -Provide evidence-based clinical decision support. -Conduct electronic prescribing. <p><i>Note: Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.</i></p>	Yes	

3.b.4	The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	Yes	
3.b.5	The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.	Yes	
3.c.1	<p>The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.</p> <p><i>Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care</i></p>	Yes	

	<p><i>coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.</i></p>		
3.c.2	<p>The CCBHC has partnerships that establish care coordination expectations with programs that utilize evidence-based practices to provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, residential substance use disorder treatment programs, school-based mental and behavioral health services, and/or social work services (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge (including a plan if the person receiving services is not being referred or receiving additional care), and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.</p> <p><i>Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party; the CCBHC may utilize guidance documents from the State for such partnerships if they exist. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care</i></p>	No	Yes

	<p><i>coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.</i></p>		
3.c.3	<p>The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required to develop partnerships with the following organizations that operate within the service area:</p> <ul style="list-style-type: none"> • Schools and Local Education Agencies (LEAs) • Child welfare agencies • Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts) • Indian Health Service youth regional treatment centers, where applicable • State licensed and nationally accredited child placing agencies for therapeutic foster care service • Other social and human services • Local Outreach to Suicide Survivors Teams (LOSS) <p>CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following:</p> <ul style="list-style-type: none"> • Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders • Suicide and crisis hotlines and warmlines 	Partial	Yes

	<ul style="list-style-type: none"> • Indian Health Service or other tribal programs • Homeless shelters or other housing supports • Housing agencies • Employment services systems • Peer-operated programs • Services for older adults, such as Area Agencies on Aging • Aging and Disability Resource Centers • State and local health departments and behavioral health and developmental disabilities agencies • Substance use prevention and harm reduction programs • Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers • Legal aid • Immigrant and refugee services • SUD Recovery/Transitional housing • Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs • Coordinated Specialty Care programs for first episode psychosis • Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs, LGBTQ+ centers or organizations) <p>In addition, the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.</p> <p>The State may require CCBHCs to establish additional partnerships based on the Community Needs Assessment.</p>		
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3.c.4	<p>The CCBHC has partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type. The CCBHC is required to have partnerships with a training provider who utilizes evidence-based and cultural fluency practices for those who are active or have served in the military.</p> <p><i>Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.</i></p>	No	Yes
3.c.5	<p>The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient</p>	No	Yes

	<p>facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge- Transfer (ADT) system.</p> <p>The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.</p> <p><i>Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.</i></p>		
3.d.1	<p>The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person- and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.</p>	Yes	

3.d.2	<p>The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. The interdisciplinary team should meet at a cadence that aligns with the person receiving service's treatment planning updates, in accordance with the treatment plan cadence, or at the request of the person receiving services. It is expected that care provided is person-centered, strengths based, wellness focused, and trauma-informed.</p> <p>The CCBHC may determine how to best staff their interdisciplinary team and which functions staff carry out. The interdisciplinary team must include staff that address short-term and long-term support/care coordination, medication management, medical needs, access to peer services, and/or coordination with other services and supports.</p>	Yes	
3.d.3	<p>The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan.</p> <p><i>Note: See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.</i></p>	Yes	

Program Requirement 3: Care Coordination Narrative

Please provide a narrative explaining your current ability to meet the Certification Criteria in Program Requirement 3. For each criterion, please address:

1. If you currently meet the criterion, how are you doing so?
2. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
3. If you are exceeding the criterion requirements, what are you doing?

3.a.1	Sandra Eskenazi MHC has long used person-centered and family-centered treatment planning (when allowed by the client or if the client is a minor) as the framework for outlining the client's goals/strengths/barriers and how the organization will operationalize those into an intervention plan that helps the client get closer to their stated goal. As the treatment plan is comprehensive and multidisciplinary, it coordinates care across the spectrum of CCBHC services.
3.a.2	Sandra Eskenazi MHC, being an integral part of Eskenazi Health, has very robust policies and safeguards in place to ensure privacy of medical records, including 42CFR Part 2. Sandra Eskenazi MHC works very closely with Eskenazi Health's Information Security and Legal departments, and the organization's Privacy Officer to ensure strict compliance with those laws and regulations.
3.a.3	Sandra Eskenazi MHC care coordination and nursing staff routinely work with clients and families of children to access needed external services as the client indicates such needs and requests such help. Staff is expected by policy to acquire all necessary Releases of Information and to document the who/what/where/why of the care coordination service. And, as part of the coordination of the client's ongoing care, monitoring and documenting follow-up is required.
3.a.4	Sandra Eskenazi MHC currently meets all conditions of this criterion except for the development of a crisis plan at initial assessment (intake). According to policy, we routinely complete safety plans (Stanley-Brown based) for all clients that have been in crisis who express or demonstrate harm to self or others (including self-injurious behavior). Safety/crisis planning at intake can be implemented before July 1, 2024, as staff currently possess the training/skill and have an electronic health record (Epic) that already has the necessary flowsheets and workflows required for implementation.
3.a.5	Sandra Eskenazi MHC follows State regulatory requirements in the use of INSPECT and acquiring releases from care providers outside the system to verify the reason for and type of medication. Sandra Eskenazi MHC can ensure that INSPECT is reviewed for all initial evaluations by prescribers prior to July 1, 2023.

3.a.6	Sandra Eskenazi MHC has all required policies and protocols in place to ensure that CCBHC clients are made aware of their rights and responsibilities, including being able to change providers without cause.
3.a.7	As a part of Eskenazi Health, Sandra Eskenazi MHC has full access to Eskenazi Health's patient financial eligibility specialists who can assist all clients through the Medicaid application and renewal process. In addition, Sandra Eskenazi MHC's care coordinators and peer recovery coaches routinely assist in acquiring all needed documents for benefits/supports and/or linking clients to those benefits/supports.
3.b.1	Sandra Eskenazi MHC utilizes Epic as its electronic health record system. Regarding 988 State-owned software, Sandra Eskenazi MHC agrees to interact with this software for mobile crisis dispatch and other required services when the State identifies the software and makes the specifications available.
3.b.2	Sandra Eskenazi MHC and Eskenazi Health utilize Epic as their electronic health record. Epic is a powerful and robust system that has the necessary protections to document client activity, connect with third party payers, and provide the analytics necessary to evaluate outcome and compliance to all necessary standards, including CCBHC. Eskenazi Health has ensured that Epic is ONC Health IT certified as this is required for promoting interoperability attestation. Additionally, Eskenazi Health has achieved Healthcare Information and Management Systems Society (HIMSS) Stage 7 for both outpatient and inpatient services. HIMSS recognition highlights an organization's use of technology to improve patient outcomes and experience.
3.b.3	Eskenazi Health utilizes Epic as an electronic health record. Eskenazi Health has ensured that Epic is ONC Health IT certified as this is required for promoting interoperability attestation. As part of Eskenazi Health, Sandra Eskenazi MHC utilizes and has full benefit of Epic.
3.b.4	Sandra Eskenazi MHC has the necessary policies/procedures/protocols in place to ensure privacy and confidentiality requirements. If Sandra Eskenazi MHC required enlistment of a DCO, the DCO would be expected to comply with those requirements. Their ability to comply will be evaluated by Eskenazi Health's legal and information security divisions before execution of any contract.
3.b.5	Sandra Eskenazi MHC is fortunate to be a part of the Eskenazi Health network, which includes the State's largest FQHC, Specialty Care clinics, and a Level 1 Burn Center, all of which utilize Epic as their health record. Additionally, through Epic's Care Everywhere, Sandra Eskenazi MHC can review admissions/visits to other partner

	<p>hospitals, such as Community Health Network or St. Francis. However, it must be noted that Care Everywhere does not provide accessibility to behavioral health records. If Sandra Eskenazi MHC needed to enter a DCO, we will develop a plan that encourages a health information exchange to improve care transition to and from the CCBHC. Sandra Eskenazi MHC has access to Eskenazi Health's Information Security service area that will work with us to ensure implementation when needed.</p>
3.c.1	<p>Sandra Eskenazi MHC is connected to the largest FQHC system in Indiana and currently documents efforts to establish care coordination agreements with other FQHCs in Marion County.</p>
3.c.2	<p>Sandra Eskenazi MHC can provide many services without the need for care coordination agreements. For example, Sandra Eskenazi MHC has its own psychiatric triage, acute psychiatric inpatient unit, opioid treatment program, and residential services. However, we are actively working to enter into care coordination agreements with the various service providers that a client could utilize within the region. Sandra Eskenazi MHC is currently developing a position that will be hired before 7/1/2024 that will focus on the coordination of care for individuals transitioning from EDs, external acute psychiatric units, addictions residential, and other such services back to outpatient treatment within the CCBHC. Additionally, Sandra Eskenazi MHC will also formalize protocols and create policies that outline the protocols needed for the transitions of care by the stated deadline.</p>
3.c.3	<p>Sandra Eskenazi MHC formally established agreements with many of the required partners, including MOUs with 20 plus schools where we provide services; a contract with the Department of Child Services, which includes services needed for those involved with the juvenile justice system; and an agreement with probation to access addiction services. Before July 1, 2024, we will establish care coordination agreements with local outreach to suicide survivors' teams (LOSS) (or a comparable postvention support group), foster care, the Veteran's Administration, and the 988-call center in our area.</p> <p>Regarding suggested partnerships, Sandra Eskenazi MHC currently partners with Wheeler Mission, the Indianapolis Continuum of Care, Vocational Rehabilitation, ICAADA, Indiana Legal Service's Medical-Legal Partnership (MLP), Marion County Public Health Department (as part of The Health & Hospital Corporation of Marion County), Indianapolis Office of Public Health Safety, Indianapolis Metropolitan Police Department, and many others. Additionally, Sandra Eskenazi MHC has the regional flagship Coordinated Specialty Care for Early Psychosis (PARC program), which we have run continuously since 2014.</p>

3.c.4	Sandra Eskenazi MHC does not have a care coordination agreement or MOU in place with the Department of Veterans Affairs' medical center or outpatient services but plans to establish an MOU before July 1, 2024. It should be noted that the attempt has been made with little or no response from the VA. When The Joint Commission (TJC) surveyed Sandra Eskenazi MHC as a CCBHC in July 2023, we requested assistance in accomplishing this and were given indication that they would help. State assistance may likely be helpful in fully meeting this requirement as we are not the only SAMHSA granted-CCBHC with this challenge.
3.c.5	Sandra Eskenazi MHC has care coordination agreements with some hospitals within the CCBHC's service area. We will ensure an agreement is established for all hospitals in the service area before July 1, 2024. Sandra Eskenazi MHC is in the process of finalizing one such agreement with Fairbanks Hospital (Community Health Network).
3.d.1	Sandra Eskenazi MHC embraced SAMHSA's Recovery Model and instituted it as its model of care in 2012. It influences and permeates through policy, language, culture, and service provision. The client (or guardian as relevant) helps drive treatment by helping the clinical team understand how they see recovery and what they hope to gain from recovery.
3.d.2	Sandra Eskenazi MHC prides itself on working with a robust and deep interdisciplinary team that includes all Sandra Eskenazi MHC staff members in their individual service areas as well as other Eskenazi Health teams (such as primary care in the FQHCs or the Gender Wellness clinic in Specialty Care). Treatment planning is approached from an interdisciplinary method understanding that the client (or guardian as relevant) is leading the team in a recovery-oriented manner to define treatment as the client conceptualizes recovery.
3.d.3	Sandra Eskenazi MHC will coordinate care and services provided by DCOs in accordance with the current treatment plan when applicable to the client and services provided.

Program Requirement 4: Scope of Services

Criterion #	Criterion	Do you currently meet this criterion?	If not, will you be able to meet this criterion by 7/1/24?
4.a.1	Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. The CCBHC organization will directly deliver the majority (51% or more) of encounters across the required service (excluding Crisis Services) rather than through DCOs. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. All DCOs that the CCBHC contracts with must be currently certified or designated when applicable in their field of service. The CCBHC must document the relationship with a DCO with an MOU or other contractual arrangement, and will inform DMHA as part of the designation/certification process.	Yes	
4.a.2	The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities. The CCBHC must include language around freedom of choice, as part of the patient's rights documents.	Yes	

	The CCBHC is required to document services they directly provide and then services they link with a DCO to provide. This information must be available online, in paper, and highly accessible.		
4.a.3	<p>With regard to either CCBHC or DCO services, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.</p> <p>The CCBHC must develop a grievance procedures client guide that explains processes, procedures, and client rights (including, but not limited to switching providers and filing a grievance). The client guide must be written in an accessible and easy to understand manner, and available in multiple languages and modalities. The CCBHC is required to post the CCBHC grievance policies in highly visible and accessible places.</p> <p>The CCBHC must display information about the DMHA consumer service line, disability rights hotline, and other relevant resources, as part of patient's rights documents. This information must be available online, in paper, and posted in highly visible and accessible places.</p>	Yes	
4.a.4	DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.	Yes	
4.b.1	The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services	Yes	

	<p>and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach.</p> <p>The CCBHC must receive consent from the person receiving services and/or their legal guardian. Criteria 4.b.1 must be included as part of patient's rights documents and be posted in high visibility areas.</p>		
4.b.2	<p>Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.</p> <p>The CCBHC must include language around person-centered and family-centered care, as part of the patient's rights documents. Person-centered and family-centered care is responsive to the person receiving services and includes care which recognizes and respects the individual's cultural and other needs.</p>	Yes	
4.c.1	<p>The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so.</p> <p>The State must request approval from HHS to certify CCBHCs that have or seek to</p>	Partial	Yes

	<p>have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.</p> <p>PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO. The CCBHC must develop and document procedures on how they provide the three crisis behavioral services below:</p> <ul style="list-style-type: none"> Emergency crisis intervention services: The CCBHC coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC)23 systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care. 24-hour mobile crisis teams: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (90 minutes in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 90-minute response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their 		
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	<p>programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan.</p> <ul style="list-style-type: none"> Crisis receiving/stabilization: The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. <p>Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The</p>		
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	<p>CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.</p> <p><i>Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.</i></p>		
4.d.1	<p>The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. All relationships with a DCO or other consultation organization must be documented by the CCBHC.</p> <p>When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. All screening tools must be evidence-based. Multiple tools may be used such as screening suicide risk and violence risk. Other screening tools and assessments may be used to measure progress and outcomes, as well as level of care (<i>i.e.</i>, LOCUS).</p>	Yes	
4.d.2	<p>Screening, assessment, and preliminary diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and meeting other CCBHC criteria for emergent, urgent, and routine appointments. They are of sufficient scope to assess the need for all services required to be provided by the CCBHC.</p>	Yes	

4.d.3	<p>The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum:</p> <ol style="list-style-type: none"> 1. Preliminary diagnoses 2. The source of referral 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services 5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications 6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful 7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications 8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors 9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence 10. Assessment of need for medical care (with referral and follow-up as required) 11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services 12. For children and youth, whether they have system involvement (such as schools, child welfare, and/or juvenile justice) <p>The initial evaluation is conducted by a licensed Master's degree level clinician, licensed clinician, or clinical trainee, set forth in its contractual agreement to provide CCBHC services</p>	Yes	
4.d.4	<p>A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians</p>	Yes	

	<p>should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs, and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall gather information for a treatment plan and crisis prevention plan. The comprehensive evaluation must be completed within 60 days of initial evaluation. Providers that oversee the treatment plan are required to see the person receiving services and family/legal guardian again, if applicable, or review the documentation to certify the treatment and specific treatment methods at intervals not to exceed 90 days, unless the state, federal, or applicable accreditation standards are more stringent. These reviews must be documented in writing. The evaluation shall include:</p> <ol style="list-style-type: none"> 1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. 2. An overview of relevant social supports; social determinants of health; and health- related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. 3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP. 4. Pregnancy and/or caregiver status. 5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments. 6. Relevant medical history and major health conditions that impact current psychological status. 7. A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications 		
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	<p>of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.</p> <ol style="list-style-type: none"> 8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement- based care), substance use disorders (including tobacco, alcohol, and other drugs), and gambling. 9. Basic cognitive screening for cognitive impairment. 10. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. 11. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. 12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services). 13. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. 14. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. 15. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions. 		
4.d.5	Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program	No	Yes

	<p>requirement 5, Attachment F Quality Metrics, and Attachment G Evidence Based Practices, Assessments, and Screeners. The CCBHC should not take non-inclusion of a specific metric in Attachment F or G as a reason not to provide clinically indicated behavioral health screening or assessment.</p> <p><i>The State will define a pre-approved list of screening and assessment tools that a CCBHC may use and is considering those listed in Attachment G. The State will also establish a list of required Evidence-Based Practices that each CCBHC must use and optional, recommended practices. These lists will be finalized during the Demonstration Program, informed by CNAs, data submitted in other State systems, and findings during the Demonstration.</i></p>		
4.d.6	The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement. The CCBHC must use State-approved screening and assessment tools.	Partial	Yes
4.d.7	The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate. The CCBHC should utilize interpreters when possible, pursuant to their community's needs. Interpreters must be fluent in English and the relevant non-English language, and meet the remaining qualifications outlined in Criteria 1.d.2.	Yes	
4.d.8	If the preliminary triage identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC, or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1.	Yes	

4.e.1	<p>The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis prevention planning (CCBHCs may work collaboratively with DCOs to complete these activities). Person-centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person receiving services involvement and self-direction.</p> <p><i>Note: See program requirement 3 related to coordination of care and treatment planning.</i></p>	Yes	
4.e.2	<p>The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The treatment plan will document how identified transportation barriers will be addressed, if applicable. The treatment plan must clearly demonstrate evidence for diagnoses and address which EBPs will be employed for said diagnoses. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.</p>	Yes	
4.e.3	<p>The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided. An initial treatment plan is required within 60 days of</p>	Yes	

	<p>first contact. The initial evaluation must be completed at first visit, with background information submitted during screening.</p> <p>Providers that oversee the treatment plan are required to see the person receiving services and family/legal guardian again, if applicable, or review the documentation to certify the treatment and specific treatment methods at intervals not to exceed 90 days, unless the state, federal, or applicable accreditation standards are more stringent. These reviews must be documented in writing.</p>		
4.e.4	Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.	Yes	
4.e.5	The treatment plan is comprehensive, addressing all services required, including recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.	Yes	
4.e.6	<p>Where appropriate, consultation is sought during treatment planning as needed for relevant topics including but not limited to: eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence, human trafficking, school-based wellbeing, and school-based social emotional supports.</p> <p>The CCBHC must document any external consultation relationships.</p>	Yes	
4.e.7	<p>The person's health record documents any advance directives related to treatment and crisis prevention planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis prevention plan with each person receiving services.</p> <p>Consistent with the criteria in 4.e.1 through 4.e.7, the State may specify other aspects of person-centered and family-centered treatment planning that will be</p>	Yes	

	<p>required based upon the needs of the population served. Treatment planning components that should be included as appropriate are: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, tailored treatment to ensure culturally and linguistically appropriate services).</p>		
4.f.1	<p>The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.</p>	Yes	

	<p>The State expects that CCBHC utilizes evidence-based and promising practices when possible across its services. The State will establish a minimum set of evidence-based practices required of the CCBHCs and optional, recommended evidence-based practices as part of the Demonstration Program and is considering, among others, those listed in Attachment G.</p> <p><i>Note: See also program requirement 3 regarding coordination of services and treatment planning.</i></p>		
4.f.2	<p>Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth- guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes.</p>	Yes	
4.f.3	<p>Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues. Examples of supports include, but are not limited to: crisis services, screening diagnosis & risk assessments, psychiatric rehabilitation services, outpatient primary care screening and monitoring, outpatient mental health and substance use services, person- and family-centered care planning, peer family support and counselor services, and/or targeted case management.</p>	Yes	

4.g.1	<p>The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. The CCBHC ensures that the person receiving services receives an initial outpatient primary care screening and is accurately monitored for physical health conditions including, at a minimum, diabetes, heart disease, obesity, tobacco and vaping usage, and chronic obstructive pulmonary disease (COPD). The CCBHC will make every attempt to connect the person receiving services with a primary care physician (PCP), either directly through the CCBHC, through consult or contract with local PCP or pediatrician, or their established PCP or pediatrician. All connection attempts must be documented.</p> <p>Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC.</p> <p>The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions:</p> <ul style="list-style-type: none"> • HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Attachment F • Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population. 	No	Yes
4.g.2	The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions	No	Yes

	<p>experienced by CCBHC populations across the lifespan. Protocols will include:</p> <ul style="list-style-type: none"> • Identifying people receiving services with chronic diseases; • Ensuring that people receiving services are asked about physical health symptoms; and • Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g. <p>In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.</p>		
4.g.3	<p>The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following:</p> <ol style="list-style-type: none"> 1. ensuring individuals have access to primary care services; 2. ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions; 3. coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and 	Yes	

	<p>4. promoting a healthy behavior lifestyle. <i>may elect to require specific other screening and monitoring to be provided by the CCBHCs in addition to the those described in 4.g.</i></p> <p><i>Note: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.</i></p> <p><i>Note: See also program requirement 3 regarding coordination of services and treatment planning.</i></p>		
4.h.1	<p>The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management services should include but are not limited to the following services:</p> <p>1) Supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization.</p> <p>2) During other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons.</p> <p>3) For individuals with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services.</p>	Yes	

	<p>Based upon the needs of the population served, states should specify the scope of other CCBHC targeted case management services that will be required, and the specific populations for which they are intended.</p> <p>The state will develop and specify required targeted case management scope and populations during the demonstration program. Additional details of service and delivery definitions for targeted case management will be further defined in the CCBHC demonstration handbook.</p>		
4.i.1	<p>The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or co-workers.²⁷ Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to:</p> <ul style="list-style-type: none"> • Participate in supported education and other educational services; • Achieve social inclusion and community connectedness; • Participate in medication education, self-management, and/or individual and family/caregiver psycho-education; and • Find and maintain safe and stable housing. 	Yes	

	<p>Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers.</p> <p><i>The State may specify which evidence-based and other psychiatric rehabilitation services will be required based upon the needs of the population served above the minimum requirements described in 4.i.</i></p> <p><i>Note: See program requirement 3 regarding coordination of services and treatment planning.</i></p>		
4.j.1	<p>The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites; warmlines; peer-led crisis prevention planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support.</p>	Yes	

	<p>Requirements for certified peer specialists include (please refer to criteria 3.d.2 for additional details on requirements for peer support professionals and the interdisciplinary team):</p> <ol style="list-style-type: none"> 1. Scope of services peers provide must be reflective of Community Needs Assessment 2. Partake in interdisciplinary team, crisis prevention planning, treatment planning, and other related activities 3. Serve within service lines that require related engagement, outreach, and other activities 4. Scope of peer specialists must be distinguishable from life skills training providers and case management services <p>The number of certified peer specialists must be appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.</p>		
4.k.1	<p>The CCBHC is responsible for providing directly, or through a DCO, intensive, community- based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook.</p>	Partial	

	<i>Note: See program requirement 3 regarding coordination of services and treatment planning.</i>		
4.k.2	<p>All individuals inquiring about services are asked whether they have ever served in the U.S. military.</p> <p>Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:</p> <ol style="list-style-type: none"> 1. Active Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF. 2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM, or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations. 3. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE- authorized provider, network or non-network. The CCBHC is required to provide direct services and/or conduct a warm handoff to an eligible TRICARE-authorized provider, network, or non-network that can provide such services. <p>Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services</p>	Yes	

	<p>Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics).</p> <p><i>Note: See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.</i></p>		
4.k.3	The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.	Yes	
4.k.4	<p>Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. The Principal Behavioral Health Provider must have specific training around military and veteran culture and/or lived experience as a veteran or in the military. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:</p> <ol style="list-style-type: none"> 1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required. 2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis. 3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity). 	No	Yes

	<ol style="list-style-type: none"> 4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. 5. The treatment plan is revised, when necessary. 6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2). 7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan. 		
4.k.5	<p>Behavioral health services are recovery-oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery:</p>	Yes	

	<ul style="list-style-type: none"> • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect <p>As implemented in VHA recovery, the recovery principles also include the following:</p> <ul style="list-style-type: none"> • Privacy • Security • Honor <p>Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.</p>		
4.k.6	<p>All behavioral health care is provided with cultural competence.</p> <ol style="list-style-type: none"> 1. Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country. Training must be completed annually. 2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity. Training must be completed annually. 	Yes	

4.k.7	<p>There is a behavioral health treatment plan for all veterans receiving behavioral health services.</p> <ol style="list-style-type: none"> 1. The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. 2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself. 3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness. 4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments. 5. The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1. 	Yes	
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Program Requirement 4: Scope of Services Narrative

Please provide a narrative explaining your current ability to meet the Certification Criteria in Program Requirement 4. For each criterion, please address:

1. If you currently meet the criterion, how are you doing so?
2. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
3. If you are exceeding the criterion requirements, what are you doing?

4.a.1	Sandra Eskenazi MHC can provide the 9 essential services required by a CCBHC, thereby meeting the 51% or more expectation. Sandra Eskenazi MHC understands that over time establishing a DCO may be necessary. If a
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	DCO is established, Sandra Eskenazi MHC will ensure 51% of all encounters will be provided by Sandra Eskenazi MHC. All DCOs that Sandra Eskenazi MHC contracts with will be currently certified or designated, when applicable, in their field of service. The Sandra Eskenazi MHC will document the DCO relationship with an MOU or other contractual arrangement and will inform DMHA as part of the designation/certification process.
4.a.2	Sandra Eskenazi MHC has all required policies and protocols in place to ensure that CCBHC clients are made aware of their rights and responsibilities, including being able to change providers without cause. If Sandra Eskenazi MHC enlists a DCO to provide a needed client service, we will ensure that the DCO adheres to this expectation per agreement.
4.a.3	Sandra Eskenazi MHC and Eskenazi Health have policies that outline client grievance procedures, which includes the involvement of a dedicated Office of Patient Experience. All our clinic locations have signage that identifies how and to whom formal grievance can be filed. This signage includes The Joint Commission, DMHSA consumer line, Disability Rights, and other relevant resources. This information is also included in patient rights documents. If Sandra Eskenazi MHC enlists a DCO to provide a needed client service, we will ensure that the DCO also adheres to this expectation, per agreement.
4.a.4	If Sandra Eskenazi MHC enlists a DCO to provide a needed client service, we will ensure that the DCO-provided services for people receiving CCBHC services meet the same quality standards as those provided by the CCBHC, per agreement.
4.b.1	Sandra Eskenazi MHC embraces SAMHSA's Recovery Model (2012) as its framework of care, and as previously stated, this model permeates language, culture, policy, and client service. The client is the hub of treatment; Sandra Eskenazi MHC is one of the spokes. As part of the Recovery Model, we know the client's care includes those they identify as family (to the degree the client agrees to their participation). We make clients aware of their rights as a patient and have such signage posted at all client locations. If Sandra Eskenazi MHC enlists a DCO to provide a needed client service, we will ensure that the DCO adheres to this expectation, per agreement.
4.b.2	Sandra Eskenazi MHC utilizes the Recovery Model as a framework of care, thereby informing service delivery that meets the expectations of this criterion. Patient Rights and Responsibilities are available online through Eskenazi Health and are culturally sensitive and person- and family-centered.

4.c.1	<p>Sandra Eskenazi MHC delivers crisis services through a Mobile Recovery Crisis Team (“MCRT”), Crisis Intervention Team (“CIU”; 24/7 walk in assessment/crisis services), and Triage (23-hour observation and care unit). The services provided are consistent with those outlined in this criterion. These teams provide suicide prevention and intervention informed by Zero Suicide best practice; can address crises related to substance use; and can address drug and alcohol related overdose and support following a non-fatal overdose (including providing naloxone if necessary). These teams are trained in crisis de-escalation (through Crisis Prevention Institute training), Motivational Interviewing, trauma-informed care, and culturally/developmentally sensitive intervention. There are items that Sandra Eskenazi MHC must address prior to July 1, 2024. Sandra Eskenazi MHC must coordinate with the 988-call center in our area and will meet the standards of risk assessment and engagement of individuals at imminent risk of suicide. We have much experience in working with dispatched mobile teams such as the Mobile Crisis Assistance Team (our co-responder team with IMPD) dispatched on behavioral health runs. This experience will aid greatly in the coordination with 988. Additionally, our CCBHC MCRT will need to expand beyond its coverage of the SAMHSA-grant funded efforts with current Sandra Eskenazi MHC CCBHC to cover the entire agency.</p>
4.d.1	<p>Sandra Eskenazi MHC, through training and by policy, ensures clinical staff can screen, assess, diagnose, and assess risk for all new and current CCBHC clients. We also have the technological infrastructure to provide telehealth/telemedicine as required (and outlined by CMS). We use validated screening and assessment tools like the C-SSRS, SAFE-T, SURE, WHODAS, ACE, PHQ-9/9M, and others.</p>
4.d.2	<p>Sandra Eskenazi MHC screening, assessment, and preliminary diagnosis are conducted in required time frames and based on preferences of the person receiving services. Sandra Eskenazi MHC, through training and by policy, ensures clinical staff can screen, assess, diagnose, and assess risk for all new and current CCBHC clients.</p>
4.d.3	<p>Sandra Eskenazi MHC has policies and Epic EHR workflows that ensure the required initial evaluation (intake) data are gathered and assessments are completed by a qualified Master’s level clinician/licensed clinician, as well as by clinical trainees at Master’s level standing or higher. The assessment meets all required standards for CCBHC and Joint Commission.</p>
4.d.4	<p>Sandra Eskenazi MHC has policies and Epic EHR workflows that ensure all elements of the comprehensive evaluation (conducted at the initial evaluation) are gathered and completed, including all domains listed in 4.d.4. All treatment plans are overseen by physicians (psychiatrist) and clinical psychologist (HSPP).</p>

4.d.5	When the State has finalized the approved list of screeners, assessments, and evidence-based practices, Sandra Eskenazi MHC is poised to implement all before July 1, 2024. We are currently working with our Epic and quality teams on a continuous quality improvement (CQI) plan to ensure quick building of required screeners/assessments in Epic as well as dashboards and reports to capture all quality metrics, training of staff, and implementation. The Epic team knows that CCBHC compliance is the number one priority for Sandra Eskenazi MHC and will build any requirement tool and associated quality monitoring when specifications are provided by the State.
4.d.6	Sandra Eskenazi MHC utilizes standardized and validated assessments and screening tools. Sandra Eskenazi MHC is also a leader among CMHCs in Motivational Interviewing with a training committee that has six Motivational Interviewing of Network of Trainers members. We ensure that all roles, from high school level through Master's level staff, are trained in Motivational Interviewing. Due to the work required, we will submit work tickets to begin builds as soon as the State announces what has been approved. This will be completed by July 1, 2024.
4.d.7	Sandra Eskenazi MHC uses culturally and linguistically appropriate screening tools and ensures that the tools can be used with all clients regardless of literacy. Following best practices, using standardized/validated tools, and implementing workflows reviewed by an internal Clinical Decision and Support Committee provides safeguards that ensure these tools are culturally and linguistically appropriate for the populations we serve.
4.d.8	At initial evaluation (intake) Sandra Eskenazi MHC evaluates the client's past and present substance use. If the client presents with unsafe substance or problematic alcohol use, the clinician uses Motivational Interviewing to evaluate the client's motivation for change and willingness to access substance use disorder services. If the client expresses willingness, the clinician and treatment team will work to get the individual connected to treatment. If the person presents with a grave disability or as being a potential danger to self/others, the clinician and treatment team will work to have the individual evaluated for psychiatric inpatient admission through Eskenazi Health's Crisis Intervention Unit and Psychiatric Triage.
4.e.1	Sandra Eskenazi MHC provides person-centered and family-centered treatment planning. This clinical process utilizes the client's goals, strengths, barriers, and successes to develop a plan of care that reflects evidence-based approaches to treating the client in a manner that reflects their needs and preferences. The treatment planning process includes a risk assessment that updates to safety plans as required. If Sandra Eskenazi MHC was to engage a DCO for any external service, we would ensure that they comply with this criterion.

4.e.2	Sandra Eskenazi MHC practices person-centered and family-centered treatment planning. The treatment planning process includes the client's goals/successes/challenges/strengths/barriers in the development of mental health and/or substance use objectives and interventions that additionally reflect the client's diagnosis. Furthermore, the treatment plan includes identification of transportation barriers, the EBPs to be used, and is developed and endorsed by the client and family (when appropriate and/or client consents). Releases of information will be obtained as necessary and are built into our Epic electronic health record.
4.e.3	Per policy and workflow, Sandra Eskenazi MHC ensures that a comprehensive treatment plan is created by a Master's-level clinician at initial evaluation and attested by either an MD or HSPP. The treatment plan is updated as clinically necessary (e.g., hospitalization, recent suicidal ideation, new symptom) or no later than 90 days since last review. We have advanced analytics that track treatment plan review completion.
4.e.4	As Sandra Eskenazi MHC practices person-centered and family-centered treatment planning, we ensure that all aspects of this criterion are met. They are built into our Epic workflows and outlined in policy.
4.e.5	Treatment planning at Sandra Eskenazi MHC comprehensively covers all interventions that will be provided by the CCBHC. This is supported through Epic workflows and is outlined in policy.
4.e.6	When Sandra Eskenazi MHC encounters challenges in determining best course of treatment due to topics requiring more expert opinion or coordination, Sandra Eskenazi MHC will hold a case conference that gathers internal staff with specialized knowledge and any relevant external partners to problem-solve and coordinate care. Per Sandra Eskenazi MHC policy, releases of information will be obtained as required. These case conferences, including who attended, are then documented in the Epic EHR.
4.e.7	Psychiatric advance directives are requested at intake and captured in the Epic system. Any safety planning that is conducted with CCBHC clients is captured in the Epic system utilizing the specialized workflows created for their completion.
4.f.1	Sandra Eskenazi MHC directly provides the outpatient behavioral health care outlined in criterion 4.f.1. Sandra Eskenazi MHC can provide very specialized services such as Coordinated Specialty Care for Early Psychosis, methadone treatment through our opioid treatment program, and dual diagnosis for those with SMI and intellectual disability. Telemedicine/telehealth can be conducted in each of these service areas. When the State determines

	the required EBPs and best practices for Indiana CCBHCs, Sandra Eskenazi MHC will implement them, utilizing the skill, knowledge, abilities, and resources of a comprehensive mental health center integrated with Marion County's safety-net hospital. Our biopsychosocial assessment is consistent with the American Society for Addiction Medicine (ASAM) 6 dimensions and care determined upon this assessment.
4.f.2	Sandra Eskenazi MHC has service lines that address the needs of specific populations. Examples are Older Adult Services, STARS (dual diagnosis treatment for those with intellectual disability and SMI), Narcotics Treatment Program (methadone treatment), Blue and Purple Adult Outpatient teams (serving those at risk of criminal justice involvement and/or homelessness), PARC (Coordinated Specialty Care for Early Psychosis), Adult Outpatient teams (serving many individuals with SMI especially psychotic disorders), Children's Outpatient, and School-based programs.
4.f.3	Sandra Eskenazi MHC's Children's Outpatient and School-based Programs meet the requirements of this criterion.
4.g.1	Sandra Eskenazi MHC is currently updating its nursing assessment to include and better address the primary care screening of diabetes, heart disease, obesity, tobacco and vaping usage, and chronic obstructive pulmonary disease (COPD). Those needing a referral to primary care will be provided a referral within Epic as behavioral health and Primary Care share the same EMR. The Medicaid Director will update all protocols to conform to screening recommendations with scores A and B of the United States Preventive Services Task Force Recommendations for HIV and viral hepatitis, primary care screening noted in attachment F, and other clinically indicated primary care key health indicators for all populations. This will be in place prior to July 1, 2024.
4.g.2	The Sandra Eskenazi MHC Chief Medical Officer (CMO; Medical Director) will update current protocols and will include screening for people receiving services who are at risk for common physical health conditions such as chronic diseases and physical health symptoms. The CMO will update protocols on collection of analysis of laboratory samples as well. Sandra Eskenazi MHC is currently able to provide venipuncture services in all clinics. All labs drawn within Sandra Eskenazi MHC are processed at our Eskenazi Health lab. All results are directly entered into Epic by our laboratory. These results are viewable by behavioral health, primary care, specialty care or any service line within Eskenazi Health System that is providing care to the client.
4.g.3	Through the Epic electronic health record, Sandra Eskenazi MHC can monitor utilization of primary care, laboratory testing, coordination of care, and promoting a healthy lifestyle. Sandra Eskenazi MHC partners with

	Eskenazi Health FQHC, the largest FQHC in Indiana. In fact, the 1660 N Illinois St. Eskenazi Health FQHC is co-located with Sandra Eskenazi MHC at the James Wright Building clinic.
4.h.1	Sandra Eskenazi MHC provides targeted case management to address the needs of special populations. We have teams that work specifically with older adults, those experiencing homelessness, and those co-diagnosed with SMI and an intellectual disability. Case management services are provided in a manner that specifically addresses the unique needs of these populations. Sandra Eskenazi MHC is also resilient and flexible, and it is the expectation of all treatment teams to meet the unique needs of their clients, such as those at high risk of suicide or overdose. When the State develops and specifies the required targeted case management scope and populations, Sandra Eskenazi MHC will quickly adapt and develop clinical workflows, as well as associated monitoring, to comply with that guidance.
4.i.1	Sandra Eskenazi MHC provides the evidence-based rehabilitation services for mental health and substance use identified in 4.i.1. Our mental health center works with individuals with very high levels of functional need. Skills development and rehabilitation services are key interventions especially for those who have SMI. Sandra Eskenazi MHC routinely provides skills development for community integration; medication training and support; developing social networks; financial management; filling out paperwork; and many of the other examples provided in this criterion. We also have internal supportive employment supports and peer recovery staff who address the very specific needs of the clients we serve.
4.j.1	Sandra Eskenazi MHC believes in peer recovery and has peer recovery specialists in multiple adult service lines. Sandra Eskenazi MHC is intent on becoming a leader in peer recovery and, through the Ackerman Center for Professional Development, has created a peer apprenticeship pathway that increases the number of peer recovery coaches in Indianapolis while also giving them six months of intense work experience while covering the cost for ICAADA training, testing, and certification. Sandra Eskenazi MHC is becoming a hub for peer recovery in Marion County and will train 45 peers over three years.
4.k.1	Sandra Eskenazi MHC provides individualized and evidence-based treatment for veterans and service members at the duration and frequency required by their unique needs. Sandra Eskenazi MHC has a program coordinator in the Ackerman Center who is a STAR Behavioral Health Program (SBHP) champion, who meets regularly with STAR for consultation. Training on veteran culture is also provided to staff at new employee orientation and yearly. Currently we are working with STAR and the Center for Deployment Psychology to receive accreditation as a

	STAR agency, which includes ensuring more clinicians receiving Tier One through Tier Three training. In addition, STAR provides monthly reporting to the Director of Clinical Services at Sandra Eskenazi MHC to ensure that (a) the agency knows who is completing STAR training and (b) data regarding referrals to ensure no veterans are lost in navigating the system.
4.k.2	At intake, clients are routinely asked if they have served in the military. If the service member is in active duty, Sandra Eskenazi MHC will follow the guidance in criterion 4.k.2.
4.k.3	Sandra Eskenazi MHC practices dual diagnosis treatment with clients, including veterans. If care must be split among providers to meet the service members unique need, Sandra Eskenazi MHC will ensure coordination of care with other service providers.
4.k.4	Sandra Eskenazi MHC currently has a STAR Behavioral Health Program (SBHP) champion who has attended consultation calls with STAR, including discussion of how to get more clinicians trained in STAR's EBPs. Discussions continue with STAR regarding obtaining a SBHP designation for Sandra Eskenazi MHC and ensuring more clinicians are trained in STAR's EBPs. Prior to July 1, 2024, Sandra Eskenazi MHC will have established Principal Behavioral Health Providers in each adult outpatient clinic. Currently we are working with STAR and the Center for Deployment Psychology to receive accreditation as a STAR agency, which includes ensuring more clinicians receiving Tier One through Tier Three training. In addition, STAR provides monthly reporting to the Director of Clinical Services at Sandra Eskenazi MHC to ensure the agency (a) knows who is completing STAR training and (b) receives data regarding referrals to ensure no veterans are lost in navigating the system.
4.k.5	Sandra Eskenazi MHC embraces SAMHSA's Recovery Model (2012) and incorporates the 10 guiding principles of recovery into the language, culture, policy, and client services of the mental health center. Sandra Eskenazi MHC ensures the recovery principles of VHA recovery and observes the VHA Uniform Mental Health Services Handbook.
4.k.6	Cultural competency, to include all training on issues listed in 4.k.6 (including cultural competency specific to veterans), is provided at new employee orientation and yearly.
4.k.7	Treatment planning for veterans is recovery oriented and family centered, as it is for all clients. The treatment plan meets the requirements of the VHA Uniform Mental Health Services Handbook.

Program Requirement 5: Quality and Data

Criterion #	Criterion	Do you currently meet this criterion?	If not, will you be able to meet this criterion by 7/1/24?
5.a.1	The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Attachment F. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards. CCBHCs are responsible for collecting data from DCOs providing services on their behalf. All data collection and reporting is required to be shared with the State of Indiana to meet State or federal requirements.	Yes	
5.a.2	Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants beginning in 2022, must collect and report the Clinic-Collected quality measures identified as required in Attachment F. Reporting is annual and, for Clinic- Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA.	Yes	

	<p>The State requires the CCBHC to collect the Quality Metrics listed in Table 1 ("Clinic-Collected Measures") of Attachment F. The CCBHC is required to follow SAMHSA, State, and CMS technical guidelines that are updated and published for existing and any additional future measures added by SAMHSA or the State.</p>		
5.a.3	<p>In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC-identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. All data collection and reporting are required to be shared with the State of Indiana to meet State or federal requirements.</p> <p>In addition to data specified in this program requirement and in Attachment F that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually.</p> <p>To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and, as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.</p>	Yes	

5.a.4	<p>CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS.</p> <p><i>Note: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified/designated by the State (if the State is selected to participate in the Section 223 Demonstration Program).</i></p>	Yes	
5.b.1	<p>In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care. This information will be made available to DMHA for quality review purposes.</p> <p>A center which has applied for certification or which has been certified must provide information related to services as requested by the division and must participate in the division's quality assurance program. A center must respond to a request from the division as fully as it is capable. Failure to comply with a request from the division may result in termination of a center's certification</p>	Yes	

5.b.2	The CCBHC develops, implements, and puts into policy a CQI plan that addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.	No	Yes
5.b.3	The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC- collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.	Yes	

Program Requirement 5: Quality and Data

Please provide a narrative explaining your current ability to meet the Certification Criteria in Program Requirement 5. For each criterion, please address:

1. If you currently meet the criterion, how are you doing so?
2. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
3. If you are exceeding the criterion requirements, what are you doing?

5.a.1	Sandra Eskenazi MHC utilizes Epic as its electronic health record, SAP as its finance software, Strata for budgeting, SuccessFactors for human resource management, HealthStream for education and training, and SharePoint and OnBase for storage. We have the tools necessary to track, compile, analyze, and report any
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	outcomes and quality data specified in criterion 5.a.1. These systems are in active use and have been used during our SAMHSA CCBHC expansion grant.
5.a.2	Sandra Eskenazi MHC can collect and report all quality measures identified in Attachment F through the systems identified in 5.a.1. As stated earlier, we are currently working with our Eskenazi Health quality and Epic teams on a CQI plan to roll out all needed clinical and analytics changes in Epic in preparation for when the State provides guidance on those required measures that are currently unidentified.
5.a.3	Sandra Eskenazi MHC appropriately files Medicaid claims to the State. Eskenazi Health has its own revenue cycle teams that ensure this process occurs according to State guidelines.
5.a.4	Sandra Eskenazi MHC can work with Eskenazi Health Finance to submit any required cost reports. This is an area of strength for the organization due to the history of submitting cost reports for HRSA and CMS.
5.b.1	Sandra Eskenazi MHC previously used a QAPI (Quality Assurance Performance Improvement) process for ongoing evaluation and process improvement of service outcomes. We have now partnered with Eskenazi Health's quality team to begin the change to CQI. This CQI plan will be used to ensure completion and monitoring of service provision across the CCBHC. CQI plans will also be used for other initiatives, such as our revision of clinical supervision and training initiatives. The Chief Medical Officer Dr. Heather Fretwell is directly involved in those aspects of CQI that are related to the quality of the medical components of care. She also leads Sandra Eskenazi MHC's Quality Council where these CQI plans will be continuously reviewed and monitored. This Council is comprised of Dr. Heather Fretwell CMO, Dr. Ashley Overley, CEO, Jim Richter LMHC Clinical Director, Jeff Catlett MBA COO, Jay Hamm HSPP, Mitzi Whitley RN acute psychiatric unit manager, Ashley Smith Behavior Health Regulatory Audit Coordinator, Jennifer Weatherspoon Eskenazi Health Chief Data Officer, and other members as required to ensure quality across Sandra Eskenazi MHC.
5.b.2	Sandra Eskenazi MHC will work with Eskenazi Health's quality team to develop a CQI plan that addresses each of the five minimum identified significant events in criterion 5.b.2. Sandra Eskenazi MHC will also partner with the assigned Eskenazi Health Behavioral Health Risk Manager to see that the data she collects and reports on suicide, overdoses, and all-cause mortality is moved to this CQI plan.
5.b.3	Eskenazi Health's Chief Data Officer, Jennifer Weatherspoon, is working with Sandra Eskenazi MHC through her

	<p>quality team to help us move our data collection and reporting to a CQI format. She is also directly involved with Epic EHR and has led her team in structuring Epic and developing analytics to identify and track populations experiencing health disparities, including those based on race, gender, and sexual minority. The CQI plan will utilize the data and analytics available to us in Epic.</p>
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Program Requirement 6: Organizational Authority and Governance

Criterion #	Criterion	Do you currently meet this criterion?	If not, will you be able to meet this criterion by 7/1/24?
6.a.1	<p>The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria:</p> <ul style="list-style-type: none"> • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code • Is part of a local government behavioral health authority • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.) • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) <p><i>Note: A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.</i></p>	Yes	
6.a.2	<p>To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs shall reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.</p>	Yes	

6.a.3	An independent financial audit is performed annually for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.	Yes	
6.b.1	<p>CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making.</p> <p>Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making.³² CCBHCs reflect substantial participation by one of two options:</p> <p>Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.</p> <p>Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board.</p>	No	No

	<p>Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:</p> <ol style="list-style-type: none"> 1. Identifying community needs and goals and objectives of the CCBHC 2. Service development, quality improvement, and the activities of the CCBHC 3. Fiscal and budgetary decisions 4. Governance (human resource planning, leadership recruitment and selection, etc.) <p>Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website. Board meeting summaries and the annual summary of recommendations must be available for auditing purposes by DMHA.</p>		
6.b.2	<p>If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so.</p> <p>If option 2 is chosen, for CCBHCs not certified by the state, the federal grant funding agency will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.</p>	No	No

	<p><i>If option 2 is chosen then the State will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.</i></p> <p><i>If option 2 is chosen then the State will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes."</i></p>		
6.b.3	<p>To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6.b.1. The CCBHC must inform DMHA about all board membership information as part of the designation/certification process.</p>	Yes	
6.b.4	<p>Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry. The demographics of the needs assessment results should be reflected in the governing board. The governing board should be made of at least 51% of individuals with lived or living experience in outpatient mental health or substance use services as a person receiving services or a family member, considering different intersections with underserved and historically marginalized individuals within the mental health and substance use space.</p>	Yes	
6.c.1	<p>The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited</p>	Yes	

	provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.		
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Criterion #	Criterion	Please confirm you will seek designation/ certification as part of the Demonstration. (Yes/No)
6.c.2	CCBHCs must be certified by their state as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services. CCBHC expansion grant recipients are encouraged to seek state certification if they are in a state that certifies CCBHCs. The CCBHC must be recertified every three years.	Yes

Criterion #	Criterion	What accreditations by appropriate independent accrediting bodies do you currently hold and/or plan on pursuing?

6.c.3	States are encouraged to require accreditation of the CCBHCs by an appropriate independent accrediting body (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean “deemed” status.	Joint Commission
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Program Requirement 6: Organizational Authority and Governance

Please provide a narrative explaining your current ability to meet the Certification Criteria in Program Requirement 6. For each criterion, please address:

1. If you currently meet the criterion, how are you doing so?
2. If you are not currently able to meet the criterion, what would you need to do to meet the criterion by the anticipated Demonstration Program start date (7/1/24)? What type of support would you need?
3. If you are exceeding the criterion requirements, what are you doing?

6.a.1	The Health & Hospital Corporation of Marion County (HHC) is a municipal corporation established by Indiana code 16-22-8. Health and Hospital Corporation of Marion County (HHC) d/b/a Eskenazi Health serves as the public hospital division. The Sandra Eskenazi Mental Health Center (Sandra Eskenazi MHC) d/b/a is a division of Eskenazi Health
6.a.2	Currently, there is no tribal authority in our area and this criterion does not apply. If one came to exist, Sandra Eskenazi MHC would work to comply with criterion 6.a.2.
6.a.3	Sandra Eskenazi is part of Eskenazi Health, and an independent financial audit is completed yearly for the entity. Sandra Eskenazi MHC will comply with all independent external financial audits and any subsequent plan of correction.
6.b.1	The Health & Hospital Corporation of Marion County (HHC) is a municipal corporation established by Indiana code 16-22-8. Health and Hospital Corporation of Marion County (HHC) d/b/a Eskenazi Health serves as the public

	hospital division. The Sandra Eskenazi Mental Health Center (Sandra Eskenazi MHC) is a division of Eskenazi Health. As such Sandra Eskenazi MHC is required to have the board structure outlined in 6.b.3 below.
6.b.2	The Health & Hospital Corporation of Marion County (HHC) is a municipal corporation established by Indiana code 16-22-8. HHC d/b/a Eskenazi Health serves as the public hospital division. The Sandra Eskenazi Mental Health Center (Sandra Eskenazi MHC) is a division of Eskenazi Health. As such Sandra Eskenazi MHC is required to have the board structure outlined in 6.b.3 below.
6.b.3	The Health & Hospital Corporation of Marion County (HHC) is a municipal corporation established by Indiana code 16-22-8. HHC d/b/a Eskenazi Health serves as the public hospital division. The Sandra Eskenazi Mental Health Center (Sandra Eskenazi MHC) is a division of Eskenazi Health. As such Sandra Eskenazi MHC is required to have the board structure outlined in 6.b.3 below. However, Sandra Eskenazi MHC does have an Advisory Board whose structure ensures those with lived experience and their families have input regarding Sandra Eskenazi MHC. The advisory board has bylaws that outline the composition of the board, which includes consumers and their families. Additionally, there is a Community Advisory Board (consumer-driven and with a charter) that provides feedback to the Advisory Board.
6.b.4	Health and Hospital Corporation of Marion County (HHC) is a municipal corporation established by Indiana code 16-22-8. Health and Hospital Corporation of Marion County (HHC) d/b/a Eskenazi Health serves as the public hospital division. The Sandra Eskenazi Mental Health Center (Sandra Eskenazi MHC) d/b/a is a division of Eskenazi Health. As such Sandra Eskenazi MHC is required to have the board structure outlined in 6.b.3. However, Sandra Eskenazi MHC does have an Advisory Board whose structure ensures those with lived experience and their families have input regarding Sandra Eskenazi MHC. The advisory board has bylaws that outline the composition of the board, which includes consumers and their families. Additionally, there is a Community Advisory Board (consumer-driven and with a charter) that provides feedback to the Advisory Board and has representation on the advisory board.
6.c.1	Sandra Eskenazi MHC is a Medicaid provider. We fully comply with all legal and regulatory requirements. Sandra Eskenazi MHC participates in the SAMHSA Behavioral Health Treatment Provider Locator and is searchable through the website.
6.c.2	Currently Sandra Eskenazi MHC is an expansion grant recipient. The initial grant period ended 8/28/2023 but we

	have received a no cost extension that ends 8/30/2024. Sandra Eskenazi MHC, per this RFS, is requesting the State of Indiana to certify the organization as a CCBHC
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