New Integrated CCBHC Certification Criteria Feasibility and Readiness Tool (I-CCFRT)

On March 31, 2014, Congress passed the Protecting Access to Medicare Act (H.R. 4302), which included a demonstration program based on the Excellence in Mental Health Act. Once again, behavioral health clinics will have a federal definition with defined quality standards and reimbursement that reflects the actual cost of care. The legislation:

- **Creates criteria for "Certified Community Behavioral Health Clinics" (CCBHCs)** as entities designed to serve individuals with serious mental illnesses and substance use disorders that provide intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services. The Secretary of the Department of Health and Human Services is directed to establish a process for selecting eight states to participate in a 2-year pilot program.
- **Provides $25,000,000 that will be available to states as planning grants** to identify how CCBHCs fit into system redesign efforts and to develop applications to participate as a demonstration state. Only states that have received a planning grant will be eligible to apply to participate in the pilot.
- **Requires participating states to develop a Prospective Payment System (PPS)** for reimbursing Certified Behavioral Health Clinics for required services provided by these entities. Participating states will receive an enhanced Medicaid match rate for all of the required services provided by the Certified Community Behavioral Health Clinics.

On October 19th SAMHSA confirmed the following states have received the one year CCBHC planning grant:

• Alaska	• Iowa	• Missouri	• Oklahoma
• California	• Kentucky	• Nevada	• Oregon
• Colorado	• Maryland	• New Mexico	• Pennsylvania
• Connecticut	• Massachusetts	• New York	• Rhode Island
• Illinois	• Michigan	• New Jersey	• Texas
• Indiana	• Minnesota	• North Carolina	• Virginia

The National Council for Behavioral Health requested that MTM Services (MTM), Community Oriented Correctional Health Services (COCHS) and McBee Associates, Inc., (McBee) collaborate to develop a more integrated CCBHC readiness assessment tool to be used by Community Behavioral Health Clinics (CBHCs) that will be participating in one of the 24 CCBH state planning grants. Below is a summary of all three organizations and the expertise and experience they bring to this new readiness assessment tool:

- **MTM Services (MTM)**, Raleigh, NC: MTM is the premiere firm for organizations who want to accomplish substantial changes in their service delivery systems to enhance access to treatment, the quality of care being delivered and the quality of life for those delivering it. Since 1995, MTM has provided to over 800 CBHCs project management for local, regional and statewide transformational change processes along with its SPQM Data Measurement system that provides performance measurement and data driven management.
- **Community Oriented Correctional Health Services (COCHS)**, Oakland, CA: COCHS is a philanthropically funded non-profit corporation that is the national leader in promoting health care connectivity in communities through the development of financially viable and sustainable health care delivery systems. COCHS has been focused on designing non-four walls, trauma-informed service delivery systems to serve the most vulnerable populations.
- **McBee Associates, Inc. (McBee**), Philadelphia, PA: McBee is a recognized national leader in providing managerial and financial consulting services to the health care industry. Established in 1973, the firm has developed into one of the nation's largest, independent health care financial consulting practices by delivering quality service throughout the industry.

Before starting the I-CCFRT assessment, it is important to understand that a CCBHC is a new provider type. Therefore, for an entity or a state to assess readiness for a new provider type, there

are specific comprehensive requirements that must be understood and incorporated into the responses to the I-CCFRT assessment as outlined below:

1. CCBHCs have a distinct service delivery model – trauma-informed recovery outside the traditional four walls of a historical community behavioral health center;
2. CCBHCs have a new Prospective Payment System (PPS) payment methodology (particularly in reference to PPS-2 rate setting states);
3. CCBHCs have a requirement to have meta-data that is tied to the definition of the provider type (not necessarily tied to the historical "four walls" delivery systems); and
4. CCBHCs have a requirement to contract with other organizations or with a Designated Collaborating Organization **(**DCO) and the CCBHC has specific compliance responsibility for the other organizations and DCOs. (I.e., the CCBHC's compliance responsibility is juxtaposed with whether the contractual organization is "related" or "unrelated" as defined under Medicaid rules. Therefore, the entity may need to be a DCO for a CCBHC rather than being a CCBHC.)

   To address these important new provider type requirements, the I-CCFRT contains specific sections as follows:

Assessment of Feasibility to become a CCBHC: Below is an outline of the section number topic areas in the I-CCFRT:

1. **Feasibility Sections**: The purpose of Sections A - E is for your clinic to consider whether or not it is feasible for the clinic to move forward to become a CCBHC or whether your clinic should consider becoming a DCO for a CCBHC:
   A. Non Four Walls Design Model and how you can objectively measure if the service delivery culture will work in the new system
   B. Trauma-Informed Care Model and objective indicators of the ability to deliver this type of care
   C. PPS Rate Setting Support Requirements
   D. Other Considerations Related to CCBHC Feasibility and Readiness:
      1. Know the State Medicaid Rules
      2. Understand How Your Relationships Translate into Costs
      3. Getting Technology Right
      4. Telemedicine
      5. Clinical Quality Assurance
      6. Corporate Practice of Medicine
      7. PPS-2--Another Level of Complication
   E. CCBHC Service Delivery Operational Requirements
2. **Readiness Sections:** If your clinic has determined that it is feasible to move forward as a CCBHC, Sections E and F support a readiness assessment of your clinic's ability to meet the CCBHC certification standards and assess the ability of your management team to support timely and effective transformational systems change:
   E. Compliance with CCBHC Certification Requirements
   F. Decision-Making and Change Management Support Assessment

The I-CCFRT provides a system for gauging the level of concern among your staff that will support awareness of the level of change management that may be needed to support enhanced service delivery processes, staffing, scope of services, quality outcomes, reporting and governance areas. The readiness tool also provides a sub-total section and overall concern level score which can support more objective identification of change management needs for the clinic to meet all criteria.

Important Definitions: Before completing the I-CCFRT, it is important to review and understand "Definitions" of important terms used in the criteria. **The SAMHSA provided CCBHC criteria terms and identified definitions as well as a summary of the quality measures and other reporting requirements are listed beginning on page 34 which follows at the end of I-CCFRT Assessment Scoring Sheet**.

Use of I-CCFRT

The I-CCFRT is a self-assessment tool that will require your management team to schedule joint time to meet and work through the six programs. The typical time frame to complete the assessment will vary from team to team ***based on the service delivery process measurement and support awareness that your team processes***.

Below is important context for your management team as preparation for your use of the I-CCFRT:

1. It is important for your team to move away from anecdotal responses to the certification criteria questions such as "We should be able to provide this support and/or meet the criteria…." to understand the reality of the actual capacity of the clinic and/or individual locations/programs to actually implement the design plan, operational requirements and meet the criteria.
2. If there are significant variances in response levels or service process data among the management team members, it is important to identify if an I-CCFRT needs to be completed for specific programs (i.e., children/adolescent vs. adult, etc.) or locations in order to fully identify process variances within the clinic. If it is determined best to use multiple I-CCFRT forms to assess programs/locations within the clinic, please add together and average the question and section scores to generate an overall score for the clinic.
3. If the question and section scores have more than a one point variance, the key issue to identify is to determine if your clinic is operating as a "group practice" or a "loosely held federation of individual practices".

   NOTE: If your clinic finds that there are significant practice variances within specific programs and/or locations, then overall clinic compliance with the required certification criteria can be significantly more difficult. Therefore, an important outcome of the I-CCFRT might be to identify specific internal practice variances and how to reduce/eliminate these variances.
4. The self assessment scoring model for each question and section of the I-CCFRT is based on a five point scale as outlined below:

1	2	3	4	5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

The level of concern that your team identifies needs to be supported by the following scoring parameters:

a. If a particular design, operational and/or certification criterion focuses on the state's ability to perform, please rate your level of concern about your CCBHC providing the state necessary information to support the state performance requirement.
b. If your team is not able to identify the specific response requested to any primary question, the level of challenge score should be documented as a "1".

c. Most assessment questions contain a “Yes” or “No” identifier prior to the concern rating. The focus for this question is for your team to confirm if the identified design, operational requirement and/or criterion is current practice within your clinic - YES or NO. If your team responds “NO”, the specific criterion concern response should be a 1 – 4 based on the level of concern you have about developing the capacity to be compliant with the criterion. Also, if your team identifies a “Yes” and does not feel that a “5” fully identifies the appropriate response, please identify the level of concern that your teams has about being fully compliant.
d. If your team identifies a level of practice variance within various programs or locations, the score should be a “2” or “3” based on the level of variance identified and the amount of effort it will take to reduce the variance to a standardized clinic wide practice.

At end of each section of the I-CCFRT, there is a “Total Cumulative Score” indicator that will allow your team to total all individual question scores in that section. Also, at the end of the I-CCFRT, there is a scoring sheet that provides for transferring the section cumulative scores to an overall score summary with recommendations for next steps.

E-Form Instructions: The I-CCFRT assessment is provided as an e-form. On the following pages, please tab through the assessment sections or click on a specific response area and enter the text or click on a checked item. Using the tab key will advance the pages.

I-CCFRT - Assessment of Feasibility and Readiness to Become a CCBHC

Clinic Name:	
Primary Contact Person :	E-mail:

Feasibility Assessment Sections A - E

Section A: Non-Four-Walls System Design Readiness Assessment:

Context for Non-Four-Walls System Design Section:

For a CCBHC to effectively address health care disparities, the traditional four-wall approach to health care delivery must be reconsidered because many individuals with the highest needs often:

- Cannot come to an on-site facility to receive the care they need;
- Require novel methods of care to integrate behavioral and physical health and appropriately manage care; and
- Require interventions that include community involvement and education—particularly individuals with substance use disorder.

As states think through the quality metrics and evidence-based practices included in the CCBHC program, incorporating the Triple Aim (individual health, population health, and controlling costs) and defining the role of a CCBHC in addressing population health is an integral part of a non-four-walls Trauma-Informed Recovery Model.

1. CCBHCs must adapt to the behavioral health needs of diverse communities and decrease health care disparities. Can your facility:

a. Reach individuals with behavioral health needs in diverse settings such as:

- o Jails and prisons,
- o Schools,
- o Churches,
- o Homes,
- o Foster families,
- o Shelters,
- o Emergency Rooms, and
- o Public parks and recreational facilities;

☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

b. Address the needs of culturally diverse individuals with culturally competent providers, staff, and peer support? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

c. Integrate the non-four-wall services into the core of CCBHC in a way that is culturally competent and reflects a trauma-informed recovery model? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

2. Ongoing cycles of victimization and trauma create vocabularies that often are foreign to many health care service providers. Is your staff and facility culturally competent to interpret and understand the vocabulary of victimization and trauma? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Health care providers have come to understand that health care is best delivered through what public health professionals call the Triple Aim: individual health, population health, and controlling costs. All three parts of the Triple Aim must be tackled at the same time—otherwise; the optimal outcomes will remain elusive. Is your clinic currently conceptualizing its service delivery in terms of the Triple Aim? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

4. As a CCBHC engages with individuals who are trapped in the cycle of victimization and trauma, successful outcome will be dependent upon the CCBHC's ability to engage with the community from which these individuals come and address the root causes of this cycle. Does your clinic currently have this capability? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

Note: Total Score for this section ranges from 6 to 30	**Section A Total Cumulative Score**:

Section B: Trauma-Informed Care Readiness Assessment:

Overview of Trauma-informed care: A trauma-informed approach to care "*realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff,

and others involved in the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization.*" The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration [2014])

Trauma-Informed Care is Community-Based Care (Non-Four Walls):
In most parts of the country the predominant model of care delivery is predicated on consumers accessing care at a clinic with occasional visits in the community. The CCBHC criteria state clearly that all services are available without "4-wall" constraints – meaning that they can be delivered anywhere in the community or via tele-health and still be considered a valid encounter. Further, the care coordination requirements in the statute and subsequent criteria require the CCBHC to have care coordination relationships with a broad range of entities, including community and psychiatric hospitals, juvenile and criminal justice facilities, child welfare, as well as specialty substance use treatment, primary care and other social service agencies.
CCBHCs are paid an all-inclusive rate that is based on costs. This payment flexibility coupled with the care coordination requirements and the emphasis on community-based care provides the CCBHC with a tremendous amount of flexibility in terms of where and how they deliver care. Consider the following opportunities to improve care:

- Emergency room diversion
- Jail Booking diversion
- Post-release "warm hand-off"
- Foster care placement support

CCBHCs have an obligation and the payment flexibility to intervene in each of these settings, facilitating access to care, supporting healthy transitions, and avoiding more expensive levels of care.

1. Based on the above definition, does your clinic currently have the service delivery culture and capacity to deliver non-four walls community-based trauma informed care?	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

2. An important indicator of a trauma-informed service delivery culture is to shift from a primary reliance on "scheduling clients" as a solution to meeting their service delivery needs, to a clinical culture of actually "seeing clients" by using all of the then currently available clinical service capacity available at that time. Does your clinic have a clinical approach that is primarily focused on "seeing clients "?	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. Within the bounds of state licensure and certification regulations, CCBHC staffing will include Medicaid-enrolled providers who adequately address the needs of the consumer population served. Credentialed, certified, and licensed professionals with adequate training in person-centered, family-centered, **trauma-informed**, culturally competent and recovery-oriented care will help ensure this objective is attained. Care meeting these standards will further help the CCBHCs achieve integrated and high quality care. Is your clinic currently able to meet this service delivery model requirement?	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

4. Organizations that are trauma informed are inherently recovery oriented and vice versa. Does your clinic currently incorporate the following principles of a trauma-informed organization/system into its clinical philosophy: • Safety • Trustworthiness and transparency • Historical, cultural, gender issues • Mutuality and collaboration • Empowerment • Voice and Choice	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. Does your clinic currently have the capacity to deliver the key elements of a non-four-wall, trauma-informed care delivery system as outlined below?

a. Comprehensive early screening and assessment for trauma that is sensitively delivered?	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

b. Consumer involvement to lend voice, choice and advocacy for persons served?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
c. A fully educated and trauma-informed workforce with an emphasis on self-care and compassion fatigue of staff?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
d. Provision of trauma-informed, evidence-based, and emerging best practices?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
e. Creating a sense of physical, psychological, social and moral safety for every person receiving services as well as the staff of the organization?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
f. Creating trauma-informed community partnerships to reach across systems in order to ensure that all services provided within the community are trauma informed?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
g. Using data to inform quality improvement, develop outcome measures and monitor the ever-changing nature of the culture within the organization?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
6. Trauma-Informed Care requires specific care coordination and capacity questions: Please confirm below if your clinic currently has experience or capacity to coordinate care in the following settings:				
a. Do you have experience providing behavioral health care in schools?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
b. Do you have experience providing behavioral health care in homeless shelters?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
c. Do you have experience providing behavioral health care in foster care settings?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
d. Do you have experience providing behavioral health care in jails and correctional settings?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
e. Do you have experience providing behavioral health care in Emergency Room settings?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
f. Do you have the capacity to coordinate behavioral health care with providers in schools?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
g. Do you have the capacity to coordinate behavioral health care with providers in homeless shelters?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
h. Do you have the capacity to coordinate behavioral health care with providers in foster care settings?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
i. Do you have the capacity to coordinate behavioral health care with providers in jails and correctional settings?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
j. Do you have the capacity to coordinate behavioral health care with providers in Emergency Room settings?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

7. Trauma-Informed Care requires timely access to treatment: Please confirm below if your clinic currently has experience or capacity to coordinate care in the following settings:

1. Can your clinic provide clients with a same day access to a clinical diagnostic assessment in the clinic and in the community? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

2. Can your clinic provide clients access to an initial psychiatric evaluation within 3-to-5 days after the initial clinical diagnostic assessment? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

Note: Total Score for this section ranges from 23 to 115

Section B Total Cumulative Score:

Section C: Prospective Payment System Rate Support Requirements:

As a prospective CCBHC, your all-inclusive rate will be based upon the costs established in a baseline cost-setting year. The baseline cost-setting year began October 1, 2015—meaning you are already in the midst of your baseline cost-setting year. Your costs will be established by your actual costs this year, but also by a set of estimated costs. As a CCBHC, you must be able to accurately estimate and justify these costs. These estimated costs will be comprised of the costs incurred by your DCOs, costs required to meet the capacity of the intended service mix, and costs to meet certification standards.

1. Does your clinic examine your balance sheet at times aside from the official audit? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

2. Does your clinic maintain and update its depreciation log to reflect the acquisition of new equipment? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. Can you produce a depreciation expense report out of your current accounting system? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

4. Does your current General Ledger contain code descriptions? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. Does your accounting system clearly identify cost centers by program? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

6. Is your payroll system designed to identify employee cost by program worked in? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. If you answered no to #4 do you have a system in place to complete quarterly time studies? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

8. Are you able to provide detailed descriptions of miscellaneous expenses? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. Do you have any related parties? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

10. Does your current software system accurately count visits by service? ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

Note: Total Score for this section ranges from 10 to 50

Section C Total Cumulative Score:

Section D: Other Considerations Related to CCBHC Feasibility and Readiness:

Readiness to become a CCBHC will require more than simply asking whether or not you are ready to be a CCBHC provider; instead, you will need to ask whether or not you are prepared to become a brand-new provider type with the responsibilities associated with this new role.

CCBHCs as a provider type have two unique elements that have not been seen in other provider types: 1) the requirements to include structured meta-data into both your organization and your relationship with your partners,

and 2) the ability to provide services outside of your CCBHC through relationships with DCOs. These two requirements create novel complications that must be considered to create successful relationships and protect you from liability that can come from the CCBHC's unique provider type structure.

The following issues will help you to begin thinking about what it means to become a new provider type with structured-data requirements and novel relationships that allow you to move your services outside the walls of your facility.

Know the State Medicaid Rules
First, it is important to understand your state's Medicaid rules in order to ensure that both you and your partners are complying with Medicaid rules. Since the CCBHC will be responsible for billing for services provided by the DCO, the CCBHC must ensure that the medical records are conformant with the Medicaid rules that are established to prevent provider fraud and abuse. Because each of your DCOs will have its own unique data systems, translating their patient data into Medicaid-conformant, structured data will be the CCBHC's ultimate responsibility.

Understand How Your Relationships Translate into Costs
The requirement to create relationships with DCOs, and to include the DCOs costs in the CCBHC cost report, can cause complications when accounting for the DCO's costs. You may have overlapping board members with many of your DCO partners, which may make you and your DCO a "related entity." Whether your partners are deemed to be "related" or "unrelated" according to Medicaid regulations will have a direct affect on how you construct your cost reports. Carefully understanding how your corporations and relationships are structured is essential to ensuring that you are complying with Medicaid rules and appropriately setting your rate.

Getting Technology Right
Collecting structured data and forming DCO relationships means that you must have a technology system that can collect handle the task before it. Since this is a new provider type, many technology systems cannot meet these requirements yet. It is also essential for a CCBHC to store and transmit medical records in compliance with Medicaid billing requirements.

Telemedicine
Telemedicine will be central to the services provided by a CCBHC. There are many ways in which billing and record keeping for telemedicine can become complicated. Thinking through these intricacies is essential for both preventing fraud and abuse and appropriately billing for services.

Clinical Quality Assurance
The CCBHC is clinically responsibly for the services provided to a CCBHC patient, even if it is provided by a DCO. A CCBHC must be able to ensure that their DCOs are providing appropriate care for its clients.

Corporate Practice of Medicine
Are you in a "Corporate Practice of Medicine" State? If so, it is important to make sure that the CCBHC and DCOs conform to these rules in your state.

PPS-2--Another Level of Complication
If you are a PPS-2 state and PPS-2 involves a cost-to-charge ratio, there are complicated issues surrounding how your charges are established that you will need to investigate as part of your readiness assessment.

The issues above are complex, but do not be discouraged! The National Council has assembled a consulting team that is primed to help you understand these issues as you blaze a trail forward into the new world of CCBHCs.

1. After reviewing the other considerations listed above that will be needed to support the CCBHC new provider type, is your management team willing to explore and make the necessary changes needed to address each area during the CCBHC Planning Grant period?	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

Note: Total Score for this section ranges from 1 to 5	**Section D Total Cumulative Score**:

Section E: Service Delivery Operational Feasibility Assessment:

Service Delivery and Operational Capacity: Please confirm below if your clinic currently has the capacity to deliver the following access to treatment capacities:

1. Has your clinic educated your Board members and staff around the changes and opportunities that becoming a CCBHC will require?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
2. If you are located in a PPS-2 rate state, does your clinic have a charge master and a process for setting charges?				☐ Not Applicable ☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Does your clinic have the capacity to establish the cost per delivered hour for each service that you have provided and for services that you will need to provide in the new CCBHC non-four walls service delivery system?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
4. Does your clinic have the capacity to run Medicaid population utilization trends tied to costs that will support the PPS rate setting? .				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. Does your clinic have the capacity to run Medicaid population **PPS rate scenarios** to determine the financial consequence for the specific PPS rate established for your clinic?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
6. Does your clinic have the capacity to develop internal Service Delivery guidelines and protocols as well as continuously monitor compliance with the guidelines to support the PPS rate model?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Does your clinic have the data measurement and reporting capacity to meet the care coordination and quality data reporting element requirements that CCBHCs will be required to measure using the 17 elements CCBHCs must report, the 15 data elements the states must report and the quality bonus indicators that PPS-2 states must report (Refer to the list of data elements at the end of this assessment)?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
8. Does your clinic have an inter-rater reliable standardized outcome assessment tool that is used for all Medicaid clients (MH and SUD as well as children, adolescent and adults) with the capacity to report outcome results?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. Is your clinic's Back Office staff effective in managing a CCBHC including establishing a sliding fee scale payment model for non-Medicaid clients				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
10. Are your clinic's staff members trained on how to best utilize Peer Support Specialists (PSS)				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
11. Does your clinic have specific written protocols and experience providing psychiatric consultation in integrated systems?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
12. Has your clinic provided rapid cycle change management and leadership training to support the transformational change management effort that will be needed during the CCBHC Planning Grant?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
13. Has the direct care staff at your clinic been provided population health management training?				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

14. Does your clinic have the capacity to quickly adapt clinical workflows and caseloads to align with a Medicaid Cost-Reimbursement model?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
15. Has your clinic developed procedures to manage the clinical relationship with DCOs from both a clinical care and data sharing requirement?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
16. Has your clinic developed guidelines and staff capacity to expand services into a non-four walls community-based service delivery environment?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
17. Has your clinic developed a marketing and re-branding plan to support the new CCBHC role in your community?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
18. Does your clinic have a proactive and effective community partnership capacity in place to support the care coordination requirements for the CCBHC new provider type?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
19. Has your clinic developed a plan to re-classify personnel to most effectively leverage the PPS cost-based reimbursement methodology?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
20. Has your clinic developed a plan to gain access to a sufficient line of credit and/or access to loans that will support the capital expenditure needs in the transition to a CCBHC?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
21. Has your clinic started to re-define the job functions for clinical, administrative and support staff to support a CCBHC?				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
Note: Total Score for this section ranges from 21 to 105				**Section E Total Cumulative Score**:

Section A - Non Four Walls Design Model	**Total Cumulative Score**:
Section B - Trauma-Informed Care Model	**Total Cumulative Score**:
Section C - PPS Rate Setting	**Total Cumulative Score**:
Section D - Other Considerations	**Total Cumulative Score**:
Section E - Operational Requirements	**Total Cumulative Score**:
Total Cumulative Score Sections A - E	**Total Sections A – E Scores**:

SUMMARY:

1. Total number of questions in the feasibility sections A – E included in the I-CCFRT is 61
2. Total Maximum Score at "5" level rating each is 305
3. Total Minimum Score at "1" level rating each is 61
4. Total Average Score at an average "3" level rating is 183
5. A cumulative clinic-wide score of less than 160 will require significant change management and system changes to a non-four-walls, trauma-informed-care, new provider-type model which can be instructive on whether or not your clinic needs to pursue becoming a CCBHC.

Readiness Assessment Sections F - G

Section F: CCBHC Program Certification Requirements Readiness Assessment:

The six program certification requirements outlined below include specific citations in quotes from Section 223 of the Protecting Access to Medicare Act (H.R. 4302), which included a demonstration program based on the Excellence in Mental Health Act:

Program Requirement 1: Staffing (*"Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.")*

Program Requirement 2: Availability and Accessibility of Services *("Availability and accessibility of services, including: crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.")*

Program Requirement 3: Care Coordination *("Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:*

(i) Federally-qualified health clinics (and as applicable, rural health clinics) to provide Federally-qualified health clinic services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment clinics, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical clinics, independent outpatient clinics, drop-in clinics, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics.")

Program Requirement 4: Scope of Services *("Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:*

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.")

Program Requirement 5: Quality and Other Reporting *("Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.")*

Program Requirement 6: Organizational Authority, Governance and Accreditation (*"Criteria that a clinic be a nonprofit or part of a local government behavioral health authority or 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.], or 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].")

Program Requirements 1: Staffing

1. (1.a.1): As part of the process leading to certification, the state will prepare an assessment of the needs of the target consumer population and a staffing plan for prospective CCBHCs. The needs assessment will include cultural, linguistic and treatment needs. The needs assessment is performed prior to certification of the CCBHCs in order to inform staffing and services. After certification, the CCBHC will update the needs assessment and the staffing plan, including both consumer and family/caregiver input. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

1. (1.a.2): The staff (both clinical and non-clinical) is appropriate for serving the consumer population 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 ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

2. (1.a.3): The Chief Executive Officer (CEO) of the CCBHC maintains a fully staffed management team as appropriate for the size and needs of the clinic as determined by the current needs assessment and staffing plan. The management team will include, at a minimum, a CEO or Executive Director/Project Director, and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO/Executive Director/Project Director and the Medical Director) may be held by the same person. The Medical Director will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated.
Note: If a CCBHC is unable, after reasonable and consistent efforts, to employ or contract with a psychiatrist as Medical Director because of a documented behavioral health professional shortage in its vicinity (as determined by the Health Resources and Services Administration (HRSA) (Health Resources and Services Administration [2015]), psychiatric consultation will be obtained on the medical component of care and the integration of behavioral health and primary care, and a medically trained behavioral health care provider with appropriate education and licensure with prescriptive authority in psychopharmacology who can prescribe and manage medications independently pursuant to state law will serve as the Medical Director. ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. (1.a.4): The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided. ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

4. (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, including any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers have and maintain all necessary state-required licenses, certifications, or other credentialing, with providers working toward licensure, and appropriate supervision in accordance with applicable state law. ☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. (1.b.2): The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state, is informed by the state's initial needs assessment, and includes clinical and peer staff. In accordance with the staffing plan, the CCBHC maintains a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of CCBHC consumers as stated in consumers' individual treatment plans and as required by program requirements 3 and 4 of these criteria. States specify which staff disciplines they will require as part of certification but 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 medications used to treat opioid and alcohol use disorders. The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists. Providers must include individuals 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) and those with substance use disorders. Examples of staff the state might require include a combination of the following: (1) psychiatrists (including child, adolescent, and geriatric psychiatrists), (2) nurses trained to work with consumers across the lifespan, (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) peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) staff trained to provide family support, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff, as necessary given program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers. **Note:** Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time or as needed; (2) in CCBHC organizations comprised of multiple clinics, providers may be shared among clinics; and (3) CCBHCs may utilize telehealth/ telemedicine and on-line services to alleviate shortages. CCBHCs are not precluded by anything in this criterion from utilizing providers working towards licensure, provided they are working under the requisite supervision.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
6. (1.c.1): The CCBHC has a training plan, for all employed and contract staff, and for providers at DCOs who have contact with CCBHC consumers or their families, which satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training which may be required by the state. Training must address cultural competence; person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration. This training, as well as training on the clinic's continuity plan, occurs at orientation and thereafter at reasonable intervals as may be required by the state or accrediting agencies. At orientation and annually thereafter, the CCBHC provides training about: (1) risk assessment, suicide prevention and suicide response; (2) the roles of families and peers; and (3) such other trainings as may be required by the state or accrediting agency on an annual basis. If necessary, trainings may be provided on-line. Cultural competency training addresses diversity within the organization's service population and, to the extent active duty military or veterans are being served, must include information related to military culture. Examples of cultural competency training and materials include, but are not limited to, those available through the website of the US Department of Health & Human Services (DHHS), the SAMHSA website through the website of the DHHS, Office of Minority Health, or through the website of the DHHS, Health Resources and Services Administration. **Note:** See criteria 4.K relating to cultural competency requirements in services for veterans.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
7. (1.c.2): The CCBHC assess 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 during the previous 12 months.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
8. (1.c.3): The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
9. (1.c.4): Individuals providing staff training are qualified as evidenced by their education, training and experience.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
10. (1.d.1): If the CCBHC serves individuals with Limited English Proficiency (LEP) or with language-based disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
11. (1.d.2): Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language 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.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
12. (1.d.3): Auxiliary aids and services are readily available, Americans With Disabilities Act (ADA) compliant, and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
13. (1.d.4): Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats				☐ Yes ☐ No

(for consumers with disabilities). Such materials are provided in a timely manner at intake. The requisite languages will be informed by the needs assessment prepared prior to certification, and as updated.				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
14. (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, including but not limited to the requirements of 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 HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends, so long as the consumer consents or does not object. If a consumer is amenable and has the capacity to make health care decisions, health care providers may communicate with a consumer's family and friends.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
Note: Total Score for this section ranges from 15 to 75		**Program Requirement 1 Total Cumulative Score**:		

Program Requirement 2: Availability and Accessibility of Services

1. (2.1.1): The CCBHC provides a safe, functional, clean, and welcoming environment, for consumers and staff, conducive to the provision of services identified in program requirement 4.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
2. (2.a.2): The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. (2.a.3): The CCBHC provides services at locations that ensure accessibility and meet the needs of the consumer population to be served.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
4. (2.a.4): To the extent possible within the state Medicaid program or other funding or programs, the CCBHC provides transportation or transportation vouchers for consumers.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. (2.a.5): To the extent possible within the state Medicaid program and as allowed by state law, CCBHCs utilize mobile in-home, telehealth/telemedicine, and on-line treatment services to ensure consumers have access to all required services.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
6. (2.a.6): The CCBHC engages in outreach and engagement activities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. (2.a.7): Services are subject to all state standards for the provision of both voluntary and court-ordered services.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
8. (2.a.8): CCBHCs have in place a continuity of operations/disaster plan.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. (2.b.1): All new consumers requesting or being referred for behavioral health services will, at the time of first contact, receive a preliminary screening and risk assessment to determine acuity of needs. That screening may occur telephonically. The preliminary screening will be followed by: (1) an initial evaluation, and (2) a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation, with the components of each specified in program requirement 4. Each evaluation builds upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards: □ If the screening identifies an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. □ If the screening identifies an urgent need, clinical services are provided and the initial evaluation completed within one business day of the time the request is made.				☐ Yes ☐ No

☐ If the screening identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. ☐ For those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed. Subject to more stringent state, federal or applicable accreditation standards, all new consumers will receive a more comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days of the first request for services. This requirement that the comprehensive evaluation be completed within 60 calendar days does not preclude either 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.	

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

10. (2.b.2): The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 90 calendar days unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent.	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

11. (2.b.3): Outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs must be provided within 10 business days of the requested date for service, unless the state has established a standard that meets the expectation of quality care and that renders this time frame unworkable, or state, federal, or applicable accreditation standards are more stringent. If an established consumer presents with an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. If an established consumer presents with an urgent need, clinical services are provided within one business day of the time the request is made.	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

12. (2.c.1): In accordance with the requirements of program requirement 4, the CCBHC provides crisis management services that are available and accessible 24-hours a day and delivered within three hours.	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

13. (2.c.2): The methods for providing a continuum of crisis prevention, response, and postvention services are clearly described in the policies and procedures of the CCBHC and are available to the public.	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

14. (2.c.3): Individuals who are served by the CCBHC are educated about crisis management services and Psychiatric Advanced Directives and how to access crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with LEP or 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).	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

15. (2.c.4): In accordance with the requirements of program requirement 3, CCBHCs maintain a working relationship with local EDs. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

16. (2.c.5): Protocols, including protocols for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a psychiatric crisis. **Note:** See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.	☐ Yes ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

17. (2.c.6): Following a psychiatric emergency or crisis involving a CCBHC consumer, in conjunction with the consumer, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family. **Note:** See criterion 3.a.4 where precautionary crisis planning is addressed.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
18. (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).				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
19. (2.d.2): The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such fee schedule will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to consumers and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
20. (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 ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
21. (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 ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
22. (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 or homelessness or lack of a permanent address.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
23. (2.e.2): CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services 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 CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
Note: Total Score for this section ranges from 23 to 115			**Program Requirement 2 Total Cumulative Score**:	

Program Requirement 3: Care Coordination

1. (3.a.1): Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including 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. **Note:** See criteria 4.K relating to care coordination requirements for veterans.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
2. (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. The HIPAA Privacy Rule allows routine – and often critical – communications between health care providers and a consumer's family and friends. Health care providers may always listen to a consumer's family and friends. If a consumer consents and has the capacity to make health care				

decisions, health care providers may communicate protected health care information to a consumer's family and friends. Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care. Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships. If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. (3.a.3): Consistent with requirements of privacy, confidentiality, and consumer preference and need, the CCBHC assists consumers and families of children and youth, referred to external providers or resources, in obtaining an appointment and confirms the appointment was kept.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
4. (3.a.4): Care coordination activities are carried out in keeping with the consumer's preferences and needs for care and, to the extent possible and in accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer. So as to ascertain in advance the consumer's preferences in the event of psychiatric or substance use crisis, CCBHCs develop a crisis plan with each consumer. Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. (3.a.5): Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and, upon appropriate consent to release of information, to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
6. (3.a.6): Nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose their provider with the CCBHC or its DCOs.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. (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 health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by program requirement 5.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
8. (3.b.2): The CCBHC uses its existing or newly established health IT system to conduct activities such as population health management, quality improvement, reducing disparities, and for research and outreach.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. (3.b.3): If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 3.b.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security. CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC)7 for ONC's Health IT Certification Program.				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
10. (3.b.4): The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consumer consent, to comply with privacy and confidentiality requirements, including but 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 ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
11. (3.b.5): Whether a CCBHC has an existing health IT system or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to				☐ Yes ☐ No

and from the CCBHC using the health IT system they have in place or are implementing for transitions of care.				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

12. (3.c.1): The CCBHC has an agreement 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 consumers 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: If an agreement cannot be established with a FQHC or, as applicable, an RHC (e.g., a provider does not exist in their service area), or cannot be established within the time frame of the demonstration project, justification is provided to the certifying body and contingency plans are established with other providers offering similar services (e.g., primary care, preventive services, other medical care services).
Note: CCBHCs are expected to work toward formal contracts with entities with which they coordinate care if they are not established at the beginning of the demonstration project.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

13. (3.c.2): The CCBHC has an agreement establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs to provide those services for CCBHC consumers. The CCHBC is able to track when consumers 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, detoxification, and residential settings to a safe community setting. This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services.
Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

14. (3.c.3): The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Services and supports to collaborate with which are identified by statute include:
- Schools;
- 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;
- State licensed and nationally accredited child placing agencies for therapeutic foster care service; and
- Other social and human services.

The CCBHC has, to the extent necessary given the population served and the needs of individual consumers, an agreement with such other community or regional services, supports, and providers as may be necessary, such as the following:
- Specialty providers of medications for treatment of opioid and alcohol dependence;
- Suicide/crisis hotlines and warmlines;
- Indian Health Service or other tribal programs;
- Homeless shelters;
- Housing agencies;
- Employment services systems;
- Services for older adults, such as Aging and Disability Resource Centers; and
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).

Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

15. (3.c.4): The CCBHC has an agreement establishing care coordination expectations 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 explore care coordination agreements with facilities of each type.

☐ Yes
☐ No

Note: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
16. (3.c.5): The CCBHC has an agreement establishing care coordination expectations with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. The agreement is such that the CCBHC can track when their consumers 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 another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge. For all CCBHC consumers being discharged from such facilities who presented to the facilities as a potential suicide risk, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk. **Note**: For these services, if an agreement cannot be established, or cannot be established within the time frame of the demonstration project, justification is provided and contingency plans are developed and the state will make a determination whether the contingency plans are sufficient or require further efforts.				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
17. (3.d.1): The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and family-centered and aligned 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. The HIPAA Privacy Rule does not cut off all communication between health care professionals and the families and friends of consumers. As long as the consumer consents, health care professionals covered by HIPAA may provide information to a consumer's family, friends, or anyone else identified by a consumer as involved in their care.				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
18. (3.d.2): As appropriate for the individual's needs, the CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native. **Note:** See criteria 4.K relating to required treatment planning services for veterans.				☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
19. (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 ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
Note: Total Score for this section ranges from 19 to 95		**Program Requirement 3 Total Cumulative Score**:		

Program Requirement 4: Scope of Services

1. (4.a.1): CCBHCs are responsible for the provision of all care specified in PAMA, including, as more explicitly provided and more clearly defined below in criteria 4.B through 4.K, crisis services; screening, assessment and diagnosis; person-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 US Armed Forces and veterans. As provided in criteria 4.B through 4.K, many of these services may be provided either directly by the CCBHC or through formal relationships with other providers that are DCOs. Whether directly supplied by the CCBHC or by a	

DCO, the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers. Despite this flexibility, it is expected CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs, as this will enhance the ability of the CCBHC to coordinate services. **Note:** See CMS PPS guidance regarding payment.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
2. (4.a.2): The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the consumer's freedom 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.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
3. (4.a.3): With regard to either CCBHC or DCO services, consumers will 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.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
4. (4.a.4): DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
5. (4.a.5): 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 ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
6. (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, reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. **Note:** See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.K relating specifically to requirements for services for veterans.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
7. (4.b.2): Person-centered and family-centered care includes care which recognizes the particular cultural and other needs of the individual. This includes but is not limited to services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
8. (4.c.1): Unless there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise, the CCBHC will directly provide robust and timely crisis behavioral health services. Whether provided directly by the CCBHC or by a state-sanctioned alternative acting as a DCO, available services must include the following: □ 24 hour mobile crisis teams, □ Emergency crisis intervention services, and □ Crisis stabilization. PAMA requires provision of these three crisis behavioral health services. As part of the certification process, the states will clearly define each term as they are using it but services provided must include suicide crisis response and services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification. States may elect to require the employment of peers on crisis teams. CCBHCs will have an established protocol specifying the role of law enforcement during the provision of crisis services. **Note:** See program requirement 2 related to crisis prevention, response and postvention services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital or ED following a psychiatric crisis.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge

9.	(4.d.1): The CCBHC directly 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., neurological testing, developmental testing and assessment, eating disorders), the CCBHC provides or refers them through formal relationships with other providers, or where necessary and appropriate, through use of telehealth/telemedicine services. **Note:** See program requirement 3 regarding coordination of services and treatment planning.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge	
10.	(4.d.2): Screening, assessment, and diagnosis are conducted in a time frame responsive to the individual consumer's needs and are of sufficient scope to assess the need for all services required to be provided by CCBHCs.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge	
11.	(4.d.3): The initial evaluation (including information gathered as part of the preliminary screening and risk assessment), 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 consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); and (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services. As needed, releases of information are obtained.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge	
12.	(4.d.4): As required in program requirement 2, a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is completed within 60 days by licensed behavioral health professionals who, in conjunction with the consumer, are members of the treatment team, performing within their state's scope of practice. Information gathered as part of the preliminary screening and initial evaluation may be considered a part of the comprehensive evaluation. This requirement that the comprehensive evaluation be completed within 60 calendar days does not preclude either the initiation or completion of the comprehensive evaluation or the provision of treatment during the intervening 60 day period.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge	
13.	(4.d.5): Although a comprehensive diagnostic and treatment planning evaluation is required for all CCBHC consumers, the extent of the evaluation will depend on the individual consumer and on existing state, federal, or applicable accreditation standards. As part of certification, states will establish the requirements for these evaluations; factors states should consider requiring include: (1) reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the consumer's presentation to the CCBHC; (2) a psychosocial evaluation including housing, vocational and educational status, family/caregiver and social support, legal issues, and insurance status; (3) behavioral health history (including trauma history and previous therapeutic interventions and hospitalizations); (3) a diagnostic assessment, including current mental status, mental health (including depression screening) and substance use disorders (including tobacco, alcohol, and other drugs); (4) assessment of imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate risks including threats from another person); (5) basic competency/cognitive impairment screening (including the consumer's ability to understand and participate in their own care); (6) a drug profile including the consumer's prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information on drug allergies; (7) a description of attitudes and behaviors, including cultural and environmental factors, that may affect the consumer's treatment plan; (8) the consumer's strengths, goals, and other factors to be considered in recovery planning; (9) pregnancy and parenting status; (10) assessment of need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services, LEP or linguistic services); (11) assessment of the social service needs of the consumer, with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate; and (12) depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk pursuant to criteria 4.G, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the consumer's primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment as required by criteria 4.G. All remaining necessary releases of information are obtained by this point.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge	

14. (4.d.6): Screening and assessment by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated behavioral health screening or assessment and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.5 or Appendix A. (**NOTE: Appendix A is located on page 28 at the end of the I-CCFRT Assessment and Definitions sections)**				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
15. (4.d.7): The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
16. (4.d.8): The CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
17. (4.d.9): If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the consumer is provided or referred for a full assessment and treatment, if applicable.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
18. (4.e.1): The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. 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 consumer involvement and self-direction. **Note:** See program requirement 3 related to coordination of care and treatment planning.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
19. (4.e.2): An individualized plan integrating prevention, medical and behavioral health needs and service delivery is developed by the CCBHC in collaboration with and endorsed by the consumer, the adult consumer's family to the extent the consumer so wishes, or family/caregivers of youth and children, and is coordinated with staff or programs necessary to carry out the plan. **Note:** States may wish to access additional resources related to person-centered treatment planning found in the CMS Medicaid Home and Community Based Services regulations at 42 C.F.R. Part 441, Subpart M, or in the CMS Medicare Conditions of Participation for Community Mental Health Centers regulations at 42 C.F.R. Part 485.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
20. (4.e.3): The CCBHC uses consumer assessments to inform the treatment plan and services provided.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
21. (4.e.4): Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the consumer's words or ideas and, when appropriate, those of the consumer's family/caregiver.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
22. (4.e.5): The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
23. (4.e.6): Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders).				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
24. (4.e.7): The treatment plan documents the consumer's advance wishes related to treatment and crisis management and, if the consumer does not wish to share their preferences, that decision is documented.				☐ Yes ☐ No
☐ **1** Serious Challenge	☐ **2** Quite a bit of Concern	☐ **3** Moderate Concern	☐ **4** Small Concern	☐ **5** Not A Challenge
25. (4.e.8): Consistent with the criteria in 4.e.1 through 4.e.7, states should specify other aspects of consumer, person-centered and family-centered treatment planning they will require based upon the needs of the population served. Treatment planning components that states might consider include: prevention; community inclusion and support (housing, employment, social				

supports); involvement of family/caregiver and other supports; recovery planning; safety 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, accommodations to ensure cultural and linguistically competent services).

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

26. (4.f.1): The CCBHC directly provides outpatient mental and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area.
Note: See also program requirement 3 regarding coordination of services and treatment planning.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

27. (4.f.2): Based upon the findings of the needs assessment as required in program requirement 1, states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT); evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care). This list is not intended to be all-inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

28. (4.f.3): Treatments are provided that are appropriate for the consumer's phase of life and development, 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. Specifically, when treating children and adolescents, CCHBCs provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver driven with respect to children and adolescents. When treating older adults, the individual consumer's desires and functioning 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.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

29. (4.f.4): Children and adolescents are treated using a family/caregiver-driven, youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

30. (4.g.1): The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs. The CCBHC ensures children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions. Prevention is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services.
Note: See also program requirement 3 regarding coordination of services and treatment planning.

☐ Yes
☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

31. (4.h.1): The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states should specify the scope of other targeted case management services that will be required, and the specific populations for which they are intended.					☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge	
32. (4.i.1): The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services. States should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served. Psychiatric rehabilitation services that might be considered include: medication education; self-management; training in personal care skills; individual and family/caregiver psycho-education; community integration services; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education. States also may wish to require the provision of supported services such as housing, employment, and education, the latter in collaboration with local school systems. **Note:** See program requirement 3 regarding coordination of services and treatment planning.					☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge	
33. (4.j.1): The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. States should specify the scope of peer and family services they will require based upon the needs of the population served. Peer services that might be considered include: peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services. Potential family/caregiver support services that might be considered include: family/caregiver psycho-education, parent training, and family-to-family/caregiver support services. **Note:** See program requirement 3 regarding coordination of services and treatment planning.					☐ Yes ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge	
34. (4.k.1): The CCBHC is responsible for 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 CCBHCs 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 ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge	
35. (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. 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, including 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 ☐ No
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge	

36. (4.k.3): In keeping with the general criteria governing CCBHCs, CCBHCs ensure 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 ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

37. (4.k.4): Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. 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 medical record. The Principal Behavioral Health Provider is identified on a consumer 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 as long as 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 ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

38. (4.k.5): In keeping with the general criteria governing CCBHCs, 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 (Substance Abuse and Mental Health Services Administration [2012]). 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 ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

39. (4.k.6): In keeping with the general criteria governing CCBHCs, 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	☐ Yes ☐ No

the unique experiences and contributions of those who have served their country. (2) All staff receives cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
40. (4.k.7): In keeping with the general criteria governing CCBHCs, 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 ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
Note: Total Score for this section ranges from 40 to 200		**Program Requirement 4 Total Cumulative Score**:		

Program Requirement 5: Quality and Other Reporting

1. (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) consumer characteristics; (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) consumer outcomes. Data collection and reporting requirements are elaborated below and in Appendix A. (**NOTE: Appendix A is located on page 28 at the end of the I-CCFRT Assessment and Definitions sections)**				☐ Yes ☐ No
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
2. (5.a.2): Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist (for example, the measure is calculated from claims), for all Medicaid enrollees in the CCBHCs.				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. (5.a.3): To the extent possible, these criteria assign to the state responsibility for data collection and reporting where access to data outside the CCBHC is required. Data to be collected and reported and quality measures to be reported, however, may relate to services CCBHC consumers receive through DCOs. Collection of some of the data and quality measures that are the responsibility of the CCBHC may require access to data from DCOs and it is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs and to ensure adequate consent as appropriate and that releases of information are obtained for each affected consumer.				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
4. (5.a.4): As specified in Appendix A (**See page 28 following I-CCFRT Assessment**), some aspects of data reporting will be the responsibility of the state, using Medicaid claims and encounter data. States must provide CCHBC-level Medicaid claims or encounter data to the evaluators of this demonstration program annually. At a minimum, consumer and service-level data should include a unique consumer identifier, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. These data must be reported through MMIS/T-MSIS in order to support the state's claim for enhanced federal matching funds made available through this demonstration program. For each consumer, the state must obtain and link the consumer level administrative Uniform Reporting System (URS) information to the claim (or be able to link by unique consumer identifier). CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures identified in Appendix A. These linked claims or encounter data must also be made available to the evaluator. In addition to data specified in this program requirement and in Appendix A that the state is to provide, the state will provide such other data, including Treatment Episode Data Set (TEDS) data and data from comparison settings, as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs are responsible for provision of data, the data will be provided to the state and, as may be required elsewhere, to HHS and the evaluator. If requested, CCBHCs will participate in discussions with the national evaluation team.				
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

5. (5.a.5): CCBHCs annually submit a cost report with supporting data within six months after the end of each demonstration year to the state. The state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each demonstration year to CMS.
Note: In order for a clinic to receive payment using the CCBHC PPS, it must be certified as a CCBHC.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

6. **(5.b.1):** The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinical services and clinical management. The CQI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity and past performance of the CCBHC's services and operations. The CCBHC-wide CQI plan addresses priorities for improved quality of care and client safety, and requires all improvement activities be evaluated for effectiveness. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes, and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals are designated as responsible for operating the CQI program.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

7. (5.b.2): Although the CQI plan is to be developed by the CCBHC and reviewed and approved by the state during certification, specific events are expected to be addressed as part of the CQI plan, including: (1) CCBHC consumer suicide deaths or suicide attempts; (2) CCBHC consumer 30 day hospital readmissions for psychiatric or substance use reasons; and (3) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

Note: Total Score for this section ranges from 7 to 35 | **Program Requirement 5 Total Cumulative Score**:

Program Requirement 6: Organizational Authority, Governance and Accreditation

1. (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 ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

2. (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, states, based upon the population the prospective CCBHC may serve, should require CCBHCs to 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 AI/AN consumers and to inform the provision of services to those consumers. 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.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

3. (6.a.3): An independent financial audit is performed annually for the duration of the demonstration 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 ☐ No

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge

4. (6.b.1): As a group, the CCBHC's board members are representative of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. The CCBHC will incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC

☐ Yes ☐ No

consumers, either through 51 percent of the board being families, consumers or people in recovery from behavioral health conditions, or through a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. (6.b.2): The CCBHC will describe how it meets this requirement or develop a transition plan with timelines appropriate to its governing board size and target population to meet this requirement.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
6. (6.b.3): To the extent the CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership, the state will specify the reasons why the CCBHC cannot meet these requirements and the CCBHC will have or develop an advisory structure and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. (6.b.4): As an alternative to the board membership requirement, any organization selected for this demonstration project may establish and implement other means of enhancing its governing body's ability to insure that the CCBHC is responsive to the needs of its consumers, families, and communities. Efforts to insure responsiveness will focus on the full range of consumers, services provided, geographic areas covered, types of disorders, and levels of care provided. The state will determine if this alternative approach is acceptable and, if it is not, will require that additional or different mechanisms be established to assure that the board is responsive to the needs of CCBHC consumers and families. Each organization will make available the results of their efforts in terms of outcomes and resulting changes.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
8. (6.b.5): Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. 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.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. (6.b.6): States will determine what processes will be used to verify that these governance criteria are being met.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
10. (6.c.1): CCBHCs will adhere to any applicable state accreditation, certification, and/or licensing requirements.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
11. (6.c.2): States are encouraged to require accreditation of the CCBHCs by an appropriate nationally-recognized organization (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.				
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
Note: Total Score for this section ranges from 11 to 55			**Program Requirement 6 Total Cumulative Score**:	
Section F (Program Requirements 1 – 6)			**Total Cumulative Score**:	

NOTE: MTM Services has provided the following assessment related to the clinic's change management and decision-making processes that can be helpful to determine the level of change leadership that will be required.

Section G - Change Management and Decision Making

As a CCBHC, it is essential to include your DCO in any of your change management and decision-making processes. Since the CCBHC is clinically responsible for the services provided by the DCO, a CCBHC will need to recognize service deficiencies and be able to nimbly adapt to counter these deficiencies. This means that your CCBHC must create close working relationships based on mutual trust and understanding of delivering trauma-informed, non-four-walls care to the individuals within your service area.

1. Does the clinic have a defined decision-making process/protocol that supports awareness of when a decision has been made?	☐ Yes ☐ No	If NO, what is the primary indicator that a decision has been made within the clinic (i.e. consensus is reached)?		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
2. Does the clinic use a formalized annual planning process to identify annual and long term goals?	☐ Yes ☐ No	If YES, what percent of the goals/objectives incorporated into the FY20014 have been accomplished (meaning fully implemented)? **%**		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
3. Has the clinic used rapid cycle change management processes (Plan, Do, Study, Act)?	☐ Yes ☐ No	If YES, what percent of the goals/objectives incorporated into last rapid cycle change plan have been fully implemented? **%**		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
The clinic develops a change management plan quickly and moves forward with timely decision-making about the solutions needed.	☐ True ☐ False	If FALSE, what is a more accurate statement:		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
4. When a decision is made to change, the clinic acts quickly to fully implement the change.	☐ True ☐ False	If FALSE, what is a more accurate statement:		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
5. When change is implemented, staff members in the clinic rarely retreat to the way things were done prior to the change.	☐ True ☐ False	If FALSE, what is a more accurate statement:		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
6. The clinic does a great job evaluating changes implemented and modifying the changes as needed to ensure positive outcomes.	☐ True ☐ False	If FALSE, what is a more accurate statement:		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
7. Staff members participating in the change process feel fully empowered through a sense of attainment based on the scope and timeliness of the decisions being made.	☐ True ☐ False	If FALSE, what is a more accurate statement:		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
8. Rate (from 1 to 10) the ease with which the clinic implements change in **areas of clinical practice**		Easy (1)……Difficult (10)		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
9. Rate (from 1 to 10) how quickly the clinic implements changes in **clinical practices/standards**?		Rapid (1) ……..Failure (10)		
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Serious Challenge	Quite a bit of Concern	Moderate Concern	Small Concern	Not A Challenge
Note: Total Score for this section ranges from 10 to 50		**Section G Total Cumulative Score**:		

I-CCFRT Scoring Summary: Please enter the total cumulative score for Section F and program requirement as listed below:

Readiness Sections:

Section F - Certification Requirements	
Program Requirement 1	**Total Cumulative Score**:
Program Requirement 2	**Total Cumulative Score**:
Program Requirement 3	**Total Cumulative Score**:
Program Requirement 4	**Total Cumulative Score**:
Program Requirement 5	**Total Cumulative Score**:
Program Requirement 6	**Total Cumulative Score**:
Total Cumulative Score Section F	**Total Section F Scores**:

SUMMARY:

6. Total number of questions in Readiness Section F included in the I-CCFRT is 115
7. Total Maximum Score at "5" level rating each is 575
8. Total Minimum Score at "1" level rating each is 115
9. Total Average Score at an average "3" level rating is 345
10. A cumulative clinic-wide score of less than 300 will require significant change management process support to effect transformational changes needed.

Section G Change Management/ Decision-Making	**Total Cumulative Score**:

SUMMARY:

1. Total number of questions in practice management portion of the I-CCFRT is 10
2. Total Maximum Score at "5" level rating each is 50
3. Total Minimum Score at "1" level rating each is 10
4. Total Average Score at an average "3" level rating is 30
5. A cumulative clinic-wide score of less than 25 will require significant change management leadership support to implement and sustain transformational changes needed.

Grand Total Cumulative Score Sections A - G	**Grand Total All Section A – G Scores**:

I-CCFRT Score and Change Management Priority Rating Sheet

Instructions:

A. **Average I-CCFRT Section Score:** Below is a list of all Program Requirements 1- 6 and Practice Management Sections A - D of the I-CCFRT which includes a formula under each section to create and enter an average score per section in Column "B".

B. **Importance Rating Determination:** Enter a score of 1, 3 or 5 in Column "C" to identify the importance rating the management team gives to the each Provider Requirement and Practice Management section that the readiness score indicates that a change is required based on the following rating values:

1 = High Importance: This item is very important to our clinic and potential healthcare partners and is a top priority

3 = Moderate Importance: This item is important but would never be a top priority for our clinic and potential healthcare partners

5 = Low Importance: This item is of little importance to our clinic or potential healthcare partners

C. **Change Need Score Column "D":** To render the total change need score, multiply the average I-CCFRT Section score in column "B" by the change importance rating in column "C". **The three Program Requirements in the I-CCFRT with the lowest change need score(s) and ties in lowest score in column "D" need to be the focus of change goals in a Rapid Cycle Change Plan for your clinic. Additionally, if the Change Management and Decision-Making score is less than 30, it is recommended that all supervisors, managers and senior leaders complete leadership skills training to support transformational change.**

Column A Program Requirements	Column B Average Section Score	Column C Importance Rating	Column D Change Need Score (B Times C)
Section A - Non Four Walls CCBHC Design: Total Section One Score = divided by 6 = Average Score enter in column "B" to the right			
Section B - Trauma-Informed Service Delivery Model: Total Score = divided by 23 = Average Score enter in column "B" to the right			
Section C - Prospective Payment System Rate Support Requirements: Total Section One Score = divided by 10 = Average Score enter in column "B" to the right			
Section D – Other Considerations: Total Section One Score = = Average Score enter in column "B" to the right			
Section E – Operational Requirements : Total Section One Score = divided by 21 = Average Score enter in column "B" to the right			
Section F: Program Requirements 1 – 6 below:			
Program Requirement 1: Staffing Total Program Requirement 1 Score = divided by 15 = Average Score enter in column "B" to the right			
Program Requirement 2: Availability and Accessibility of Services Total Program Requirement 2 Score = divided by 23 = Average Score enter in column "B" to the right			

Program Requirement 3: Care Coordination Total Program Requirement 3 Score = divided by 19 = Average Score enter in column "B" to the right			
Program Requirement 4: Scope of Services Program Total Program Requirement 4 Score = divided by 40 = Average Score enter in column "B" to the right			
Requirement 5: Quality and Other Reporting Total Program Requirement 5 Score = divided by 7 = Average Score enter in column "B" to the right			
Program Requirement 6: Organizational Authority, Governance and Accreditation Total Program Requirement 6 Score = divided by 11 = Average Score enter in column "B" to the right			
Section G: Change Management and Decision-Making: Change management capacity including the use of Rapid Cycle Change models Total Section Score = divided by 10 = Average Score enter in column "B" to the right **NOTE: If the Change Management and Decision-Making score is less than 30, it is recommended that all supervisors, managers and senior leaders complete leadership skills training to more effectively support transformational change.**			

NOTE: This I-CCFRT has been developed based on final certification criteria for CCBHCs. After completion of the I-CCFRT, MTM Services through the National Council can provide:

1. A written summary of findings and recommendations for individual clinic organizational change consultation support to effectively address areas of concern identified in the I-CCFRT; and/or
2. Provide an aggregate summary of findings and written recommendations for a statewide group of clinics that will help direct adequate consultation and technical assistance for specific clinics and for specific certification program requirements.
3. Leadership Skills to support transformational change needs

For more information about these additional support services, please contact: Brianna Williams at the National Council at BriannaW@thenationalcouncil.org or Marian Bradley at MTM Services at marian.bradley@mtmservices.org

CCBHC Criteria Definitions

Important terms used in the CCBHC criteria are defined below. SAMHSA recognizes states may have existing definitions of the terms included here and these definitions are not intended to supplant state definitions to the extent a state definition is more specific or encompasses more than the definition used here.

Agreement: As used in the context of care coordination, an agreement is an arrangement between the CCBHC and external entities with which care is coordinated. Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity. The agreement describes the parties' mutual expectations and responsibilities related to care coordination.

Behavioral health: Behavioral health is a general term "used to refer to both mental health and substance use" (SAMHSA-HRSA [2015]).

Care coordination: The Agency for Healthcare Research and Quality (2014) defines care coordination as "deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." As used here, the term applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each consumer as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.

Case management: Case management may be defined in many ways and can encompass services ranging from basic to intensive. The National Association of State Mental Health Program Directors (NASMHPD) defines case management as "a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery" (NASMHPD [2014]). See also the definition of "targeted case management."

CCBHC or Clinic: CCBHC and Clinic are used interchangeably to refer to Certified Community Behavioral Health Clinics as certified by states in accordance with these criteria and with the requirements of PAMA. A CCBHC may offer services in different locations. For multi-site organizations, however, only clinics eligible pursuant to these criteria and PAMA may be certified as CCBHCs.

CCBHC directly provides: When the term, "CCBHC directly provides" is used within these criteria it means employees or contract employees within the management structure and under the direct supervision of the CCBHC deliver the service.

Consumer: Within this document, the term "consumer" refers to clients, persons being treated for or in recovery from mental and/or substance use disorders, persons with lived experience, service recipients and patients, all used interchangeably to refer to persons of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations)

for whom health care services, including behavioral health services, are provided by CCBHCs. Use of the term “patient” is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word “consumer” is used.

Cultural and linguistic competence: Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers (Office of Minority Health [2014]).

Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid.

Engagement: Engagement includes a set of activities connecting consumers with needed services. This involves the process of making sure consumers and families are informed about and initiate access with available services and, once services are offered or received, individuals and families make active decisions to continue receipt of the services provided. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care, also promote consumer engagement.

Family: Families of both adult and child consumers are important components of treatment planning, treatment and recovery. Families come in different forms and, to the extent possible, the CCBHC should respect the individual consumer’s view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, care givers, friends, and others as defined by the family.

Family-centered: The Health Resources and Services Administration defines family-centered care, sometimes referred to as “family-focused care,” as “an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family’s relationship with the child’s health care providers and recognize the family’s customs and values” (Health Resources and Services Administration [2004]). More recently, this concept was broadened to explicitly recognize family-centered services are both developmentally appropriate and youth guided (American Academy of Child & Adolescent Psychiatry [2009]). Family-centered care is *family-driven* and *youth-driven*.

Formal relationships: As used in the context of scope of services and the relationships between the CCBHC and DCOs, a formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. This formal relationship does not extend to referrals for services outside either the CCBHC or DCO, which are not encompassed within the reimbursement provided by the PPS.

Limited English Proficiency (LEP): LEP includes individuals who do not speak English as their primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

Peer Support Services: Peer support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery. This also includes services designed and delivered by family members of those in recovery.

Peer Support Specialist: A peer provider (e.g., peer support specialist, recovery coach) is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member of such a person, plus skills learned in formal training, to deliver services in behavioral health settings to promote recovery and resiliency. In states where Peer Support Services are covered through the state Medicaid Plans, the title of "certified peer specialist" often is used. SAMHSA recognizes states use different terminology for these providers.

Person-centered care: Person-centered care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services [June 6, 2014]). That guidance defines "person-centered planning" as a process directed by the person with service needs which identifies recovery goals, objectives and strategies. If the consumer wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the consumer to the maximum extent possible. Person-centered planning also involves self- direction, which means the consumer has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers (Department of Health & Human Services [June 6, 2014]).

Practitioner or Provider: Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).

Recovery: 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 10 guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes: Health (abstinence,"making informed healthy choices that support physical and emotional wellbeing"); Home (safe, stable housing); Purpose ("meaningful

daily activities … and the independence, income and resources to participate in society"); and Community ("relationships and social networks that provide support, friendship, love, and hope") (Substance Abuse and Mental Health Services Administration [2012]).

Recovery-oriented care: Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual's assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community (Substance Abuse and Mental Health Services Administration [2015]).

Shared Decision-Making (SDM): SDM is an approach to care through which providers and consumers of health care come together as collaborators in determining the course of care. Key characteristics include having the health care provider, consumer, and sometimes family members and friends acting together, including taking steps in sharing a treatment decision, sharing information about treatment options, and arriving at consensus regarding preferred treatment options (Schauer, Everett, delVecchio, & Anderson [2007]).

Targeted case management: Targeted case management is case management, as defined above, directed at specific groups, which may vary by state. CMS defines targeted case management as case management furnished without regard to requirements of statewide provision of service or comparability that typically apply for Medicaid reimbursement. 42 CFR § 440.169(b). Examples of groups that might be targeted for case management are children with serious emotional disturbance, adults with serious mental and/or substance use disorders, pregnant women who meet risk criteria, individuals with HIV, and such other groups as a state might identify as in need of targeted case management. See also the definition of "case management."

Trauma-informed: A trauma-informed approach to care "*realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization.*" The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration [2014]).

Appendix A:

Quality Measures and Other Reporting Requirements

Appendix A contains the data and quality measures required to be reported as part of these criteria.[8] The requirements are based on the measurement landscape as of the time the CCBHC criteria were drafted (March 2015) and, given the rapid change occurring in the measurement field, might change, particularly if altering these quality measures enables better alignment with other reporting requirements. For the same reason, Quality Bonus Measures (QBMs) are not specified in these criteria or Appendix, rather they are established by CMS as part of the PPS. Appendix A is divided into data/measures required to be reported by the CCBHCs (Table 1) and those required to be reported by the states (Table 2). Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist, for all Medicaid enrollees in the CCBHCs.

In addition to these reporting requirements, the demonstration program evaluator will require the reporting of additional data to be used as part of the project evaluation. Those additional data are not specified in these criteria. All data collected and reported by the state must be flagged to distinguish the individual CCBHCs and consumers served by CCBHCs, as well as a comparison group of clinics and consumers. In addition, the consumer's unique Medicaid identifier must be attached.

Table 1: CCBHC Required Reporting = 17

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
EHR, Patient records, Electronic scheduler	Number/Percent of clients requesting services who were determined to need routine care	N/A
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
EHR, Patient records, Electronic scheduler	Mean number of days before the comprehensive person-centered and family centered diagnostic and treatment planning evaluation is performed for new clients	N/A
EHR, Patient records	Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment	N/A
EHR, Patient records	Documentation of Current Medications in the Medical Records	0419
MHSIP Consumer survey	Patient experience of care survey	No
MHSIP Family survey	Family experience of care survey	No
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
EHR, Encounter data	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)[9]	0024
EHR, Encounter data	Controlling High Blood Pressure (see Medicaid Adult Core Set)[10]	0018
Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
EHR, Patient records	Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
EHR, Patient records	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
EHR, Patient records	Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
EHR, Patient records; Consumer follow-up with standardized measure (PHQ-9)	Depression Remission at 12 months	0710

Table 2. State Required Reporting = 15

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Claims data/encounter data	Number of Suicide Attempts Requiring Medical Services by Patients Engaged in Behavioral Health (CCBHC) Treatment	N/A
Claims data/encounter data	Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence	2605
Claims data/encounter data	Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Claims data/encounter data	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
Claims data/encounter data	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	2607
Claims data/encounter data	Metabolic Monitoring for Children and Adolescents on Antipsychotics	No
Claims data/encounter data	Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	1927
Claims data/encounter data	Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia	1933
Claims data/encounter data	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1880
Claims data/encounter data	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	No
Claims data/encounter data	Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Claims data/encounter data	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Claims data/encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
Claims data/encounter data	Antidepressant Medication Management (see Medicaid Adult Core Set)	0105

Table 3. Quality Bonus Payment Medicaid Adult and Core Set Measures

For the state to make QBP, the CCBHC must demonstrate that it has achieved all of the required quality measures shown in Table 3. The state can make QBP using the additional measures provided in this guidance, but only after the certified clinic has met performance goals for the required set of measures. States may propose quality measures for QBP; however, CMS approval is required. The QBP measures included in this guidance are derived primarily from the Medicaid adult and child core set measures. In applying to participate in this demonstration the state must demonstrate how it plans to implement QBP if it plans to make such payments.

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures	Included in Table 1 or 2 above
FUH-AD	**Follow-Up After Hospitalization for Mental Illness (adult age groups)**	**NCQA/HEDIS**	**Yes**	**Yes**	**Yes**
FUH-CH	**Follow-Up After Hospitalization for Mental Illness (child/adolescents)**	**NCQA/HEDIS**	**Yes**	**Yes**	**Yes**

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures	Included in Table 1 or 2 above
SAA-AD	**Adherence to Antipsychotics for Individuals with Schizophrenia**	**NCQA/HEDIS**	**Yes**	**Yes**	**Yes**
IET-AD	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	**NCQA/HEDIS**	**Yes**	**Yes**	**Yes**
NQF-0104	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**	**AMA-PCPI**	**Yes**	**Yes**	**Yes**
SRA-CH	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment**	**AMA-PCPI**	**Yes**	**Yes**	**Yes**
ADD-CH	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	Yes	No	**Yes**
CDF-AD	Screening for Clinical Depression and Follow-Up Plan	CMS	Yes	No	**Yes**
AMM-AD	Antidepressant Medication Management	NCQA/HEDIS	Yes	No	**Yes**
PCR-AD	Plan All-Cause Readmission Rate	NCQA/HEDIS	Yes	No	**Yes**
NQF-0710	Depression Remission at Twelve Months-Adults	MPC	Yes	No	**Yes**

[1]CMS-developed acronyms, except NQF-0104 and NQF-0710. CH refers to measures in the 2015 Medicaid Child Core Set, AD refers to measures in the 2015 Medicaid Adult Core Set.

[2]The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes. This list may change based on the current measurement landscape. The steward websites are provided below:

- **http://www.ncqa.org**
- **www.usqualitymeasures.org**
- **http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance- improvement.page**

Abbreviations: AMA, American Medical Association; CMS, Centers for Medicare & Medicaid Services; HEDIS, Healthcare Effectiveness Data and Information Set; MPC, Measurement Policy Council; NCQA, National Committee for Quality Assurance; PCPI, Physician Consortium for Performance Improvement