**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?

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# Program Requirement 1: General Staffing Requirements

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| **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 | 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.  Additional community needs assessment requirements include:   * 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 marginalized individuals within the mental health and substance use space | **Yes** |  |  |
| 1.a.2 | 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.  *Note: See criteria 4.k relating to required staffing of services for Veterans.* | **Yes** |  |  |
| 1.a.3 | 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.  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.   *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 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.* | **Yes** |  |  |
| 1.a.4 | The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided. | **Yes** |  |  |
| 1.b.1 | 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.   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. | **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 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.  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 reflect the communities identified in the CCBHC’s needs assessment in lived experiences, cultures, and identities.   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.  Additional staff requirements include:   * 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.   *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.* | **Yes** |  |  |
| 1.c.1 | 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:   * Evidence-based practices as defined by the State during demonstration * 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   Trainings may be provided on-line. Training logs must be kept and made available for QI auditing purposes.  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.  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 *TIP 59: Improving Cultural Competency Quick Guide for Clinicians (*[*https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf*](https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf)*).*  *Note: See criteria 4.k relating to cultural competency requirements in services for Veterans.* | **Yes** |  |  |
| 1.c.2 | 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. | **Yes** |  |  |
| 1.c.3 | 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. | **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 | 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.   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. | **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 CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed. | **Yes** |  |  |
| 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:

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?

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| **We currently meet the criterion for the following items:**  **1.a.1 Our most updated CNA addresses all requirements listed. We have recently updated our assessment after partnering with 3 other CMHCs in Marion Co. to complete a comprehensive assessment specific to that county and to incorporate that information and updated information for Johnson Co., the two counties A&C is designated to serve. Our staffing responsive plan addresses the needs identified in the updated CNA (2023).**  **1.a.2 We currently staff appropriately for our needs, recognizing the development of future programming and the need for an increase in crisis peers. We have Star Behavioral trained providers for Veterans. We have a DEI committee to ensure we are providing CLAS-appropriate services.**  **1.a.3 We meet and exceed this criterion as our CMO is a Psychiatrist (Dr. Christine Negendank)**  **1.a.4 A&C meets this criterion. A&C maintains liability and malpractice insurance for all care providers, including the Patient Compensation Fund for primary care and psychiatric prescribers, clinical psychologists, addiction fellows, and other relevant healthcare providers. A&C reviews agency and provider insurance needs on an annual basis.**  **1.b.1 All providers practice in their scope of work and/or under supervision. Supervision is provided by the following: HSPPs, Licensed Clinical Providers, Integrated Staffing, and MDs. We also have a clinical council dedicated to overseeing and reviewing the scope of work practiced.**  **1.b.2 A&C meets and exceeds the staffing plan requirements of DMHA, Joint Commission, and FQHC LAL. As identified in our CNA, Indianapolis is home to the largest Burmese community in the country. We have increased our recruitment and hiring efforts to successfully hire individuals who are part of the Burmese community. Under our first two CCBHC grants, we created a Care Coordination team. We expanded their role in our organization to assist individuals in navigating treatment services, barriers, and referrals and ensure access to care. A&C has several psychiatrists or behavioral health APRNs who can prescribe medications, including MAT (suboxone and vivitrol). A&C’s medical director is an experienced SUD provider, but we also have two contracted addiction-specialized psychiatrists who oversee an addictions fellowship program partnering with the Indiana School of Medicine. We are currently an Addictions Medicine Fellowship training site. A&C has staff that are trained in addressing trauma and promoting recovery with children with SUD and adults with SMI. Training occurs annually at onboarding, and ongoing clinical supervision and auditing ensure continued practice to fidelity. Staff have the ability, through internal or external training options, to expand their clinical expertise to provide these needed services. A&C has a care coordination team that works to ensure that clients understand how to access the care needed, how to eliminate barriers to care and ensure that the whole health goals of clients are represented in the clinical treatment plan.**  **1.c.1 A&C has training plans for each individualized position/role within our organization and has updated trainings in response to our most updated CLAS assessment, including training specific to cultural competencies and offering external training opportunities for continued education. A&C staff has advanced training during onboarding and meeting annual requirements, including training for Veteran services (STAR-trained providers)**. **Our training plans cover all the areas listed in the criterion.**  **1.c.2 A&C meets this criterion and has a policy regarding staff training. We track all training requirements and completion in Relias.** **Competency is assessed initially through a 90-day job-specific competency review. Ongoing competency is reviewed in annual training criteria and annual reviews. Our Clinical Council reviews our training plans.**  **1.c3 A&C documents supervision and coaching in alignment with the CQI plan, policies, and clinical practice guidelines. Our records will be made available for auditing as requested.**  **1.c.4 Per policy, A&C requires our training team to maintain documentation of ongoing CEUs and certifications. We have specialized trainers for our Peer, Therapy, and Nursing positions.**  **1.d.1 A&C meets and exceeds this as we provide immediate access utilizing VOYCE services for LEP. It is accessible via the web, phone, and tablet and utilized during virtual visits to ensure access to care.**  **1.d.2 We provide documentation translated into Burmese and Spanish and provide a quick turnaround for any additional client-specific documents. Our website allows the user to translate into Burmese, Spanish, or French (these languages were identified in our CNA).**  **1.d.3 A&C meets this criterion and is compliant and responsive to the needs of individuals with physical, cognitive, and/or developmental disabilities. This includes ASL, TTY, physically accessible facilities, the ability to send electronic PDF documents for visually impaired clients, and adaptability equipment for staff providing therapeutic services.**  **1.d.4 A&C meets this requirement. Our documentation and information to access services, including crisis services, is available in Burmese, Spanish, and English as a response to our CNA. Our website includes all this information and translates into Burmese, Spanish, and French at the user request.** **VOYCE allows translation of documents in a timely manner for any additional needs.**  **1.d.5 A&C meets this requirement for confidentiality and privacy for service providers through our HIPPA policy, MOUs, BAA, and 42CFR Part 2.** |

# Program Requirement 2: Availability and Accessibility of Services

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| **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 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. | **Yes** |  |
| 2.a.5 | 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.   All listed and related technologies must adhere to the same in-person confidentiality guidelines that are outlined in Criteria 3.a.2. | **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.   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. | **Yes** |  |
| 2.b.1 | All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in- person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs (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.   * 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.   The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC’s discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.  *Note: Requirements for these screenings and evaluations are specified in criteria 4.d.*  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. | **Yes** | **.** |
| 2.b.2 | 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. | **Yes** |  |
| 2.b.3 | 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.  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. | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 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 | 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.  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. | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 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 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). | **Yes** |  |
| 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 | 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.  *Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.* | **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.   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.  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. | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 2.d.1 | 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. | **Yes** |  |
| 2.d.2 | 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. | **Yes** |  |
| 2.d.3 | The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation. | **Yes** |  |
| 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.  All listed and related technologies must adhere to the same in-person confidentiality guidelines that are outlined in Criteria 3.a.2. | **Yes** |  |

**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?

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| **A&C Meets the following criterion:**  **2.a.1 A&C offers safe, functional, clean, sanitary, inclusive, and welcoming environments for staff and people receiving services. All of our sites are tobacco-free, and we are accredited by the Joint Commission and HRSA.**  **We survey clients and staff annually on the safety and accessibility of our spaces. We have welcome signage in multiple languages.**  **2.a.2 A&C meets this criterion. As a SAMHSA grantee, we expanded our primary care and behavioral health service hours to include evenings and weekends. Our community-based, specialty, school-based, home-based, and child welfare programs are all offered outside regular business hours. In-person and telehealth services are also available. In addition, we have increased our transportation assistance. Our mobile crisis team is available 24 hours, 7 days a week. In response to our current CNA, we are opening crisis stabilization services in early 2024, increasing our evening and weekend availability to therapy, peer, and medication management for persons experiencing crisis.**  **2.a.3 A&C meets and exceeds location availability for services as evidenced by our services in office settings, community, school settings, partnership locations such as Wheeler Mission, home, and alternative settings identified by the client to meet their needs. We are a partner serving youth and families in 119 schools.**  **2.a.4 We meet and exceed this standard by providing bus passes (including applying for funding to support purchasing), partnerships with IndyGo, providing Z-trip (a local cab company), and a Lyft contract to provide free transportation. Our Care Coordination team, support staff, and community teams provide education and training on access and utilization of transportation services, including education on Medicaid resources. Also, if transportation is a barrier, we can offer telehealth services as a treatment modality when clinically appropriate.**  **2.a.5 We meet this criterion by utilizing telehealth platforms and E-Medicine video conferencing. All these platforms adhere to state and federal confidentiality guidelines. We provide training on the platforms, utilization, and regulations around telehealth.**  **2.a.6 Informed by the CNA, A&C meets this criterion by utilizing engagement teams, care coordination, homeless outreach services, crisis services, peer support specialists, telehealth services, and EMR platforms (population health tool) for outreach to support inclusion and access for underserved individuals and populations. Also, A&C participates in local resource fairs, panel discussions, and committees geared toward outreach and resource sharing.**  **2.a.7 We meet and exceed this criterion by providing state hospital gatekeeper services. Also, we receive auditing conducted by FSSA for compliance. We are also a DCS provider.**  **2.a.8 A&C meets this criterion as we maintain an effective emergency management plan, disaster response plan, downtime procedures, and medication downtime procedures, including shortages. We have a dedicated Resilience in Stressful Times (RISE) team that responds internally and as a Resilience and Emotional Support Team (REST) when externally contracted by DMHA for disaster response in Area 5.**  **2.b.1 A&C meets the initial/preliminary triage and risk identification criterion followed by an initial evaluation as stated in our clinical practice guidelines. All teams in our organization utilize a triage assessment, and if risk is identified, we have an immediate connection to emergency service crisis teams. Intakes are prioritized based on clinical acuity and in-person/walk-in appointments are offered, but individuals can choose telehealth appointments. A&C meets the 10-day criterion for non-urgent cases, and last month's data shows an average intake completion rate was within 4 days from initial contact. We are compliant with a review of OHS records, utilizing IHIE and our population health tools. A&C also has a dedicated hospital discharge process to ensure clients discharged from an inpatient psychiatric hospitalization have expedited services. This process ensures all medical records are obtained and can be reviewed before intake or follow-up appointment. This process notifies the hospital if the individual does not show up for the intake.**  **2.b.2 A&C meets criterion with expectations around treatment planning as indicated in our clinical practice guidelines highlighting person-centered and family-centered treatment planning practiced by all staff and teams. This process is demonstrated and managed during internal and external auditing and through leadership oversight. Treatment plans are updated when clinically indicated and/or at the request of the client and/or family.**  **2.c.1 A&C meets and exceeds this criterion, our crisis services are available 24 hours/7 days, and our mobile crisis services are staffed with therapists and peers. In February of 2024 we will be providing/launching crisis receiving and stabilization services through a living room model.**  **Our mobile crisis response is a two-person response that includes a peer specialist.**  **2.c.3 A&C meets the criterion as we educate individuals at the time of triage, intake, and at crisis events on the availability and how to access crisis hotlines and warmlines. This is also provided to individuals as they remain in our services. We educate on psychiatric advance directives, which are documented in our EHR; safety planning is completed when clinically indicated, discussed at the time of intake, and at the resolution of a crisis event. This is provided in the client's indicated language need or preference. Documentation can be provided in the client's preferred/indicated language as well.**  **2.c.4 A&C meets this criterion. We have long-established working relationships with local hospitals and emergency rooms in both Marion County and Johnson County. We currently provide crisis services within Johnson Memorial Hospital’s emergency department. We have established protocols with a warm handoff approach that includes checking back with emergency rooms to learn the outcome of assessment and follow-up/referral needs.**  **2.c.5 A&C meets this criterion; we are a local Johnson County JRAC (Justice Reinvestment Advisory Council) participant. We have protocols for problem-solving court and participate in both Marion and Johnson County. We have expedited services for referrals from problem-solving courts and partnerships with multiple law enforcement agencies in Marion County and Johnson County. Our crisis team partners with law enforcement to engage individuals who interact with law enforcement in which law enforcement/CIT has identified a possible mental health need. This is to minimize ongoing interactions for individuals with law enforcement.**  **2.d.1 A&C meets the criterion; no individuals are denied services based on their ability to pay. A&C has a policy on sliding scale fee services that align annually with federal household income requirements. Also, we have a financial assistance program designed to provide free or discounted care to those with no means or limited means to pay for their medical services. In addition, we offer financial counseling to those individuals who cannot pay in full.**  **2.d.2 A&C meets this criterion. Our sliding fee schedule is posted in our buildings, on our website, and available in multiple languages and additional languages at the client's request.**  **2.d.3 A&C meets this criterion and utilizes the federal poverty guidelines (**[**http://aspe.hhs.gov/poverty**](http://aspe.hhs.gov/poverty)**)**  **2.d.4 A&C meets this criterion. Adult and Child Health will offer a Sliding Fee Discount Program to all clients. A&C will base program eligibility on a person’s ability to pay and will not discriminate based on race, color, religion, sex, sexual orientation, gender identity or status as transgender, national origin, age, military service, disability, genetic information, or any other category protected by applicable federal, state or local laws. The Federal Poverty Guidelines,** [**http://aspe.hhs.gov/poverty**](http://aspe.hhs.gov/poverty)**, will be used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.**  **2.e.1 A&C meets the criterion; we have dedicated homeless outreach services and partnerships that provide services in shelters regardless of a person’s housing status. The crisis team partners with outreach specialists to provide crisis continuum of services. We have a dedicated ACT team that services persons experiencing homelessness and lack of a permanent address.**  **2.e.2 A&C meets this criterion. We provide treatment for individuals not living near our locations in various ways. We provide telehealth outpatient, addictions, and psychiatry services. Our crisis services provide support wherever the client resides via telephone and/or linking to a local mobile crisis response team. For example, our crisis services have assisted individuals in other states, including Pennsylvania and Michigan. Other teams providing services include community services and school-based services in multiple counties. If an individual clinically requires community-based services and lives outside our service area, A&C links the individual to the appropriate service provider and ensures that connection through our care coordination team. A&C is part of collaborative projects that address re-entry needs connecting individuals with appropriate services in their local community. A&C is a Recovery Works provider. We share medical records as requested and as part of transitions of care.**  **We do not fully meet the criteria for the following:**  **2.b.3 A&C meets the criteria for crisis response and hospital discharge planning, but on average, clients are seen outside the recommended timeline of one business day. A&C can comply by 7.1.2024, and we will change our walk-in services by expanding our walk-in availability and streamlining our intake process through our EMR.**  **2.c.2 A&C does not fully meet this criterion but can comply by 7.1.2024. We provide postvention connection to LOSS services in Johnson Co. with Upstream Prevention. In Marion Co., we are working with MHAI to solidify our partnership with the LOSS team. Currently, Marion Co. does not have a LOSS team, but it is being established, and we have volunteered as a partner. Postvention services will be added to our policies and procedures. But currently, after a crisis response, we do have a protocol for the crisis team to follow up with individuals until connected to treatment or no longer in need.**  **2.c.6 A&C meets the criteria for completing crisis prevention and safety planning for acute hospitalizations and/or crisis events. This plan includes information about A&C’s mobile crisis team, 988, and national hotlines. At this time, we do not meet the criterion for completing a crisis plan for everyone at the time of intake; however, we provide crisis planning when clinically indicated. This change can be implemented by July 1, 2024, and we will change our process across the organization to complete crisis planning for everyone at the time of intake.** |

# Program Requirement 3: Care Coordination

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| **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 | 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.  *Note: See criteria 4.k relating to care coordination requirements for Veterans.* | **Yes** |  |
| 3.a.2 | 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.  *Note: CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.* | **Yes** |  |
| 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. | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 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 must connect with the Opioid Treatment Program (OTP) to adequately provide services. | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 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 with988 state-owned software for mobile crisis dispatch and Crisis Receiving and Stabilization Services providers and outpatient follow-up referral. | **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.   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. | **Yes** |  |
| 3.b.3 | 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:  -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.  *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.* | **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 | 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.   *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.* | **Yes** |  |
| 3.c.2 | 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.   *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 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.* | **Yes** |  |
| 3.c.3 | 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:   * 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)   CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following:   * Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders * Suicide and crisis hotlines and warmlines * Indian Health Service or other tribal programs * Homeless shelters 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)   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.  The State may require CCBHCs to establish additional partnerships based on the Community Needs Assessment. | **Yes** |  |
| 3.c.4 | 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.  *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.* | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 3.c.5 | The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge- Transfer (ADT) system.   The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.   *Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.* | **Yes** |  |
| 3.d.1 | 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. | **Yes** |  |
| 3.d.2 | 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.  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. | **Yes** |  |
| 3.d.3 | The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan.   *Note: See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.* | **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?

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| **A&C meets the following criteria:**  **3a.1 A&C believes that the quality of our services is dependent upon delivering family-involved care whenever possible. We strive to assess the holistic needs of the client and family to provide effective coordination of care across various systems and agencies. In Family-Centered Planning, this adherence to the client and family’s wishes includes**   **recognizing their preference in treatment providers, treatment approach, and their involvement in reviewing their care**   **at least every 90 days. A&C‘s commitment to person and family-centered care is also in our clinical practice guidelines that outline and guide the scope and implementation of our clinical treatment. A&C’s Child Welfare services provide various clinical and non-clinical services to children, adults, and families involved in the child welfare or juvenile justice system. A&C requires ongoing and regular communication with criminal justice, juvenile justice, and child welfare services and internal coordination to ensure high-level patient and family-involved clinical care. A&C provides care coordination to all Veteran clients receiving care through our agency and looks forward to expanding these efforts.**  **3a.2 A&C meets this criterion by ensuring that all documentation meets all HIPPA and 42CFR part 2 requirements, including for our minor clients. A&C obtains ROIs for care coordination needs, including family/natural support as identified by the client, external agencies, or outside clinical providers. All attempts to obtain ROIs are documented in the clinical record to ensure compliance with whole health and patient-centered care. A&C utilizes an electronic documentation system to record ROIs to document consent as frequently as possible. If A&C cannot utilize an electronic signature, then A&C utilizes a paper document.**  **3a.3 A&C initiated this process under the most recent CCBHC IA grant. Our care coordination team ensures that patients referred to external partners/agencies successfully connect to these external providers. In the last quarter, we ensured connection 70% of the time.**  **3a.6 A&C meets the criterion as evidenced by our Clients’ Rights and Responsibilities policy, highlighting freedom of choice for providers within the CCBHC and other partnerships.**  **3.a.7 A&C meets the criterion as evidenced by our Navigator role, providing access to benefits for clients and non-client community members. A&C has long partnered with local homeless shelters in Marion County to provide this resource to those entering shelter services. A&C offers this at resource drop-in centers in Johnson County.**  **3.b.1 A&C utilizes an EMR that integrates with population health tools such as EMR-specific pop health, IHIE and Azara integration. A&C agrees to interact with 988 state-owned software for mobile crisis dispatch and crisis receiving and stabilization services provider and outpatient follow-up referrals.**  **3.b.2 All of A&C EMR and IT health tools comply with the ability to conduct activities related to population health management, disparity reductions, and quality improvement, measurement, and reporting. All technology updates recognize and utilize HHS-adopted standards when available. We currently utilize IHIE, Next Gen Population Health, Azara and look forward to a data warehouse within the state. We will comply with submitting data to the state as needed, as we are familiar with these processes through our DMHA reporting, UDS reporting, and other state/federal data reporting guidelines.**  **3.b.3 A&C exceeds this criterion as evidenced by our utilization of EMR technology that captures demographic information, including race, ethnicity, sexual and gender identity, preferred name/pronoun, and disability status for all patients entering our system. Our EHR supports sending and receiving a summary of care records through our patient portal or referral system. A&C is also a part of the IHIE network for clinical information sharing. Clients can access and download their individual patient care records through our patient portal system. Our EHR provides evidence-based tools and clinical decision support. A&C utilizes electronic prescribing through our EMR. A&C’s EMR already implements all the criteria in this category.**  **3.b.4 A&C will work with all DCOs to ensure that obtained consents comply with all privacy and confidentiality requirements, including any care provided to minor clients.**  **3.b.5 Within two years, A&C will develop a plan to continue improving our electronic interfacing to focus on improving the care coordination we are already doing between the CCBHC and all DCOs using our health IT systems.**  **3.c.1 A&C has established protocols with FQHC-LALs, both internal and external, to ensure care coordination for clients in primary care services. A&C has signed agreements or established protocols to ensure care coordination for clients receiving primary care outside of our internal or external partners.**  **3.c.2 A&C meets this criterion based on our established protocols to track and monitor clients admitted to psychiatric inpatient services, residential substance abuse treatment programs, OTP services, medical withdrawal, and ambulatory withdrawal services. A&C utilizes care coordination agreements and the IHIE network to track admissions and discharges and has established protocols for follow-up post-discharge. We also partner with MCEs to be notified of admissions, discharges, and engagement.**  **3.c.3 A&C is compliant in this criterion as evidenced by formal partnerships with several local schools, child welfare agencies, juvenile and criminal justice programs, state-licensed and nationally accredited therapeutic foster care, and various social service agencies, including local LOSS teams. A&C is also a child welfare and licensed therapeutic foster care agency. A&C already has established partnerships with MAT providers, suicide crisis hotlines and providers, homeless shelters/housing supports, employment service systems, peer-operated programs, aging and disability resource centers, state and local health departments, SUD prevention and harm reduction programs, criminal and juvenile justice programs including LEA, courts and jails, legal aid, immigrant and refugee services, SUD Recovery and transitional housing, and WIC. A&C has a partnership with CHOICES, who is the mobile crisis designee currently in the counties we serve. A&C staff actively participate in multiple community systems of care, community corrections advisory boards, JRAC programs, CIT training programs and committees, fatality reviews, and human trafficking resources. These partnerships have been based on our community needs assessments, and A&C is willing to expand these partnerships as CCBHC programming is developed within the state.**  **3.c.5 A&C has established protocols to track and follow up with our patients who are seen in inpatient facilities and emergency rooms. Our procedures include connecting with peer specialists and care coordination to ensure continuity of care and minimize transition time upon discharge. These procedures are done through a variety of protocols based on the facility, with the goal of occurring before the discharge from the discharging facility. A&C requests medical records from all outside systems and utilizes the IHIE/ADT system to ensure continuity of care. Our mobile crisis team connects within 24 hours of discharge to provide appropriate postvention transition care for any patient touched by crisis services. A&C will continue to expand this care coordination intervention as we grow into a complete CCBHC state system.**  **3.d.1 All services at A&C, including care coordination and treatment planning, are patient and family-focused as outlined in our client’s rights and responsibilities, day-to-day practice standards, and our clinical practice guidelines.**  **3.d.2 Each A&C patient has a designated interdisciplinary treatment team that collaborates with the patient, family, potential outside partners, and whole health care providers to develop a person-centered, strength-based trauma-informed clinical care plan. The interdisciplinary team meets at a minimum of every 90 days and can meet sooner if clinically indicated. The interdisciplinary team works with the patient and family to ensure that culturally competent care needs are met for the patient.**  **3.d.3 A&C has established protocols to collaborate with our current partners to meet care coordination needs. As A&C grows additional DCOs, we will ensure that care coordination language and expectations are clearly outlined in those formal DCO agreements.**    **A&C does not fully meet the criteria for the following:**  **3a.4 Currently, A&C does not do a written crisis prevention plan for ALL patients; however, we comply with several aspects of this criteria. A&C educates all patients on the national suicide hotlines, local crisis hotlines (including A&Cs crisis services), 211, and 988. We do implement written crisis prevention plans when the need is clinically identified. Families and natural supports are included in crisis prevention planning. We will comply with the criterion by July 2024.**  **3a.5 Currently, A&C does not consult the PDMP for ALL patients prescribed medications. A&C does consult the state PDMP when the prescriber clinically identifies it as appropriate and before prescribing any controlled substance. A&C does ask for a self-report at the initial evaluation for any prescribed medications and performs medication reconciliation processes at all new and ongoing prescriber appointments. A&C attempts to obtain outside records as patients enter our medical clinics to obtain accurate medication records, which could include checking with IHIE, pharmacies, and OSH providers if the client is unsure. A&C will implement updated workflows to comply with all patients by July 2024.**  **3.c.4 A&C has been unsuccessful in obtaining formalized partnerships with any local VA office/system clinical provider or any local training provider. A&C provides crisis responses to any individual who seeks care, including Veterans. We have STAR-trained staff to provide treatment to those Veterans or families that do seek services within our agency. Our EMR collects data related to Veteran status, along with agency HR systems collecting employee Veteran status. We participated in crisis intercept mapping for Veterans and their families within Johnson County. We will be an active participant in any state-focused VA partnership development.** |

# Program Requirement 4: Scope of Services

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| **Criterion #** | **Criterion** | **Do you currently meet this criterion?** | **If not, will you be able to meet this criterion by7/1/24?** |
| 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.  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. | **Yes** |  |
| 4.a.3 | 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.   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.   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. | **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 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.   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. | **Yes** |  |
| 4.b.2 | 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.  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. | **Yes** |  |
| 4.c.1 | 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.  The State must request approval from HHS to certify CCBHCs that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.  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:   * **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 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. * **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.   Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.   *Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.* | **No** | **Yes, we will meet this criterion by 7/1/2024** |
| 4.d.1 | 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.  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.e.,* LOCUS). | **Yes** |  |
| 4.d.2 | 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. | **Yes** |  |
| 4.d.3 | The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum:   1. Preliminary diagnoses 2. The source of referral 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services 5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications 6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful 7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications 8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors 9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence 10. Assessment of need for medical care (with referral and follow-up as required) 11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services 12. For children and youth, whether they have system involvement (such as schools, child welfare, and/or juvenile justice)   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 | **Yes** |  |
| 4.d.4 | A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs, and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall 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:   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 of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. 8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement- based care), 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. | **Yes** |  |
| 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 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.   *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.* | **Yes** |  |
| 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. | **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 | 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.   *Note: See program requirement 3 related to coordination of care and treatment planning.* | **Yes** |  |
| 4.e.2 | 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. | **Yes** |  |
| 4.e.3 | 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 first contact. The initial evaluation must be completed at first visit, with background information submitted during screening.  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. | **Yes** |  |
| 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 | 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.  The CCBHC must document any external consultation relationships. | **Yes** |  |
| 4.e.7 | 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.  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 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). | **Yes** |  |
| 4.f.1 | The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.   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.  *Note: See also program requirement 3 regarding coordination of services and treatment planning.* | **Yes** |  |
| 4.f.2 | 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. | **Yes** |  |
| 4.f.3 | 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. | **Yes** |  |
| 4.g.1 | 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.   Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC.   The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions:   * 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, we will be able to meet this by July 1, 2024** |
| 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 experienced by CCBHC populations across the lifespan. Protocols will include:   * 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.   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. | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 4.g.3 | 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:   1. ensuring individuals have access to primary care services; 2. ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions; 3. coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and 4. promoting a healthy behavior lifestyle.  *may elect to require specific other screening and monitoring to be provided by the CCBHCs in addition to the those described in 4.g.*   *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.   Note: See also program requirement 3 regarding coordination of services and treatment planning.* | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 4.h.1 | 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:  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. 2) During other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons.  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.   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.  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. | **Yes** |  |
| 4.i.1 | The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery 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:   * 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.   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.  *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.*  *Note: See program requirement 3 regarding coordination of services and treatment planning.* | **No** | **Yes, we will be able to meet this by July 1, 2024** |
| 4.j.1 | 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.  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):   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   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. | **Yes** |  |
| 4.k.1 | 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.  *Note: See program requirement 3 regarding coordination of services and treatment planning.* | **Yes** |  |
| 4.k.2 | All individuals inquiring about services are asked whether they have ever served in the U.S. military.  Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:   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.   Veterans: Persons affirming former military service (Veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics).  *Note: See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.* | **Yes** |  |
| 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 | 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:   1. Regular contact is maintained with the Veteran as clinically indicated if ongoing care is required. 2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each Veteran’s psychiatric medications on a regular basis. 3. Coordination and development of the Veteran’s treatment plan incorporates input from the Veteran (and, when appropriate, the family with the Veteran’s consent when the Veteran possesses adequate decision-making capacity or with the Veteran’s surrogate decision maker’s consent when the Veteran does not have adequate decision-making capacity). 4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. 5. The treatment plan is revised, when necessary. 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. | **Yes** |  |
| 4.k.5 | 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:   * Hope * Person-driven * Many pathways * Holistic * Peer support * Relational * Culture * Addresses trauma * Strengths/responsibility * Respect   As implemented in VHA recovery, the recovery principles also include the following:   * Privacy * Security * Honor   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. | **Yes** |  |
| 4.k.6 | All behavioral health care is provided with cultural competence.   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 | There is a behavioral health treatment plan for all Veterans receiving behavioral health services.   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** |  |

**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?

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| **A&C meets the following criteria:**  **4.a.1 A&C is able to and currently provides all of the 9 required services within our internal agency. We will continue strengthening DCO relationships to ensure that patients have freedom of choice. A&C will participate in any state-facilitated DCO relationships with all twenty-three additional CMHCs.**  **4.a.2 A&C can provide all 9 required services within our internal agency. When A&C enters into a DCO agreement, we will comply with the requirements. A&C already includes language related to freedom of choice in our patient’s rights documentations and policies. A&C already has a referral process and management system that allows us to track any current specialty care that we provide, which will continue to be utilized and enhanced as we expand our DCO relationships. A&C currently documents any external referrals in our EMR through progress notes, our referral order/management tool, and our care coordination documentation. A&C currently has all of our services listed online, and physical copies are available for our patients and partnering locations.**  **4.a.3 A&C has a formal grievance and complaint process that follows the Medicaid and DMHA state-required guidelines. A&C patient’s rights and responsibilities guidelines outline this process, which is posted on our website and in each physical location and is available in multiple languages. We display information about DMHA consumer services hotlines and other resources. This is posted in our physical locations as well as on our website.**  **4.a.4 A&C can provide all 9 required services internally within our agency. When A&C enters into a DCO agreement, we will ensure that they will meet the same quality standards and will be compliant with all data and care coordination requirements. A&C will participate in any state facilitated DCO relationships with all 23 additional CMHCs.**  **4.b.1 A&C’s clinical treatment planning and interventions follow all patient-centered guidelines and criteria. Clients are active participants in their treatment planning and development, including minors. Consents and treatment plans are signed by the patient and/or the legal guardian or POA, and clients are provided with a copy of their treatment plan document. This is included in our Patient rights/responsibilities to be an active participant in their treatment which are posted in the lobbies of our physical locations and available online.**  **4.b.2 A&C complies with person and family-centered care and is responsive to race, ethnicity, sexual orientation, and gender identity, and includes cultural and other individualized needs in the care/treatment provided. This is highlighted in our clients’ rights and responsibilities documents/policies, clinical practice guidelines, and training process.**  **4.d.1 A&C has a referral tracking process allowing us to track referrals to external agencies and ensure connection with that provider through our EMR and care coordination team. A&C utilizes telehealth and telemedicine services to provide screening assessment and diagnosis. A&C utilizes CANS and ANSA, PHQ 2 and 9, GAD 2 and 7, Columbia, Access to lethal means screenings, CALMS, and ACEs, along with EMR access to several additional clinical evidence-based screening tools to utilize when clinically appropriate. A&C is in the process of exploring LOCUS as a screening tool but is not currently utilizing this specific screening tool.**  **4.d.2 A&C meets the criteria for emergent, urgent, and routine services based on client choice. A&C has immediate crisis interventions, and walk-in clinical services are available. In the last quarter, A&C’s average time from initial client contact to intake was 6 days, with the average days to initial ongoing treatment appointment being 16 days (triage to ongoing treatment provider). Over the past month, those numbers have improved by an average of 4 days from initial contact to intake.**  **4.d.3 A&C meets the criteria by completing an initial evaluation and triage for all patients that includes all program requirements, including a self-report medication and herbal supplement list, along with the reconciliation of any outside records related to medication or clinical treatment needs. A&C assesses risk and other safety concerns at initial triage, initial/comprehensive evaluation, every 90 days, and as clinically indicated. A&C identifies at the time of registration if a patient is a current or previous member of the armed forces. With our minor clients, A&C assesses other system/social service agencies involved in the client’s care. These are documented ROIs to ensure care coordination is obtained based on minor/legal guardian choice. A&C gathers clinical information related to previous mental health, SUD, hospitalizations, physical health needs, current ETOH or SUD usage, medications and compliance, nutrition status, primary care enrollment, tobacco usage, dental and vision screenings if developmentally appropriate, along with immunizations and other physical health history. A&C’s initial evaluation is conducted by a master-level clinician, licensed clinician, or master-level trainee. A&C utilizes a trauma-informed care approach, including ACES and assessing for intimate partner violence.**  **4.d.4 A&C meets all evaluation criteria 1 through 15. A&C’s comprehensive evaluation gathers information for treatment planning and a crisis prevention plan that can be implemented if clinically indicated. Our comprehensive plan is currently completed within 60 days. Our assessment is clinically driven and can be continually updated when indicated by the treatment team, client, or family. Ongoing clinical treatment includes seeing the client and/or including family and natural supports in treatment planning that does not exceed 90 days. Currently we do not provide a crisis prevention plan for every patient. We will comply with the implementation of this process by July 2024. We currently collect all SDOH criteria required; however, we will be rolling out the formalized PRAPARE tool to all our clients at initial/comprehensive evaluation to be able to better track our data. For criterion 7, we get a self-report of medications, herbal supplements, dietary supplements, or utilize data from OSH hospital records to include medications the patient is prescribed. A&C utilizes the state PMDP system for controlled substances or, when clinically indicated, to further evaluate our medication needs and prescribing practices. A&C will comply with state-identified screening and assessment tools finalized during the demonstration program.**  **4.d.5 A&C will comply with any state-identified screening and assessment tools finalized during the demonstration program. A&C will be an active participant with the Indiana Council of Community Mental Health Centers, along with Indiana DMHA, IPHCA, and IHA, working on developing a Data Warehouse that will measure the quality and outcomes of CCBHC services as listed in Attachment F, Quality Metrics Response Template. Indiana is unique because no other system has undertaken the initiative to develop a Data Warehouse before/during demonstration implementation. A unified data collection and reporting structure is a foundation of CCBHC and will position our CMHC system to provide these services in Indiana. The data warehouse will be built in the next year to help support a successful demonstration**. **A&C actively participates in the data analytics committee and data warehouse demonstrations.**  **4.d.6 A&C utilizes state-approved screening tools based on evidence-based practices that are developmentally appropriate based on age and clinical presentation. A&C will utilize additional screening tools based on clinical need and has access to these additional tools electronically within our EMR. All of our staff are trained in motivational interviewing.**  **4.d.7 A&C utilizes culturally and linguistically appropriate screening tools and clinical interventions. A&C can utilize interpreters as needed through VOYCE translation services or bilingual staff that are approved to provide bilingual services. A&C uses self-report, legal guardian, family members, or natural supports report of cognitive needs or behaviors to tailor treatment to the most clinically appropriate and effective based on the client’s needs. Where applicable, A&C utilizes outside community resources/partners currently working with our clients to ensure a wholistic, comprehensive treatment plan that reflects the cognitive needs of our clients.**  **4.d.8 A&C, during preliminary triages, assesses for problematic and unsafe substances, including ETOH. A&C provides these individuals with a full assessment and clinical treatment plan for their SUD needs. If a patient has an acute SUD need that A&C’s SUD continuum cannot meet, then a referral is made to one of our referring partners to ensure the highest level of care is obtained. If an emergent need is indicated at either triage or initial evaluation, the patient is connected to our mobile crisis team for evaluation, assessment, and clinical intervention needed which could include referrals to acute detox programming.**  **4.e.1. A&C provides person and family-centered treatment planning, including risk assessment and crisis prevention planning. These satisfy the CCBHC outlined requirements and are in compliance with the Affordable Care Act.**  **4.e.2 A&C meets this criterion by developing an individualized patient-centered treatment plan that is based on clinical information obtained through the comprehensive evaluation, including patient goals and preferences for treatment. These plans are developed collaboratively, including shared decision-making with the client, natural supports and/or family (based on client choice), POA along with legal guardians if the client is a minor. The comprehensive plan includes clinical interventions addressing medical, physical, and behavioral health, potential SUD, and prevention needs. The comprehensive outlines the appropriate clinical EBP for the corresponding diagnosis, and the clinical criteria supporting that diagnosis and intervention. Barriers to clinical treatment, including transportation, if identified, are documented with interventions identified to prevent/resolve barriers to access to care. The clinical treatment plan is coordinated with the staff/programs that are appropriate for ongoing clinical intervention at a minimum of every 90 days. All appropriate ROIs are obtained as needed to provide the most comprehensive care feasible. As a PIPBHC grantee, integration is a core value to enhance client care. Initial/comprehensive evaluations are reviewed for the intersection between medical and behavioral diagnoses complicating treatment.**  **4.e.3. A&C completes initial and comprehensive evaluations, which include initial triage and background information including crisis information. These, along with ongoing screening at a minimum of every 90 days, are used to inform the treatment and services clinically indicated. A&C complies with comprehensive/initial treatment planning being done within the first 60 days of contact with client. Treatment plans are reviewed with the client and family/natural supports if permitted, and legal guardian at a minimum every 90 days and are documented within the EMR system.**  **4.e.4 A&C’s treatment plans include but are not limited to patient and/or clinician-identified strengths, needs, abilities, preferences, and goals for treatment. A&C utilizes the patient’s words and ideas along with the family/caregiver of the client to ensure strong engagement and patient-centered clinical care.**  **4.e.5 A&C’s treatment plans are comprehensive, addressing all services required, including recovery supports, with an intervention monitoring plan and process. Clients actively participate in the development and decision making needed for their clinical treatment.**  **4.e.6 As clinically indicated A&C will seek out consultation during the treatment plan for clinical specialty needs such as eating disorders, TBIs, intellectual or developmental disabilities, interpersonal violence, human trafficking, school-based well-being, along with school-based social-emotional supports. All external consultation relationships are documented with ROI, progress notes, outside agency records, care coordination, attendance to specialty appointments, or multi-disciplinary staffing based on clinical need.**  **4.e.7 A&C documents in a client’s individual record and advance directives relevant to treatment and crisis prevention planning. Documentation is included if patients refuse to share their wishes. As mentioned previously, A&C does provide crisis prevention planning when clinically indicated but is not formalized for all patients. A&C does educate all patients on National Suicide hotlines, 988 utilization, and local text suicide lines, along with A&C’s mobile crisis response team. A&C will comply with ALL clients receiving a crisis prevention plan by July 2024. A&C will comply with any state-identified aspects of person or family-centered requirements based on the needs identified in our community needs assessment.**  **4.e.8 is referenced in 4.e.1, but no criterion is found to address**  **4.f.1 A&C provides outpatient behavioral health care for all ages within office, school, and community-based settings. A&C also provides SUD services and tobacco cessation services, including ASAM levels 1.0 and 2.1. A&C also provides pharmaceutical services, including medication-assisted treatment. These services are provided both in person or using telehealth/telemedicine services. If a patient’s clinical intervention is higher than the acuity provided in the A&C continuum, then a referral can be made to an external referral source for a higher level of care. A&C, through our care coordination and referral arrangements, ensures connection to these referral providers. A&C utilizes motivational interviewing and harm reduction to provide or reduce substance use. As a CCBHC staff, we can consult with specialized service providers through our already developed integrated staffing process, along with consultation from our HSPP and clinical leadership program. A&C utilizes several evidence-based practices to provide these services and will comply with any additional identified by the state.**  **4.f.2 A&C provides clinical treatment and interventions that are appropriate for the client’s phase of life and development, ensuring the unique needs of youth and older adults are met. If the client presents with developmental or other cognitive disabilities, the level of functioning, as assessed by CANS and ANSA tools, is considered to ensure the most appropriate evidence-based treatments are utilized. Staff gather external documentation, including IEPs, previous psychological testing, and 504 plans, to gain a comprehensive clinical picture. For our older population, staff utilize MMSEs, education, and awareness of cognitive decline, and partnerships with other neurological and medical providers to ensure a complete clinical picture and intervention is developed. Staff are trained in these evidence-based programs, and all outcome measures are monitored based on evidence-based strategies to ensure the highest quality care provided or improvement in clinical outcomes.**  **4.f.3 A&C comprehensively addresses supports provided for our youth/adolescent clients to ensure that they address medical, mental health, SUD, psychosocial, and environmental issues. Through clinical assessment and the utilization of our CANS assessment tool, referrals for potential further interventions such as crisis services, further psychological testing, or additional social service needs are identified to create a comprehensive care plan. These assessments and decisions are made in conjunction with client, family, and natural supports’ goals and desires for treatment.**  **4.h.1 A&C can provide targeted case management for clients identified as high risk for suicide and overdose, especially during high-risk transition periods, through our Zero Suicide Pathway program. Targeted case management is also provided for our clients involved in our ACT programming, our homeless and housing outreach programs, embedded homeless shelter programming, and A&C partnership programs, where A&C provides TCM for high-risk individuals transitioning back into the community from jails or prison. A&C will comply with any state-identified TCM programming during the demonstration program.**  **4.j.1 A&C provides peer supports and recovery coaches as part of our continuum of care for our clients. A&C currently has peer supports on our mobile crisis teams, community-based teams, our addictions services, and will be a part of the staffing for our living room model crisis receiving unit opening early 2024. Peer services provide family and caregiver support services. For example, during mobile crisis response, peers provide community resource education and crisis resources to the client and the identified family and natural supports. A&C recently received a Workforce development grant that will enhance the utilization and training of peers throughout our agency. A&C mobile crisis peers will work from the initial point of crisis contact until the successful connection to ongoing clinical treatment. Addictions peers also collaborate with patients related to engagement, outreach, court appointments, recidivism prevention programs, and other services required to keep them successfully engaged in treatment. Peers embedded into services and staffing is an identified need in our community needs assessment. Peers are a part of the integrated multi-disciplinary team staffing to ensure that all aspects of the client’s care are represented.**  **4.k.1 A&C can provide all of the required services for members of the U.S Armed Forces and Veterans. Due to our proximity to a strong VA system for all our clinical locations, we do not have a large Veteran client population. A&C participated in the only 2023 SAMHSA Crisis Intercept Mapping for service members, Veterans, and their families to help communities recognize systemic gaps and strengthen the delivery of evidence-based suicide prevention policies and practices. We have STAR -trained therapists for clients to provide the highest quality behavioral health care. We participated in the Governors Challenge Training Portal (Psych Armor) as a resource for additional military training as needed. We have participated with IN IDVA for donations and distribution of gun locks in our Go Bags with our Mobile Crisis Teams. We are active participants in the Veteran’s Court in Marion County and will be a participant when Johnson County implements it in Jan. 2024. A&C will actively participate in any state-focused DCO relationship development with the VA system.**  **4.k.2 A&C inquires about the status of every client and their service in the U.S. Military. A&C has tri-care providers that can be utilized to provide all required services. A&C strives to have an enhanced partnership with the VA system to better help us serve our Veteran population. With the state’s help in building relationships with the VA, Veteran’s services will be improved and enhanced.**  **4.k.3 A&C ensures there is coordination and integration of care between substance use disorders, other mental health conditions, and physical health care for all clients receiving services, including active military service members Veterans.**  **4.k.4 A&C ensures that a principal behavioral health provider is identified who is trained in military and Veteran cultural competency. This provider ensures that all the treatment criteria that are required are met including regular contact, prescriber involvement, care coordination, and client input treatment plan and decision making. The treatment plan is updated every 90 days or when clinically indicated, and all medications are reconciled by our psychiatric provider. All treatment plans reflect the goals and wishes for the treatment of the individual client. A&C will continue to update and expand our STAR behavioral health providers based on A&C client population.**  **4.k.5 A&C ensures that all behavioral health services are recovery-oriented and are in accordance with SAMHSA working definition and set of principles. A&C ensures that the additional recovery principles are followed when serving our Veteran population. These guiding principles of recovery are outlined in our clinical practice guidelines, which direct our clinical interventions and treatment.**  **4.k.6 A&C ensures that all behavioral health care is provided in a culturally competent manner. All staff are trained in military and Veteran’s culture. All staff receive cultural competency training on race, ethnicity, age, sexual orientation, and gender identity. All of these trainings are completed annually.**  **4.k.7 A&C ensures that all Veterans receiving behavioral health services, the diagnoses and evidence-based interventions are outlined, including monitoring, clinical goals, and a plan for re-evaluation. If clinically indicated, the plan includes interventions to improve functioning and prevent relapses. All A&C plans are recovery-oriented and are based on client values and preferences, utilizing evidence-based practices. All treatment plans include input from the clients, including Veterans and their family members. A&C obtains written and verbal consent for treatment plans for all clients receiving services. All evidence-based practices agency-wide are approved by our Chief Quality Officer and Clinical Excellence team. Client-specific EBPs are identified based on clinical diagnosis and approved by our HSPP team in interdisciplinary staffings.**    **A&C does not meet the following criteria:**    **4.c.1 A&C does meet the criteria by providing mobile crisis services 24/7, 365 days a year, including emergency crisis intervention. A&C mobile crisis providers carry naloxone as part of their mobile crisis response as an overdose reversal intervention. A&C will open a crisis-receiving service living room model by early 2024. Our hours of operations will be in response to feedback from our community needs assessment, focusing on evening/weekend hours. We are not currently the 988 designated response in our counties, but we are currently working on designation submission aligning with the CMS Medicaid guidance. We will comply by July 2024.**  **4.g.1 A&C screens for basic physical health needs such as primary care engagement, tobacco and vaping use, and other physical health indicators-dental, vision, nutrition, pain. A&C does not currently formally screen for diabetes, heart disease, obesity, or COPD in all patients. However, we do collect self-report data of physical health conditions and would document these in the comprehensive evaluation if the client indicated. A&C works to ensure that every patient is connected to a primary care provider, either through our own internal primary care or to an external provider based on client choice. These connection attempts are documented in our EMR. Our Medical Director and Associate Medical Director for Primary Care will establish protocols that ensure we comply with a more formalized process for screening for all of these physical indicators by July 2024.**  **4.g.2 While A&C does collect this data through self-report information from clients, we still need a formalized process to ensure that every patient is screened for common physical health conditions. These protocols will be developed and implemented by July 2024. As a Promoting Integration of Primary and Behavioral Healthcare grantee, A&C has expanded our screening to new clients with high LON for co-occurring primary diseases. This experience allows us to continue to expand the process. A&C is a primary care provider, so we have the experience and the potential resources to expand these processes to all clients receiving services throughout our agency. A&C also has a formalized partnership with QUEST laboratory services within our primary and psychiatry clinics, which will also be able to be utilized in the expansion of these screenings. Clients have access to laboratory services done by QUEST in our local clinics, or based on choice, can receive labs at any QUEST location under the A&C contract umbrella. A&Cs care coordination program already has processes established to obtain results of tests and screenings of health conditions for our clients, so this experience will allow ease of implementation across the agency.**  **4.g.3 A&C meets the criteria for ensuring that all patients have access to primary care services, whether through A&C-provided primary care or an external provider. A&C does not currently ensure that ALL patients receive ongoing laboratory testing and physical measurements of health indicators, coordination with primary care and specialty health providers, and promoting a healthy lifestyle. A&C does ensure that we do these services with our current primary care patients through our care coordination and referral management system, so we will have experience in implementation needed to comply by July 2024. A&C currently utilizes CHWs and will look at expanding their role.**  **4.i.1 A&C is currently in compliance with all rehabilitation services provided under A&C’s scope of services, except employment services, due to recent staff changes. A&C has current partnerships with Easter Seals Crossroads to ensure that there will be no gap in care in being able to provide these services. A&C will ensure that we comply with a formal DCO by July 2024.** |

# Program Requirement 5: Quality and Data

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| **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.  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. | **Yes** |  |
| 5.a.3 | In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC- identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state’s claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. All data collection and reporting are required to be shared with the State of Indiana to meet State or federal requirements.  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.  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. | **Yes** |  |
| 5.a.4 | 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.  *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).* | **Yes** |  |
| 5.b.1 | 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.  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 | **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. | **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?

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| **A&C meets the following criteria:**  **5.a.1 A&C can track all of the data required electronically within our EMR system. A&C reviews the demographic data, clinical outcomes, and other outcome measures at the program and agency level. This is also reviewed with our clinical excellence team and during quality meetings. A&C currently reports NOMS data as a CCBHC-IA grantee.**  **5.a.2 A&C currently complies with all data submissions to SAMHSA as a current CCBHC-IA and previous initial CCBHC grantee. These reporting requirements are currently done for all patients receiving CCBHC services and are done quarterly. A&C will comply with any additional data requirements and submissions.**  **5.a.3. A&C will be compliant with all data requirements and submissions at all state, federal, and evaluator levels. A&C has experience in cost reporting and submission of cost reports due to being an FQHC-LAL for the last several years.**  **5.a.4 A&C will be able to comply with the submission of cost reporting. We are familiar with this process and submission due to having to create annual costs for our FQHC-LAL program.**  **5.b.1 A&C currently has a CQI plan that focuses on quality improvement throughout our agency, with interventions focused on clinical outcomes such as but not limited to ER utilization reduction, decrease in hospital readmission, increased utilization of crisis services, overdose prevention, clinical outcome improvements, and overall population health metric improvement. A&C’s leadership team, including the medical director, is a part of the CQI development, analysis, and ongoing interventions as identified by clinical need. Care coordination and integration of all CCBHC and primary care services are a major focus of our CQI as part of our growth as a CCBHC and CCBHC-IA grant recipient. A&C will provide all data required as part of a demonstration program.**  **5.b.2 A&C’s current CQI plan includes significant event reviews of critical events such as death by suicide, suicide attempts of our patients, fatal and non-fatal overdoses, and all-cause mortality among people receiving services. These are reviewed at a high level within our clinical council, individual team levels, along with a clinical outcome and evidence-based practice measure to ensure the highest quality care and prevention interventions are in place for our clients.**  **5.b.3 A&C’s CQI plan meets the minimum requirements outlined by SAMHSA and the State Demonstration Project Section 223. We are currently implementing a health disparity tool for every patient that enters our facilities which will allow us to incorporate a more specific clinical focus for those health disparity outcomes in our CQI plans.** |

# Program Requirement 6: Organizational Authority and Governance

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| **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 | The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria:   * 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.)   *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.* | **Yes** |  |
| 6.a.2 | 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. | **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 | CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making.  Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making.32 CCBHCs reflect substantial participation by one of two options:  Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.  Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board.  Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:   1. Identifying community needs and goals and objectives of the CCBHC 2. Service development, quality improvement, and the activities of the CCBHC 3. Fiscal and budgetary decisions 4. Governance (human resource planning, leadership recruitment and selection, etc.)   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. | **Yes** |  |
| 6.b.2 | 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.  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.  *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. 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."* | **Yes** |  |
| 6.b.3 | 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. | **Yes** |  |
| 6.b.4 | 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. | **Yes** |  |
| 6.c.1 | The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator. | **Yes** |  |

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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** |

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| **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, DMHA for mental health and substance abuse, HRSA LAL Certification, Planning on pursuing CARF and PCMH** |

**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?

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| **A&C meets the following criteria:**  **6.a.1 A&C maintains all appropriate documentation related to being a non-profit under Section 501 (c) (3) of the United States Internal Revenue Code.**  **6.a.2 A&C will partner with local Indian organizations, including the Native American Indian Affairs Commission for the State of Indiana. A&C is not operated under the authority of Indian Health Services, an Indian tribe, or an Indian organization. 6a.3 A&C currently meets this criterion as we have already completed an independent financial audit with Blue and Company on an annual basis. This audit reviews all the criteria, including costs and material weaknesses, and all findings are reviewed by the executive team and governing board for further intervention if required. This process will continue as a CCBHC demonstration participant.**  **6.b.1 A&C meets this criterion under option 1 where 51% of our board has lived experience. \*\* A&C is currently meeting this goal at 50% lived experience due to the recent unexpected demise of a board member. Our policy and procedures comply with this metric, and we will return to compliance upon replacing the board member. Regarding option 2, A&C has a family/patient advisory council we utilize for clinical and patient experience guidance and outcomes or interventions. This council shares with the agency governing board.**  **6.b.2 A&C meets this criterion with a board population made up of 51% of the board are either a patient of A&C or have lived experience. All our procedures and governing policies require patient participation or lived experience for our governance. In relationship to option 2, A&C has a family/patient advisory council we utilize for clinical and patient experience guidance and outcomes or interventions. This council shares with the agency governing board. Our policy and procedures are compliant with this metric, and we will return to compliance upon replacement of the board member.**  **6.b.3 A&C is not comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization. In the event this changes, we will comply.**  **6.b.4 A&C meets this criterion based on our board demographic make-up, including lived experience, and no more than 10% of the board receiving funding in the healthcare industry. These criteria are all outlined in our governing board policies for our agency.**  **6.c.1 A&C is enrolled as a Medicaid provider and certified with DMHA for mental health and SUD services. We participate in the SAMHSA behavioral health treatment locator. We adhere to all state accreditation certification and/or licensing requirements.**  **6.c.2 A&C has submitted an attestation as part of our CCBHC SAMHSA requirements. We currently are participating in the CCHBC-IA (2026) grant and were previously awarded the CCBHC original funding which ends in Feb 2024. A&C is due for recertification with SAMHSA in 2024.**  **6.c.3 A&C is Joint Commission certified, DMHA certified for mental health and substance abuse disorders, and HRSA certified as a FQHC-LAL. We plan on CARF accreditation and Primary Care Medical Home Certification in the upcoming fiscal year.** |