CCBHC Criteria 2023 Crosswalk

Crosswalk between SAMHSA's CCBHC's Certification Criteria and Social Current's COA Accreditation Standards

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1.a.1 General Staffing Requirements As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment (see Appendix A: Terms and Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years. Certifying states may specify additional community needs assessment requirements	GOV 3.02 The organization conducts ongoing community outreach and education to: 1. communicate its mission, role, functions, capacities, and scope of services; 2. provide information about the strengths, needs, and challenges of the individuals, families, and groups it serves; 3. build community support and presence and maintain effective partnerships; and 4. elicit feedback as to unmet needs in the community that can be addressed by the organization as its top advocacy priorities. GOV 3.03 The organization collaborates with community members and persons served to advocate for issues of mutual concern consistent with the organization's mission, such as: 1. improvements to existing services;	The Criteria is more prescriptive than the standard regarding what needs to be included in the community needs assessment.

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	2. filling gaps in service to offer a full array of community supports; 3. the full and appropriate implementation of applicable laws and regulations regarding issues concerning the service population; 4. improved supports and accommodations for individuals with special needs or marginalized communities; 5. solutions to community-specific needs including racial equity and cultural and linguistic diversity; 6. service coordination; and 7. a coordinated community response to public health emergencies. HR 1 The organization assesses its workforce as part of annual planning and prepares for future needs by: 1. comparing the composition of its current workforce, including number of employees, skills, demographics, and cultural characteristics, with projected workforce needs; and 2. determining how to close gaps, when needed, through recruitment, training, leadership development, and/or outsourcing.	
1.a.2 General Staffing Requirements The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer. Note: See criteria 4.k relating to required staffing of services for veterans.	HR 1 The organization assesses its workforce as part of annual planning and prepares for future needs by: 1. comparing the composition of its current workforce, including number of employees, skills, demographics, and cultural characteristics, with projected workforce needs; and 2. determining how to close gaps, when needed, through recruitment, training, leadership development, and/or outsourcing.	
1.a.3 General Staffing Requirements The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as	GOV 6.01 The executive director's primary responsibilities are: 1. management of the organization;	

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appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care. Note: If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.	2. implementation of organization-wide, long-term strategic planning and periodic reviews; 3. development of policies governing the organization's program of services with the governing body; 4. attendance at all meetings of the governing body; and 5. provision of regular reports to the governing body on the organization's operations, finances, and implementation of the long-term plan. MHSU 7.01 A licensed physician, or another qualified health professional, with experience, training, and competence in engaging, diagnosing, and treating individuals with mental health and/or substance use disorders is responsible for the medical aspects of treatment. Interpretation: When an appropriately qualified health professional is not employed by the organization, their participation on the treatment team should be secured through contract or formal agreement. Interpretation: Medical aspects should include the following, when applicable: 1. prescribing medication and medication management, including appropriate management of pharmacotherapy for people with co-occurring conditions or those receiving office-based opioid treatment; 2. providing or reviewing diagnostic, toxicological, and other health related examinations of people not currently under medical care and supervision or those receiving office-based opioid treatment; 3. review of complicated cases where co-occurring substance use, health, and mental health conditions intersect; and 4. other medical and psychiatric related issues, such as seizure disorders, psychosomatic disorders, or traumatic brain injury.	

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	Examples: The qualifications and training of the physician may vary as appropriate to the program. For example, organizations that provide mental health services may have a board-eligible psychiatrist who is responsible for the medical aspects of treatment. Qualified health professionals may include: psychiatric or mental health nurse practitioners, physician assistants, or health professionals that are permitted by law in their state to provide medical care and services (e.g., prescribe and monitor medications) without direction or supervision.	
1.a.4 General Staffing Requirements The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.	RPM 3.01 The organization annually assesses insurance needs in consultation with insurance professionals or experienced legal counsel and obtains coverage that is commensurate with the scope and complexity of its services. Examples: Relevant types of insurance can include: 1. general liability; 2. worker's compensation; 3. disability; 4. fire and theft; 5. medical; 6. indemnification; 7. professional liability; 8. officer's or director's liability; 9. automobile liability; 10. property and casualty; 11. malpractice; 12. cybersecurity or cyberliability; and 13. bonding or other forms of employee theft insurance, for all staff and governing body members who sign checks, handle cash or contributions, or manage funds.	
1.b.1 License and Credentialing of Providers 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	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities;	

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local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.	3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. RPM 7.01 Contractors who provide human or social services 1. have sufficient human and financial resources to fulfill the terms of the contract; and 2. are licensed or otherwise legally authorized to provide the contracted services. TS 3.04 Supervisors provide additional support to personnel when they are: 1. new; 2. developing competencies, including personnel who have not yet obtained professional licensure or certification; 3. experiencing challenging or traumatic circumstances with the individuals and families they work with; or 4. experiencing higher caseloads. Interpretation: The suicide attempt or death of a service recipient can be a traumatic experience for staff. To help staff	

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	process the loss of a service recipient to suicide, voluntary non-judgmental support services should be made available to help the affected staff and other personnel grieve and prepare for future contact with individuals at risk for suicide. MHSU 2.01 Clinical personnel are qualified by education, training, supervised experience, and licensure or the equivalent as appropriate to the services provided and program design. Interpretation: Clinical personnel may also include individuals who are license-eligible and supervised by experienced, licensed staff.	
1.b.2 License and Credentialing of Providers The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location.	

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coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers. Note: Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies, to the extent possible, to alleviate shortages,	HR 1 The organization assesses its workforce as part of annual planning and prepares for future needs by: 1. comparing the composition of its current workforce, including number of employees, skills, demographics, and cultural characteristics, with projected workforce needs; and 2. determining how to close gaps, when needed, through recruitment, training, leadership development, and/or outsourcing. HR 2 The organization hires appropriately qualified personnel to meet the demand for services and support the achievement of the organization's mission. TS 2.03 Direct service personnel receive training on: 1. communicating respectfully and effectively with service recipients; 2. engaging service recipients, including building trust, establishing rapport, and developing a professional relationship; 3. understanding the science of trauma and the impact of trauma on individuals, families, and personnel; and 4. trauma-informed care, including screening, assessment, and service delivery practices. Interpretation: Training on trauma should be tailored to the type of service being provided. For example, it may not be appropriate or necessary for assessments in an Early Childhood Education (ECE) setting to be trauma informed. It is up to the organization to assess the applicability of this standard for each of its programs and service population and design the training accordingly. TS 3.04	

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provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision. Certifying states should specify which staff disciplines they will require as part of certification.	Supervisors provide additional support to personnel when they are: 1. new; 2. developing competencies, including personnel who have not yet obtained professional licensure or certification; 3. experiencing challenging or traumatic circumstances with the individuals and families they work with; or 4. experiencing higher caseloads. Interpretation: The suicide attempt or death of a service recipient can be a traumatic experience for staff. To help staff process the loss of a service recipient to suicide, voluntary non-judgmental support services should be made available to help the affected staff and other personnel grieve and prepare for future contact with individuals at risk for suicide. MHSU 2 Program personnel have the competency and support needed to provide services and meet the needs of the target population. Interpretation: Competency can be demonstrated through education, training, experience, or licensure. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas. MHSU 2.01 Clinical personnel are qualified by education, training, supervised experience, and licensure or the equivalent as appropriate to the services provided and program design. Interpretation: Clinical personnel may also include individuals who are license-eligible and supervised by experienced, licensed staff. MHSU 2.02 Supervisor qualifications are tailored to the services provided and program design, and include:	

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	1. an advanced degree in a human services field and a minimum of two years professional experience; 2. specialized training in supervision; and 3. certification and/or licensure by the designated authority in their state, as appropriate. Interpretation: Regarding element (a), supervisors overseeing withdrawal management may have an advanced degree in a medical field. Interpretation: Regarding element (b), supervisors of peer support staff should be trained on recognizing and responding to signs of trauma among peer support workers. Examples: Qualifications for supervisors in substance use treatment programs may include training and experience in alcohol and other drug use, diagnosis, and treatment, and/or certification by the designated authority in their state as approved alcohol and/or drug counseling supervisors. MHSU 2.03 Clinical personnel are trained on, or demonstrate competence in: 1. evidence-based practices and other relevant emerging bodies of knowledge; 2. psychosocial and ecological or person-in-environment perspectives; 3. criteria to determine the need for more intensive services; 4. methods of crisis prevention and intervention, including assessing for and responding to signs of suicide risk or other safety threats/risks; 5. understanding child development and individual and family functioning; 6. identifying and building on strengths and protective factors; 7. working with difficult to reach or disengaged individuals and families;	

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	8. recognizing and working with individuals with co-occurring physical health, mental health, and substance use conditions; and 9. collaborating with other disciplines, systems, and services. Interpretation: When the organization serves military or veteran populations, it is essential that staff have the competencies needed to effectively support and assist service members, veterans, and their families, including sufficient knowledge regarding: military culture, values, policies, structure, terminology, unique barriers to service, traumas and signature injuries, applicable regulations, benefits, and other relevant issues. When providers possess the requisite military competency, they are capable of supporting improved communication and more effective care. Signature injuries and co-occurring conditions often found in this population include post-traumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), substance use, and intimate partner violence, which could subsequently increase the risk for suicide. Personnel serving military and veteran populations should have the competencies to identify, assess, and develop a treatment plan for these injuries and conditions. MHSU 2.04 Clinical personnel are trained on, or demonstrate competence in the latest information, theories, and proven practices related to the treatment of alcohol and other drug use disorders, including: 1. diagnostic criteria for substance use disorders and their severity; 2. the signs and symptoms of withdrawal; addiction as a disease; 3. ASAM level of care assessments; 4. treatment needs of special populations including women, individuals experiencing homelessness, adolescents, and individuals with HIV/AIDS; 5. relapse prevention;	

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	6. management of drug overdose; 7. the benefits and limitations of tests that screen for drug use, when applicable; 8. harm reduction interventions or practices; and 9. FDA-approved medications used to treat opioid use disorder, their benefits and limitations, and current federal policy regulating their use, when applicable. MHSU 2.05 Individuals who provide peer support: 1. obtain certification, as defined by their state; 2. are willing to share their personal recovery stories; 3. have a job description and clearly understand the role of a peer support worker; and 4. have adequate supports in place and appropriate supervision, including mentoring and/or coaching from more experienced peers when indicated. MHSU 2.06 Individuals who provide peer support receive pre- and in-service training on: 1. how to recognize the need for more intensive services and how to make an appropriate referral; 2. established ethical guidelines, including setting appropriate boundaries and protecting confidentiality and privacy; 3. wellness support methods, trauma-informed care practices, and recovery resources; 4. managing personal triggers that may occur during the course of their role as a peer support provider; and 5. skills, concepts, and philosophies related to recovery and peer support. MHSU 2.09 Personnel who prescribe or dispense opioid treatment medication in office-based settings have received a waiver under the Drug Addiction Treatment Act of 2000 and stay current with all applicable federal, state, and local laws and	

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	regulations applicable to the delivery of office-based opioid treatment. Interpretation: Practitioners that may qualify for a waiver include physicians, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse-midwives (CNMs). MHSU 7.01 A licensed physician, or another qualified health professional, with experience, training, and competence in engaging, diagnosing, and treating individuals with mental health and/or substance use disorders is responsible for the medical aspects of treatment. Interpretation: When an appropriately qualified health professional is not employed by the organization, their participation on the treatment team should be secured through contract or formal agreement. Interpretation: Medical aspects should include the following, when applicable: 1. prescribing medication and medication management, including appropriate management of pharmacotherapy for people with co-occurring conditions or those receiving office-based opioid treatment; 2. providing or reviewing diagnostic, toxicological, and other health related examinations of people not currently under medical care and supervision or those receiving office-based opioid treatment; 3. review of complicated cases where co-occurring substance use, health, and mental health conditions intersect; and 4. other medical and psychiatric related issues, such as seizure disorders, psychosomatic disorders, or traumatic brain injury.	

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	Interpretation: Health professionals should be knowledgeable of appropriate prescribing practices for individuals with substance use disorders. MHSU 7.02 A licensed physician, or other qualified health professional, and a clinical team led by a licensed provider, collaborate with the individual to make decisions about level of care, treatment, and aftercare or discharge planning. Examples: Clinical teams may include social work, medical, psychological, and psychiatric professionals with specialized training in mental health and/or substance use disorders.	
1.c.1 Cultural Competence and Other Training The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on: • Evidence-based practices • Cultural competency (described below) • Person-centered and family-centered, recovery-oriented planning and services • Trauma-informed care • The clinic's policy and procedures for continuity of operations/disasters • The clinic's policy and procedures for integration and coordination with primary care • Care for co-occurring mental health and substance use disorders • At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their property owner or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location.	See National CLAS Standards and COA Crosswalk for how COA Accreditation standards meet the National CLAS standards.

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roles of family and peer staff. Trainings may be provided on-line. • Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. • To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Note: See criteria 4.k relating to cultural competency requirements in services for veterans. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.	TS 1.01 A personnel development plan: 1. is reviewed annually and revised in accord with an assessment of the organization's training needs; 2. incorporates a variety of educational methods; 3. is responsive to the history, cultural backgrounds, and related needs of personnel; 4. outlines specific competency expectations for each job category; 5. provides opportunities for personnel to fulfill the continuing education requirements of their respective professions; 6. provides opportunities to support advancement within the organization and profession; and 7. provides opportunities for personnel to practice cultural humility. TS 1.02 New personnel are oriented within the first three months of hire to the organization's mission, philosophy, goals, and services. TS 2.03 Direct service personnel receive training on: 1. communicating respectfully and effectively with service recipients; 2. engaging service recipients, including building trust, establishing rapport, and developing a professional relationship; 3. understanding the science of trauma and the impact of trauma on individuals, families, and personnel; and 4. trauma-informed care, including screening, assessment, and service delivery practices. Interpretation: Training on trauma should be tailored to the type of service being provided. For example, it may not be appropriate or necessary for assessments in an Early Childhood Education (ECE) setting to be trauma informed. It is up to the organization to assess the applicability of this standard for each	

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	of its programs and service population and design the training accordingly. TS 2.04 Training for direct service personnel addresses differences within the organization's service population, as appropriate to the type of service being provided, including: 1. interventions that address cultural and socioeconomic factors in service delivery; 2. the role cultural identity plays in motivating human behavior; 3. procedures for working with non-English speaking persons or individuals with communication impairments; 4. understanding explicit and implicit bias and discrimination; 5. recognizing individuals and families with special needs; 6. the needs of individuals and families in crisis, including recognizing and responding to a mental health crisis; 7. the needs of victims of violence, abuse, or neglect and their family members; and 8. basic health and medical needs of the service population. TS 2.05 Direct service personnel are trained on, or demonstrate competency in, providing inclusive care to individuals with intellectual and developmental disabilities including: 1. communication techniques; 2. de-escalation techniques for individuals with intellectual and developmental disabilities; and 3. implementing the principles of self-determination and inclusion. ASE 6.04 Personnel from all the organization's programs and administrative offices, and persons served in residential or daytime group care settings when applicable, receive training on implementing the organization's emergency response plan that is tailored as appropriate to:	

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	1. the specific types of emergencies faced by the organization; 2. the level of staff responsibility; 3. the needs, age, and developmental level of service recipients; 4. program type; and 5. geographic location. MHSU 2.03 Clinical personnel are trained on, or demonstrate competence in: 1. evidence-based practices and other relevant emerging bodies of knowledge; 2. psychosocial and ecological or person-in-environment perspectives; 3. criteria to determine the need for more intensive services; 4. methods of crisis prevention and intervention, including assessing for and responding to signs of suicide risk or other safety threats/risks; 5. understanding child development and individual and family functioning; 6. identifying and building on strengths and protective factors; 7. working with difficult to reach or disengaged individuals and families; 8. recognizing and working with individuals with co-occurring physical health, mental health, and substance use conditions; and 9. collaborating with other disciplines, systems, and services. Interpretation: When the organization serves military or veteran populations, it is essential that staff have the competencies needed to effectively support and assist service members, veterans, and their families, including sufficient knowledge regarding: military culture, values, policies, structure, terminology, unique barriers to service, traumas and signature injuries, applicable regulations, benefits, and other relevant issues. When providers possess the requisite military competency, they are capable of supporting improved	

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	communication and more effective care. Signature injuries and co-occurring conditions often found in this population include post-traumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), substance use, and intimate partner violence, which could subsequently increase the risk for suicide. Personnel serving military and veteran populations should have the competencies to identify, assess, and develop a treatment plan for these injuries and conditions. MHSU 2.04 Clinical personnel are trained on, or demonstrate competence in the latest information, theories, and proven practices related to the treatment of alcohol and other drug use disorders, including: 1. diagnostic criteria for substance use disorders and their severity; 2. the signs and symptoms of withdrawal; addiction as a disease; 3. ASAM level of care assessments; 4. treatment needs of special populations including women, individuals experiencing homelessness, adolescents, and individuals with HIV/AIDS; 5. relapse prevention; 6. management of drug overdose; 7. the benefits and limitations of tests that screen for drug use, when applicable; 8. harm reduction interventions or practices; and 9. FDA-approved medications used to treat opioid use disorder, their benefits and limitations, and current federal policy regulating their use, when applicable. MHSU 2.06 Individuals who provide peer support receive pre- and in-service training on: 1. how to recognize the need for more intensive services and how to make an appropriate referral;	

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	2. established ethical guidelines, including setting appropriate boundaries and protecting confidentiality and privacy; 3. wellness support methods, trauma-informed care practices, and recovery resources; 4. managing personal triggers that may occur during the course of their role as a peer support provider; and 5. skills, concepts, and philosophies related to recovery and peer support. ICHH 2.01 Personnel are trained on, or demonstrate competency in: 1. coordinating and providing access to needed services; 2. facilitating transition planning and coordination; 3. applicable evidence-based interventions; 4. physical health issues commonly associated with mental health or substance use conditions; 5. health conditions and treatment responses particular to the service population; 6. chronic disease management, including promoting self-management; 7. developing a person- or family-centered care plan; 8. understanding the roles played by different child-serving systems, as applicable; and 9. using health information technology to link services and facilitate collaboration among providers, the person, and his or her family.	
1.c.2 Cultural Competence and Other Training The CCBHC regularly assesses the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.	HR 4.01 The organization provides every full-time and part-time employee with an annual, written performance review that involves the employee and the supervisor. HR 4.02 Staff performance reviews emphasize self-development and professional growth and include: 1. specific expectations defined in the job description; 2. organization-wide expectations for personnel; 3. objectives established in the most recent review, accomplishments and challenges since the last review	

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	period, and objectives for future performance, including developmental and professional objectives; 4. strategies to continue developing cultural humility; 5. recommendations for training; and 6. an assessment of the staff member's knowledge and competence related to the characteristics and needs of service recipients, if applicable. HR 5.01 Personnel records are updated regularly and contain: 1. identifying information and emergency contacts; 2. application for employment, hiring documents including job postings and interview notes, and past employment verification; 3. job description signed by the employee; 4. compensation documentation, as appropriate; 5. pre-service and in-service training records; 6. health information or reports for annual physical examinations, appropriate to the job position or when required by law; and 7. performance reviews and all documentation relating to performance, including disciplinary actions and termination summaries if applicable. Interpretation: An organization may maintain records in separate files according to its own record keeping system as required by law or regulation. For example, EAP records, health benefits enrollment forms, documentation of a grievance/complaint and response documents, immigration status documentation, and EEOC-related records must be kept separately from other personnel records. TS 3.03 Supervisors' administrative, educational, and supportive functions include: 1. delegating and overseeing work assignments;	

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	2. ensuring that service delivery is performed according to the organization's mission, policies and procedures, and applicable law and regulation; 3. promoting knowledge acquisition and skill development through various professional development opportunities; 4. assisting personnel in transferring the skills and knowledge obtained in the classroom to their work in the field; and 5. implementing policies and procedures designed to prevent, recognize, and respond to work-related stress. Examples: In regard to element (d), ways to support knowledge transference can include, but are not limited to: 1. working with personnel to identify the most appropriate trainings for their position; 2. clarifying the purpose and relevance of the training before it is delivered; 3. following up with personnel to establish a plan for incorporating acquired skills and knowledge into their work, including setting performance goals and methods for tracking progress when appropriate; 4. modeling appropriate practice and/or establishing mentorships with more experienced colleagues; and 5. observing practice in the field accompanied by constructive feedback.	
1.c.3 Cultural Competence and Other Training The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. CCBHCs are encouraged to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.	HR 5.01 Personnel records are updated regularly and contain: 1. identifying information and emergency contacts; 2. application for employment, hiring documents including job postings and interview notes, and past employment verification; 3. job description signed by the employee; 4. compensation documentation, as appropriate; 5. pre-service and in-service training records; 6. health information or reports for annual physical examinations, appropriate to the job position or when required by law; and	Evidence submitted for all training standards includes "documentation tracking staff completion of required training" and a review of personnel records containing records of all pre- and in-service training.

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	7. performance reviews and all documentation relating to performance, including disciplinary actions and termination summaries if applicable. Interpretation: An organization may maintain records in separate files according to its own record keeping system as required by law or regulation. For example, EAP records, health benefits enrollment forms, documentation of a grievance/complaint and response documents, immigration status documentation, and EEOC-related records must be kept separately from other personnel records. TS 3.03 Supervisors' administrative, educational, and supportive functions include: 1. delegating and overseeing work assignments; 2. ensuring that service delivery is performed according to the organization's mission, policies and procedures, and applicable law and regulation; 3. promoting knowledge acquisition and skill development through various professional development opportunities; 4. assisting personnel in transferring the skills and knowledge obtained in the classroom to their work in the field; and 5. implementing policies and procedures designed to prevent, recognize, and respond to work-related stress. Examples: In regard to element (d), ways to support knowledge transference can include, but are not limited to: 1. working with personnel to identify the most appropriate trainings for their position; 2. clarifying the purpose and relevance of the training before it is delivered; 3. following up with personnel to establish a plan for incorporating acquired skills and knowledge into their work, including setting performance goals and methods for tracking progress when appropriate;	

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	4. modeling appropriate practice and/or establishing mentorships with more experienced colleagues; and 5. observing practice in the field accompanied by constructive feedback.	
1.c.4 Cultural Competence and Other Training Individuals providing staff training are qualified as evidenced by their education, training, and experience.	HR 2.01 Job descriptions and selection criteria: 1. state the credentials, job expectations, core competencies, essential functions, and responsibilities for each position or group of like positions; 2. include inclusive language and demonstrate the organization's commitment to equity, diversity, and inclusion; 3. include sensitivity to the service population's cultural and socioeconomic characteristics; and 4. are reviewed and updated regularly to evaluate their continued relevancy against the needs and goals of the organization's programs and persons served. Examples: Credentials can include, for example: 1. education; 2. training; 3. relevant experience; 4. competence in the required role; 5. recommendations of peers and former employers; and 6. any available state registration, licensing, or certification for the respective disciplines. TS 2 Personnel are prepared to fulfill their job responsibilities. Interpretation: Standards in TS S 2 should be applied to independent contractors based on their role and the competencies stipulated in their contract. While organizations typically would not provide training to contractors directly, they should maintain documentation from contractors that demonstrates their competency in applicable areas. Competency can be demonstrated through education, training,	

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	experience, degree requirements, certifications, licenses, and pursuit of CEUs, as applicable.	
1.d.1 Linguistic Competence The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.	ASE 3.02 The organization designs and adapts its programs and services, as appropriate, to accommodate the visual, auditory, linguistic, and motor abilities of persons served. ASE 3.03 The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level. Examples: Examples of ways the organization can demonstrate standard implementation include, but are not limited to: 1. providing basic program information in languages representative of consumer groups; 2. proactively reaching out to ensure that all individuals can use its services and fully participate in planning; 3. hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery; 4. ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload; 5. offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without	

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	depending upon children or other individuals unable to maintain the integrity of the client-provider relationship; and 6. using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate.	
1.d.2 Linguistic Competence Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.	ASE 3.03 The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level. Examples: Examples of ways the organization can demonstrate standard implementation include, but are not limited to: 1. providing basic program information in languages representative of consumer groups; 2. proactively reaching out to ensure that all individuals can use its services and fully participate in planning; 3. hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery; 4. ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload; 5. offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without depending upon children or other individuals unable to	

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	maintain the integrity of the client-provider relationship; and 6. using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate.	
1.d.3 Linguistic Competence Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).	ASE 3.03 The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level. Examples: Examples of ways the organization can demonstrate standard implementation include, but are not limited to: 1. providing basic program information in languages representative of consumer groups; 2. proactively reaching out to ensure that all individuals can use its services and fully participate in planning;hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery; 3. ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload; 4. offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without depending upon children or other individuals unable to	

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	maintain the integrity of the client-provider relationship; and 5. using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate. PRG 5.03 The organization provides assistive technology, or helps the person gain access to assistive resources, as needed, and the person is: 1. involved in the selection of specific technologies; 2. afforded the opportunity to try the device prior to purchase or assignment; and 3. trained on the use of specific assistive devices being provided.	
1.d.4 Linguistic Competence Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.	CR 1.01 All persons served receive, and are helped to understand, information about their rights and responsibilities that is: 1. provided in writing; 2. distributed during their initial contact; 3. available in the major languages of the defined service population; 4. effectively and appropriately communicated to persons with special needs; and 5. posted in the reception or common area of each service delivery site or residential facility, Interpretation: If an organization provides services remotely using technology, client rights and responsibilities should be made available on the organization's public website and the organization must implement a system for assuring and documenting that clients receive and understand their rights and responsibilities. Interpretation: If a client is disoriented, suffering from impaired cognition, or in immediate crisis at initial contact, the summary	

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	of client rights and responsibilities should be provided at an appropriate time. CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity. ASE 3.03 The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level. Examples: Examples of ways the organization can demonstrate standard implementation include, but are not limited to: 1. providing basic program information in languages representative of consumer groups; 2. proactively reaching out to ensure that all individuals can use its services and fully participate in planning; 3. hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery;	

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	4. ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload; 5. offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without depending upon children or other individuals unable to maintain the integrity of the client-provider relationship; and 6. using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate.	
1.d.5 Linguistic Competence The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	RPM 5 Electronic and printed information is protected against intentional and unintentional destruction or modification and unauthorized disclosure or use. Interpretation: The standards in this section address security of all types of paper and electronic information maintained by the organization, unless otherwise noted, including: *1.* case records and other information of persons served; *2.* administrative, financial, and risk management records and reports; *3.* personnel files and other human resources records; and *4.* performance and quality improvement data and reports. RPM 5.01 The organization protects confidential and other sensitive information from theft, unauthorized use or disclosure, damage, or destruction by: 1. limiting access to authorized personnel on a need-to-know basis; 2. using firewalls, anti-virus and related software, and other appropriate safeguards; 3. monitoring security measures on an ongoing basis; 4. having the ability to remotely wipe or disable mobile devices, if applicable, in the event that a device is lost, stolen, repurposed, or discarded; and	

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	5. maintaining paper records in a secure location when not in use by authorized staff. RPM 5.02 Proper safeguards protect confidential information when transmitted electronically. RPM 5.03 The organization has policies and procedures addressing the use and monitoring of: 1. social media; 2. electronic communications; and 3. mobile devices, including staff-owned devices, if applicable. RPM 5.05 The organization ensures its electronic system for managing health records or protected health information limits access to information in accordance with confidentiality rules and the person's privacy preferences to the greatest extent possible. Interpretation: If the electronic health record system employed by the organization is not able to meet all client privacy preferences and/or all of the necessary confidentiality rules, the organization informs the service recipient of the system's limitations and obtains consent for the exchange of electronic health information based on those restrictions. TS 2.01 All personnel who have regular contact with clients receive training on legal issues, including: 1. mandatory reporting, pursuant to relevant professional standards and as required by law, and the identification of clinical indicators of suspected abuse and neglect, as applicable; 2. federal and state laws requiring disclosure of confidential information for law enforcement purposes, including compliance with a court order, warrant, or subpoena;	

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	3. duty to warn, pursuant to relevant professional standards and as required by law; 4. the agency's policies and procedures on confidentiality and disclosure of service recipient information, and penalties for violation of these policies and procedures; and 5. the legal rights of service recipients. Interpretation: Standards in TS S 2 should be applied to independent contractors based on their role and the competencies stipulated in their contract. While organizations typically would not provide training to contractors directly, they should maintain documentation from contractors that demonstrates their competency in applicable areas. TS 2.02 Personnel receive training on the following, as appropriate to their position and job responsibilities: 1. proper documentation techniques; 2. the maintenance and security of records; and 3. the use of technology and information systems including refresher trainings when changes or updates are made. Interpretation: Standards in TS S 2 should be applied to independent contractors based on their role and the competencies stipulated in their contract. While organizations typically would not provide training to contractors directly, they should maintain documentation from contractors that demonstrates their competency in applicable areas. CR 2 The organization protects the confidentiality of information about clients and assumes a protective role regarding the disclosure of confidential information. CR 2.01 When the organization receives a request for confidential information about a client, or when the release of confidential	

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	information is necessary for the provision of services, prior to releasing such information, the organization: 1. determines if the reason to release information is valid; 2. obtains informed, written authorization to release the information from the client and/or parent or legal guardian, as appropriate; and 3. maintains each authorization of consent in the case record and provides a copy to the client and/or parent or legal guardian. CR 2.02 Prior to the disclosure of confidential or private information, the organization informs the client about circumstances when it may be legally or ethically permitted or required to release such information without his or her consent and notifies the client of such a release when it occurs. CR 2.03 The organization obtains informed, written consent from the individual or a legal guardian prior to recording, photographing, or filming, or the organization has a clear policy prohibiting recording, photographing, or filming. CR 2.04 The release form for disclosure of confidential information includes the following elements: 1. the name of the person whose information will be released; 2. the signature of the person whose information will be released, or the parent or legal guardian of a person who is unable to provide authorization; 3. the specific information to be released; 4. the purpose for which the information is to be used; 5. the date the release takes effect; 6. the date, event, or condition upon which the consent expires in relation to the individual purpose for disclosure, not to exceed one year from when the release takes effect;	

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	7. the name of the person(s) or organization(s) that will receive the disclosed information; 8. the name of the person or organization that is disclosing the confidential information; and 9. a statement that the person or family may withdraw their authorization at any time except to the extent that action has already been taken. Interpretation: Blanket release forms signed by clients when service is initiated do not meet the requirements of this standard except as put forth by federal regulation, for example, when making application to FEMA/DHS in a declared disaster. Interpretation: When a release form is used to authorize the exchange of information between multiple parties, the form must comply with all elements of the standard. All relevant parties must be authorized to disclose and receive the information specified, for the purpose indicated, in the consent. Interpretation: Elements (b) and (i) will not apply when law, regulation, or court order, permits confidential information to be released without the authorization of the person or legal guardian. MHSU 7.03 Organizations that employ or have formal agreements with telemedicine practitioners, or individuals that provide telehealth services, monitor and share information in a way that ensures privacy and security of confidential information.	
2.a.1 General Requirements of Access and Availability The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.	ASE Purpose The organization's administrative and service environments are respectful, safe, and accessible and contribute to organizational effectiveness. ASE 1 In its daily operations, the organization ensures:	

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	1. the health and safety of its personnel and the individuals and families it serves; and 2. that its administrative and service environments are respectful and promote the dignity of personnel. ASE 2.04 The organization maintains a work environment for its personnel that is conducive to effectively providing services to individuals and families in a private and confidential manner, as needed. ASE 2.05 The environment promotes a non-threatening, welcoming, and inclusive approach that fosters trust and engagement for all people. Interpretation: Programs should provide a supportive, safe, and welcoming environment for all people. Programs can help to signal that they provide an environment that is safe and welcoming by posting "visual cues" of their commitment to equity, diversity, and inclusion in the reception or common area such as a copy of the nondiscrimination policy, a copy of the equity statement, culturally diverse décor, LGBTQ+ symbols, or posters and stickers promoting racial justice. ASE 4.01 All facilities in which the organization operates are properly maintained through: 1. monthly inspections to ensure the organization's facilities are safe and heating, lighting, and other systems are functioning properly; 2. preventive maintenance by a qualified professional; and 3. quick responses to emergency maintenance issues and potentially hazardous conditions. Interpretation: If the organization is a tenant in its facilities, some or all of the above activities may be conducted by the	

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	property owner. In such instances, the organization must be able to demonstrate that it monitors and documents the completion of elements (a) through (c) to provide a safe environment for people to work and receive services. ASE 4.03 When services are offered on a consistent and on-going basis, in a location that is not owned or leased by the organization, prior to using the facility, the organization develops a memorandum of understanding (MOU) or a contractual agreement with the host that includes: 1. space and equipment needs; 2. health and safety expectations; and 3. each group's responsibility for cleaning, maintenance, liability risk, and other costs (e.g., utilities, insurance, and repairs).	
2.a.2 General Requirements of Access and Availability Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.	MHSU 5 The organization provides trauma-informed clinical counseling services that: 1. provide an appropriate level and intensity of support and treatment; 2. recognize individual and family values and goals; 3. accommodate variations in lifestyle; 4. emphasize personal growth, development, and situational change; and 5. promote recovery, resilience, and wellness. Interpretation: Outpatient withdrawal management programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies), provided to persons served on an individual or group basis. Services aim to enhance the person's understanding of addiction, manage their withdrawal symptoms, and connect them with an appropriate level of care for ongoing substance use treatment. The delivery of services will vary and depends on the assessed needs of the person and his or her treatment progress.	

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	MHSU 5.04 When working with children and youth, services are designed to: 1. focus on the family as a whole; 2. involve all family members to the extent possible; and 3. be provided at times that accommodate family members' schedules and needs.	
2.a.3 General Requirements of Access and Availability Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.	ASE 3.01 In planning the location and use of offices and branches, the organization considers: 1. accessibility, availability, and affordability of public transportation; 2. location of other relevant community resources; and 3. the special needs of the defined service population as well as the needs of persons with disabilities.	
2.a.4 General Requirements of Access and Availability The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.	MHSU 11.01 The organization provides, either directly or by referral, necessary support services which may include, as appropriate: 1. basic needs, such as food, clothing, and housing; 2. work-related services and job placement; 3. transportation; 4. legal services; 5. financial counseling; 6. social skills training; 7. public benefits; 8. educational services; and 9. respite care. Interpretation: Service members and veterans should be linked to any services or benefits for which they may be eligible, including Veterans Affairs health services.	
2.a.5 General Requirements of Access and Availability The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent	PRG 4.02 For each individual, the organization: 1. assesses the appropriateness of technology-based service delivery based on established criteria and suitability factors;	

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possible, in alignment with the preferences of the person receiving services to support access to all required services.	2. monitors whether or not the service delivery model is effective; and 3. arranges for services to be delivered in-person when necessary.	
2.a.6 General Requirements of Access and Availability Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.	GOV 3 The organization: 1. informs the public of its mission; 2. remains knowledgeable about community needs and strengths; 3. advocates for comprehensive and coordinated service delivery within the community; and 4. encourages the elimination of social and economic injustice. Interpretation: The standards in GOV 3 describe a variety of activities related to the organization's role within the community, including outreach and education, participation in community-wide advocacy efforts, and advocacy on behalf of service recipients who need help navigating the system. Given the broad range of activities outlined in GOV 3, activities conducted by "the organization" are the responsibility of the governing body, CEO, stakeholder advisory group, management, direct service personnel, and/or other personnel, as appropriate to the activity and their role. GOV 3.01 The organization provides the public with clear, timely, and accurate information about the organization's mission, programs, activities, service recipients, and finances. GOV 3.02 The organization conducts ongoing community outreach and education to: 1. communicate its mission, role, functions, capacities, and scope of services; 2. provide information about the strengths, needs, and challenges of the individuals, families, and groups it serves;	

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	3. build community support and presence and maintain effective partnerships; and 4. elicit feedback as to unmet needs in the community that can be addressed by the organization as its top advocacy priorities. GOV 3.03 The organization collaborates with community members and persons served to advocate for issues of mutual concern consistent with the organization's mission, such as: 1. improvements to existing services; 2. filling gaps in service to offer a full array of community supports; 3. the full and appropriate implementation of applicable laws and regulations regarding issues concerning the service population; 4. improved supports and accommodations for individuals with special needs or marginalized communities; 5. solutions to community-specific needs including racial equity and cultural and linguistic diversity; 6. service coordination; 7. a coordinated community response to public health emergencies.	
2.a.7 General Requirements of Access and Availability Services are subject to all state standards for the provision of both voluntary and court-ordered services.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the	

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	required documentation from their property owner or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location.	
2.a.8 General Requirements of Access and Availability The CCBHC has a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.	ASE 6 The organization plans for and coordinates emergency response preparedness. ASE 6.01 The organization develops an emergency response plan that outlines its response to medical emergencies, facility and security-related emergencies, public health emergencies, and natural disasters, and addresses: 1. coordination with appropriate authorities and emergency responders; 2. communication with the governing body, personnel, service recipients and their families, and as appropriate, the public, and the media; 3. evacuation procedures including accounting for the whereabouts of staff and service recipients and the evacuation of persons with mobility challenges and other special needs; and 4. participation with community partners and stakeholders in community recovery efforts, as appropriate. Interpretation: It is critical that emergency response plans include arrangements for the provision of needed medications when applicable. Individuals that may require an individualized plan for providing medications in the event of an emergency include: individuals with psychiatric conditions, individuals taking opioid treatment medications, and older adults. Arrangements can include maintaining a list of service recipients	

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	likely to be affected and pre-arranging for services outside the area likely to be evacuated. ASE 6.02 The emergency response plan includes provisions for service continuity that ensures ongoing mission-critical functions in the event of a disruption of normal services, and: 1. identifies temporary administrative and service delivery sites in the event of facility closure; 2. addresses the temporary delegation of decision-making authority when normal channels have been disrupted; 3. establishes alternative methods of communication with staff and stakeholders during periods of disruption; 4. ensures uninterrupted continuity of critical IT operations; and 5. is reviewed, tested, and updated at least annually. ASE 6.03 The organization is prepared to treat injuries and respond to medical emergencies by: 1. maintaining a readily available communication device, poison control information, and first aid supplies and manuals at all program sites and during off-site activities when applicable; 2. consulting with a health professional, as necessary, to develop procedures for such situations; and 3. maintaining emergency contact information for personnel and service recipients. Interpretation: Organizations that maintain Naloxone or opioid antagonist kits to treat opioid overdose cases: *1.* maintain at least two unexpired doses in accessible locations; *2.* store personal protective equipment (PPE) close to the kit to facilitate quick response;	

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	3. ensure staff trained in SAMHSA-approved protocols and procedures for reversing opioid drug crisis are available to administer these treatments; *4.* have procedures and appropriate training in place to get affected individuals to medical care immediately following overdose treatment to preempt the reoccurrence or worsening of symptoms; *5.* have procedures for documenting each incident where opioid antagonists were administered; and *6.* have systems for maintaining and restocking opioid overdose equipment and medication to ensure availability of unexpired medication in an emergency. RPM 5.04 The organization is prepared for planned and unplanned interruptions of data and limits the disruption to its operations and service delivery by: 1. maintaining procedures for managing data interruptions and resuming operations; 2. backing up electronic data regularly, with copies maintained off premises; and 3. regularly testing the organization's back-up plan including data restoration processes. Interpretation: This standard applies to any instance of prolonged data disruption, regardless of whether there is a corresponding emergency.	
2.b.1 General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in-person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and	This criterion is more prescriptive than the standards regarding timelines and when to use telephone versus in-person contact. CRI 3.04 only applies when the organization is providing crisis services directly and

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emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up. If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made. If the triage 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 by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth	5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 3.03 Persons served, and families as appropriate, participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is: 1. completed within established timeframes; 2. appropriately tailored to meet the age and developmental level of persons served; 3. conducted through a combination of interviews, discussion, and observation; and 4. focused on information pertinent for meeting service requests and objectives. Interpretation: For an assessment to be trauma-informed, the organization understands and recognizes the role of traumatic life events in the development of mental health and/or substance use disorders. Personnel should focus on the experiences and strengths of the individual or family rather than deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially re-traumatize persons served. ICHH 4.03 The assessment incorporates applicable information from a variety of sources, which include, but are not limited to: 1. the person;	these standards are assigned.

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populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period. Note: Requirements for these screenings and evaluations are specified in criteria 4.d.	2. the person's family; 3. medical and/or clinical case records; 4. the results of screening tools; 5. relevant content from assessments completed by partnering or referring providers; 6. other providers; and 7. members of the care planning team. CRI 3.04 An ongoing, rapid risk assessment is conducted in a culturally and linguistically responsive manner to determine: 1. if the individual is in imminent danger; 2. potential lethality including harm to oneself or others and risk for suicide; 3. the individual's emotional status and imminent psychosocial needs; 4. individual strengths and available coping mechanisms; and 5. resources that can increase service participation and success.	
2.b.2 General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or applicable accreditation standards are more stringent.	MHSU 3.07 Reassessments are conducted as necessary, according to the needs of the individual or family. Interpretation: Certain events may heighten or trigger suicide risk, as could a new physical or mental health diagnosis, and should prompt a new suicide risk assessment as part of the reassessment. Once any potential suicide risk is identified, it may be important to conduct reassessments regularly even if these trigger events are not observed. Examples: Timeframes for reassessment depend on the service population and length of treatment, or may be delineated by regulatory requirements. The organization may conduct a reassessment during specific milestones in the treatment process, for example: 1. after significant treatment progress; 2. after a lack of significant treatment progress;	

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	3. after new symptoms are identified; 4. after changes in treatment strategy and/or medication; 5. when significant behavioral changes are observed; 6. when there are changes to a family situation; or 7. when significant environmental changes or external stressors occur. MHSU 4.03 The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess: 1. service plan implementation; 2. progress toward achieving service goals and desired outcomes; and 3. the continuing appropriateness of the agreed upon service goals. Interpretation: When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard. MHSU 4.04 The worker and individual, and his or her family when appropriate: 1. review progress toward achievement of agreed upon service goals; and 2. sign revisions to service goals and plans.	
2.b.3 General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and	This criterion is more prescriptive than the standard regarding timelines.

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needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.	5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made.	
2.c.1 Access to Crisis Management Services In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.	CRI 5.01 Crisis hotlines operate 24 hours a day, seven days a week.	CRI 5.01 will apply when the organization provides 24/7 crisis care directly and CRI standards are applied.
2.c.2 Access to Crisis Management Services A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.	GOV 3.01 The organization provides the public with clear, timely, and accurate information about the organization's mission, programs, activities, service recipients, and finances. MHSU 3.01 Individuals and families served are screened and informed about: a. how well their request matches the organization's services; b. what services will be available and when; and c. rules and expectations of the program. CRI Purpose Crisis Response and Information Services operate as part of the community's crisis response system to provide immediate, dependable responses and reliable information to promote safety and stability for the individual in crisis. Interpretation: Stabilization is a combination of methods used to return the service recipient to his or her pre-crisis level of functioning, including:	The following procedures must be developed in response to the CRI standards when crisis response services are provided directly: 1. Procedures for accessing supervisory support 2. Debriefing procedures 3. Screening and intake procedures 4. Risk assessment procedures 5. Action planning proceduresSafety planning procedures 6. Treatment and referral proceduresSupervisory review procedures

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	1. identifying the precipitating event; *2.* mobilizing support and resources; *3.* identifying coping skills; and *4.* developing plans to ensure safety. CRI 3.01 The organization provides information about: 1. hours of operation; 2. how to access the organization's services; and 3. whether crisis services have a particular focus (e.g., mental health or rape crisis intervention).	7. Service coordination procedures 8. Procedures for collecting and summarizing community needs 9. Procedures for evaluating referral resources
2.c.3 Access to Crisis Management Services Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. 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.d.	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 4.02 The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that:	

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	1. is individualized and centered around strengths; 2. identifies individualized warning signs of a crisis; 3. identifies coping strategies and sources of support that persons served can implement during a suicidal crisis, as appropriate; and 4. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization. Interpretation: For individuals who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that individuals can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal individuals cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required. Interpretation: For organizations serving children and youth, when safety issues are identified, the organization: 1. involves supervisory personnel in reviewing safety concerns and plans; and 2. reports safety concerns in accordance with mandated reporting requirements.	
2.c.4 Access to Crisis Management Services In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.	MHSU 10: Care Coordination The organization coordinates services in order to promote continuity of care and whole-person wellness. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served.	The MHSU standards do not require working relationships with hospitals specifically but they do support care coordination activities with partnering providers. When crisis response services are provided directly, CRI 6.01 would apply, which does require

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	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. CRI 6.01 To ensure rapid and efficient access, the organization establishes procedures for working with emergency responders including: 1. police and fire departments; 2. hospital emergency rooms; 3. mental and physical health crisis teams; and 4. child and adult protective services.	procedures for working with hospital emergency rooms.
2.c.5 Access to Crisis Management Services Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;	The criterion is more prescriptive than the MHSU standard regarding the involvement of law enforcement. CRI standards will only apply

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recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations. Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.	2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 3.05 The organization uses a comprehensive, evidence-based suicide risk assessment tool to assess the following when suicide risk is identified: 1. suicidal desire; 2. capability; 3. intent; and 4. buffers/protective factors. MHSU 4.02 The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that: 1. is individualized and centered around strengths; 2. identifies individualized warning signs of a crisis; 3. identifies coping strategies and sources of support that persons served can implement during a suicidal crisis, as appropriate; and	when the CCBHC is providing crisis services directly.

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	4. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization. Interpretation: For individuals who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that individuals can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal individuals cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required. Interpretation: For organizations serving children and youth, when safety issues are identified, the organization: *1.* involves supervisory personnel in reviewing safety concerns and plans; and *2.* reports safety concerns in accordance with mandated reporting requirements. CRI 3.04 An ongoing, rapid risk assessment is conducted in a culturally and linguistically responsive manner to determine: 1. if the individual is in imminent danger; 2. potential lethality including harm to oneself or others and risk for suicide; 3. the individual's emotional status and imminent psychosocial needs; 4. individual strengths and available coping mechanisms; and 5. resources that can increase service participation and success. CRI 6.01 To ensure rapid and efficient access, the organization establishes procedures for working with emergency responders including:	

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	1. police and fire departments; 2. hospital emergency rooms; 3. mental and physical health crisis teams; and *3.* child and adult protective services.	
2.c.6 Access to Crisis Management Services Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises. Note: See criterion 3.a.4 where precautionary crisis planning is addressed.	MHSU 4.02 The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that: 1. is individualized and centered around strengths; 2. identifies individualized warning signs of a crisis; 3. identifies coping strategies and sources of support that persons served can implement during a suicidal crisis, as appropriate; and 4. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization. Interpretation: For individuals who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that individuals can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal individuals cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required. Interpretation: For organizations serving children and youth, when safety issues are identified, the organization: *1.* involves supervisory personnel in reviewing safety concerns and plans; and *2.* reports safety concerns in accordance with mandated reporting requirements.	
2.d.1 No Refusal of Services due to Inability to Pay The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis	MHSU 12.03 If an individual or family has to leave the program unexpectedly or they voluntarily discontinue services, the organization makes	The criterion is more prescriptive than the standard regarding no

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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).	every effort to identify other service options and link them with appropriate services. Interpretation: The organization must determine on a case-by-case basis its responsibility to continue providing services to individuals whose third-party benefits are denied or have ended and who are in critical situations. Interpretation: See MHSU 9.13 for more information on withdrawal from office-based opioid treatment.	refusal of services due to inability to pay.
2.d.2 No Refusal of Services due to Inability to Pay The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.	CR 1.07 Clients receive a schedule of any applicable fees and estimated or actual expenses, and are informed prior to service delivery about: 1. the amount that will be charged; 2. when fees or co-payments are charged, changed, refunded, waived, or reduced; 3. the manner and timing of payment; and 4. the consequences of nonpayment. ASE 3.03 The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level.	The criterion is more prescriptive than the standard regarding maintaining a sliding fee discount schedule and where it must be posted.

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	Examples: Examples of ways the organization can demonstrate standard implementation include, but are not limited to: 1. providing basic program information in languages representative of consumer groups; 2. proactively reaching out to ensure that all individuals can use its services and fully participate in planning; 3. hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery; 4. ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload; 5. offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without depending upon children or other individuals unable to maintain the integrity of the client-provider relationship; and 6. using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate.	
2.d.3 No Refusal of Services due to Inability to Pay 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.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their property owner or from relevant public or private health and safety authorities, the	The criterion is more prescriptive than the standard regarding how the fees are set.

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	organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location.	
2.d.4 No Refusal of Services due to Inability to Pay 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.	CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity.	The criterion is more prescriptive than the standard regarding how to apply the sliding fee discount schedule.
2.e.1 Provision of Services Regardless of Residence The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address.	MHSU 3.01 Individuals and families served are screened and informed about: 1. how well their request matches the organization's services; 2. what services will be available and when; and 3. rules and expectations of the program. CR 1.02 Written rights and responsibilities include, but are not limited to: 1. basic expectations for use of the organization's services including the responsibility to provide information needed to receive services; 2. hours in which services are available; 3. rules, behavioral expectations, and other factors that could result in discharge or termination; 4. the right of the person served to receive service in a manner that is non-coercive and that protects the person's right to self-determination; 5. the right of the person served, families, and/or legal guardians to participate in decisions regarding the services provided; and	The criterion is more prescriptive than the standard regarding provision of services regardless of residence

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	6. basic information about how to lodge complaints, grievances, or appeals. CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity.	
2.e.2 Provision of Services Regardless of Residence The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking non-crisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made.	The criterion is more prescriptive than the standard regarding how to provide services to individuals who live outside the CCBHC service area

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out-of-home placements and adults who are displaced by incarceration or housing instability.		
3.a.1 General Requirements of Care Coordination Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.9 Note: See criteria 4.k relating to care coordination requirements for veterans.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. MHSU 10 The organization coordinates services in order to promote continuity of care and whole-person wellness. Interpretation: The standards in MHSU 10 address the efforts an organization makes to promote information sharing and collaboration with the various systems touching the individual or family. Organizations are not required to provide integrated care to implement the standards in this section. Organizations that offer integrated behavioral health and primary care	Integrated Care/Health Home Standards can be assigned when integrated care is being provided directly by the CCBHC, otherwise MHSU 10: Care Coordination would apply.

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	services (e.g., health homes) will complete the Integrated Care; Health Home (ICHH) standards. MHSU 10.01 The organization works in active partnership with individuals and families to: 1. ensure that they receive appropriate advocacy support; 2. assist with access to the full array of services to which they are eligible; and 3. mediate barriers to receiving coordinated services. MHSU 10.02 Individuals with co-occurring mental health and substance use disorders receive coordinated treatment either directly or through active involvement with a cooperating service provider. Interpretation: This standard is applicable to all programs regardless of the services offered. Organizations that only treat substance use disorders are expected to have the core capability to address co-occurring mental health conditions, and organizations that only treat mental health disorders are expected to have the core capability to address co-occurring substance use disorders. MHSU 10.03 The organization supports the coordination of behavioral and physical health care to increase access to needed services by: 1. providing referrals to identified primary care providers; 2. communicating with the primary care doctor about treatment planning; and 3. linking individuals to providers that can help them navigate the health care system. MHSU 10.04 In collaboration with individuals and families, the organization coordinates with, as needed: 1. the child welfare system;	

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	2. the justice system; 3. courts; and 4. the school system. Interpretation: The organization should coordinate with the justice system to advocate for continuous medication-assisted treatment with buprenorphine for individuals receiving office-based opioid treatment who are incarcerated or on probation or parole. Interpretation: Implementation of MSHU 10.04 should include collaboration with the referral source when families are referred and mandated to receive services by an agency with statutory responsibility. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served.	
3.a.2 General Requirements of Care Coordination The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant	The criterion is more prescriptive than the standard regarding revisiting attempts to obtain consent to release information when consent is not obtained after reasonable attempts.

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Note: CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.	public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. CR 2 The organization protects the confidentiality of information about clients and assumes a protective role regarding the disclosure of confidential information. CR 2.01 When the organization receives a request for confidential information about a client, or when the release of confidential information is necessary for the provision of services, prior to releasing such information, the organization: 1. determines if the reason to release information is valid; 2. obtains informed, written authorization to release the information from the client and/or parent or legal guardian, as appropriate; and 3. maintains each authorization of consent in the case record and provides a copy to the client and/or parent or legal guardian. CR 2.02 Prior to the disclosure of confidential or private information, the organization informs the client about circumstances when it may be legally or ethically permitted or required to release such information without his or her consent and notifies the client of such a release when it occurs. CR 2.04 The release form for disclosure of confidential information includes the following elements:	

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	1. the name of the person whose information will be released; 2. the signature of the person whose information will be released, or the parent or legal guardian of a person who is unable to provide authorization; 3. the specific information to be released; 4. the purpose for which the information is to be used; 5. the date the release takes effect; 6. the date, event, or condition upon which the consent expires in relation to the individual purpose for disclosure, not to exceed one year from when the release takes effect; 7. the name of the person(s) or organization(s) that will receive the disclosed information; 8. the name of the person or organization that is disclosing the confidential information; and 9. a statement that the person or family may withdraw their authorization at any time except to the extent that action has already been taken. Interpretation: Blanket release forms signed by clients when service is initiated do not meet the requirements of this standard except as put forth by federal regulation, for example, when making application to FEMA/DHS in a declared disaster. Interpretation: When a release form is used to authorize the exchange of information between multiple parties, the form must comply with all elements of the standard. All relevant parties must be authorized to disclose and receive the information specified, for the purpose indicated, in the consent. Interpretation: Elements (b) and (i) will not apply when law, regulation, or court order, permits confidential information to be released without the authorization of the person or legal guardian.	
3.a.3 General Requirements of Care Coordination Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the	MHSU 10.01 The organization works in active partnership with individuals and families to: 1. ensure that they receive appropriate advocacy support;	

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CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.	2. assist with access to the full array of services to which they are eligible; and 3. mediate barriers to receiving coordinated services. ICHH 6.04 Individuals are assisted in making appointments for needed or requested services, and the care coordinator follows up to: 1. ensure the service was received; 2. identify any needed follow-up; and 3. make needed changes to the care plan in partnership with the person and his or her family.	
3.a.4 General Requirements of Care Coordination The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.	MHSU 10 The organization coordinates services in order to promote continuity of care and whole-person wellness. Interpretation: The standards in MHSU 10 address the efforts an organization makes to promote information sharing and collaboration with the various systems touching the individual or family. Organizations are not required to provide integrated care to implement the standards in this section. Organizations that offer integrated behavioral health and primary care services (e.g., health homes) will complete the Integrated Care; Health Home (ICHH) standards. MHSU 4.02 The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that: 1. is individualized and centered around strengths; 2. identifies individualized warning signs of a crisis; 3. identifies coping strategies and sources of support that persons served can implement during a suicidal crisis, as appropriate; and 4. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization.	

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	Interpretation: For individuals who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that individuals can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal individuals cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required. Interpretation: For organizations serving children and youth, when safety issues are identified, the organization: *1.* involves supervisory personnel in reviewing safety concerns and plans; and *2.* reports safety concerns in accordance with mandated reporting requirements. PRG 1.03 The case record contains essential medical and legal information including, as applicable: 1. orders for and results of psychological, medical, toxicological, diagnostic, or other evaluations; 2. documentation of all prescribed and over-the-counter medications including copies of all written orders for medications, when applicable; 3. special treatment procedures, allergies, or adverse treatment responses; and 4. court reports, documents of guardianship or legal custody, birth or marriage certificates, and any legal directives related to the service being provided.	
3.a.5 General Requirements of Care Coordination Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing	PRG 3.03 When individuals are receiving prescription medication: 1. qualified personnel obtain and/or update information about the medications the individual is taking at each visit; and 2. the prescribing clinician compares current medications the individual is taking at each visit, including vitamins or other non-prescription medications, with new or changed	The criterion is more prescriptive than the standard regarding when to consult the PDMP. MHSU 9.03 only applies when office-based opioid

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medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to the release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.	medication orders to identify possible adverse interaction of medications. MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures. Interpretation: The nature of problems resulting from mental health and/or substance use disorders may require medical services to be available. The organization is not required to provide services directly, but the results of medical screens, tests, and services should be documented in the case record when available and incorporated into service planning and monitoring. Interpretation: Organizations providing treatment services for mental health and/or substance use disorders are expected to have a licensed physician or other qualified health professional with appropriate training and experience on staff or available through a contract or formal arrangement. See MHSU 7.01 for more information. All other services must have, at minimum, an established referral relationship with a licensed physician or other qualified health professional. MHSU 9.03 The organization queries the state prescription drug monitoring program (PDMP): 1. prior to initiating medication-assisted treatment; and 2. once per quarter or more frequently when required by state law.	treatment is being provided directly.
3.a.6	CR 1.04	

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General Requirements of Care Coordination Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its DCOs, or with any other provider.	Individuals provide consent prior to receiving services and have the right to: 1. participate in all service decisions; 2. be informed of the benefits, risks, side effects, and alternatives to planned services; 3. be offered the most appropriate and least restrictive or intrusive service alternative to meet their needs; 4. receive service in a manner that is free from harassment or coercion and that protects the person's right to self-determination; 5. refuse any service, treatment, or medication, unless mandated by law or court order; and 6. be informed about the consequences of such refusal, which can include discharge. Interpretation: In regard to element (d), organizations should ensure that services or interventions do not include strategies that are coercive, threatening, or harmful to an individual's overall wellbeing. Research shows that services and interventions that attempt to alter sexual orientation, gender identity, or gender expression (e.g., conversion or reparative therapies) are harmful and, as such, should be prohibited from agency practice.	
3.a.7 General Requirements of Care Coordination The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.	TS 2.06 Direct service personnel demonstrate competence in, or receive training on how to: 1. identify and access needed community resources; 2. collaborate with other service providers; 3. access financial assistance, including public assistance and government subsidies; and 4. empower service recipients and their families to advocate on their own behalf. MHSU 11.01 The organization provides, either directly or by referral, necessary support services which may include, as appropriate: 1. basic needs, such as food, clothing, and housing;	

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	2. work-related services and job placement; 3. transportation; 4. legal services; 5. financial counseling; 6. social skills training; 7. public benefits; 8. educational services; and 9. respite care. Interpretation: Service members and veterans should be linked to any services or benefits for which they may be eligible, including Veterans Affairs health services.	
3.b.1 Care Coordination and Other Health Information Systems The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.	RPM 4 The organization's technology and information systems have sufficient capability to support operations, service delivery, strategic planning, and quality improvement activities. Interpretation: The standards in this section address the management of all types of paper and electronic information maintained by the organization including: *1.* case records and other information of persons served; *2.* administrative, financial, and risk management records and reports; *3.* personnel files and other human resources records; and *4.* performance and quality improvement data and reports. ICHH 3.03 The organization uses health information technologies to: 1. link services including shared access to the person's health information; 2. organize, track, and analyze critical program information including referrals and needed follow-up; and 3. satisfy applicable reporting requirements.	
3.b.2 Care Coordination and Other Health Information Systems The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in	RPM 4.02 The organization has an information management system that: 1. gives personnel consistent, timely, and appropriate access to all types of electronic and paper records; and	The criterion is more prescriptive than the standard regarding alignment with federal,

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place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.	2. supports continuity and integration of care across programs and services by giving timely access to information about persons served to practitioners across the organization, as appropriate. Interpretation: Organizations moving to electronic systems may need to develop procedures for maintaining both electronic and paper records including procedures for maintaining consistency between the two file types and ensuring the electronic record is comprehensive and complete. If there are components of paper records that cannot be accommodated electronically, the organization should consider how it will retain and document the existence of supplemental, paper-based portions of records. RPM 4.03 The organization's electronic information systems are capable of: 1. capturing, tracking, and reporting financial, compliance, and other business information; 2. longitudinal reporting and comparison of performance and outcomes over time; and 3. the use of clear and consistent formats and methods for reporting and disseminating data. Interpretation: “Electronic information systems” are used for collecting, storing, analyzing, and disseminating information electronically. An electronic information system may consist of a single desktop or larger network of computers, laptops, and/or devices. Organizations are not required to implement robust electronic information systems; rather they must have systems that are appropriate for supporting their administrative operations and service delivery. RPM 5 Electronic and printed information is protected against intentional and unintentional destruction or modification and unauthorized disclosure or use.	HHS-adopted standards for data-driven activities.

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	Interpretation: The standards in this section address security of all types of paper and electronic information maintained by the organization, unless otherwise noted, including: *1.* case records and other information of persons served; *2.* administrative, financial, and risk management records and reports; *3.* personnel files and other human resources records; and *4.* performance and quality improvement data and reports. RPM 5.01 The organization protects confidential and other sensitive information from theft, unauthorized use or disclosure, damage, or destruction by: 1. limiting access to authorized personnel on a need-to-know basis; 2. using firewalls, anti-virus and related software, and other appropriate safeguards; 3. monitoring security measures on an ongoing basis; 4. having the ability to remotely wipe or disable mobile devices, if applicable, in the event that a device is lost, stolen, repurposed, or discarded; and 5. maintaining paper records in a secure location when not in use by authorized staff. RPM 5.02 Proper safeguards protect confidential information when transmitted electronically. RPM 5.05 The organization ensures its electronic system for managing health records or protected health information limits access to information in accordance with confidentiality rules and the person's privacy preferences to the greatest extent possible. Interpretation: If the electronic health record system employed by the organization is not able to meet all client privacy	

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	preferences and/or all of the necessary confidentiality rules, the organization informs the service recipient of the system's limitations and obtains consent for the exchange of electronic health information based on those restrictions.	
3.b.3 Care Coordination and Other Health Information Systems The CCBHC uses technology that has been certified to current criteria under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities (see footnotes for citations to the required health IT certification criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs: Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible). At a minimum, support care coordination by sending and receiving summary of care records. Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice. Provide evidence-based clinical decision support. Conduct electronic prescribing. Note: Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a	RPM 4 The organization's technology and information systems have sufficient capability to support operations, service delivery, strategic planning, and quality improvement activities. Interpretation: The standards in this section address the management of all types of paper and electronic information maintained by the organization including: *1.* case records and other information of persons served; *2.* administrative, financial, and risk management records and reports; *3.* personnel files and other human resources records; and *4.* performance and quality improvement data and reports. RPM 4.01 The organization assesses its technology and information management needs including a review of: 1. current technology and information systems in use by the organization; 2. short- and long-term goals for utilizing technology; and 3. current technical skills of staff and need for staff training. RPM 4.02 The organization has an information management system that: 3. gives personnel consistent, timely, and appropriate access to all types of electronic and paper records; and 4. supports continuity and integration of care across programs and services by giving timely access to information about persons served to practitioners across the organization, as appropriate. Interpretation: Organizations moving to electronic systems may need to develop procedures for maintaining both electronic and	The criterion is more prescriptive than the standard regarding the capabilities of the information systems.

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single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have	paper records including procedures for maintaining consistency between the two file types and ensuring the electronic record is comprehensive and complete. If there are components of paper records that cannot be accommodated electronically, the organization should consider how it will retain and document the existence of supplemental, paper-based portions of records. RPM 4.03 The organization's electronic information systems are capable of: 1. capturing, tracking, and reporting financial, compliance, and other business information; 2. longitudinal reporting and comparison of performance and outcomes over time; and 3. the use of clear and consistent formats and methods for reporting and disseminating data. Interpretation: "Electronic information systems" are used for collecting, storing, analyzing, and disseminating information electronically. An electronic information system may consist of a single desktop or larger network of computers, laptops, and/or devices. Organizations are not required to implement robust electronic information systems; rather they must have systems that are appropriate for supporting their administrative operations and service delivery. ICHH 3.03 The organization uses health information technologies to: 1. link services including shared access to the person's health information; 2. organize, track, and analyze critical program information including referrals and needed follow-up; and 3. satisfy applicable reporting requirements. PRG 2.02	

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	Service recipients may review and, when desired, add a statement to their files in accordance with applicable laws and regulations, and: 1. reviews are conducted in the presence of professional personnel on the organization's premises; 2. reviews are carried out in a manner that protects the confidentiality of family members and others whose information may be contained in the record; 3. any personnel responses to service recipient additions are added with the service recipient's knowledge; and 4. the service recipient is given the opportunity to review and comment on personnel responses.	
3.b.4 Care Coordination and Other Health Information Systems The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	RPM 6.02 Written contracts: 1. are reviewed by legal counsel or another qualified individual prior to signing; and 2. contain all significant terms and conditions in accordance with applicable law. Interpretation: "Significant terms" should include, as appropriate to the type of contract: *1.* roles and responsibilities of participating organizations; *2.* services to be provided; *3.* clearly defined performance goals; *4.* measurable outcomes; *5.* service authorization, including eligibility criteria; *6.* provisions for training and technical support, as necessary; *7.* duration of contract, including delineation of follow-up services; *8.* policies and procedures for sharing information; *9.* methods for resolving disputes; *10.* a plan and procedure for timely payment, and consequences for failure to pay; *11.* necessary documentation and means of reporting to, funding or oversight bodies; and *12.* conditions for termination of the contract.	

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	CR 2.01 When the organization receives a request for confidential information about a client, or when the release of confidential information is necessary for the provision of services, prior to releasing such information, the organization: 1. determines if the reason to release information is valid; 2. obtains informed, written authorization to release the information from the client and/or parent or legal guardian, as appropriate; and 3. maintains each authorization of consent in the case record and provides a copy to the client and/or parent or legal guardian.	
3.b.5 Care Coordination and Other Health Information Systems The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health record	RPM 4.01 The organization assesses its technology and information management needs including a review of: 1. current technology and information systems in use by the organization; 2. short- and long-term goals for utilizing technology; and 3. current technical skills of staff and need for staff training. RPM 6.02 Written contracts: 1. are reviewed by legal counsel or another qualified individual prior to signing; and 2. contain all significant terms and conditions in accordance with applicable law. Interpretation: “Significant terms” should include, as appropriate to the type of contract: 1. roles and responsibilities of participating organizations; 2. services to be provided; 3. clearly defined performance goals; 4. measurable outcomes; 5. service authorization, including eligibility criteria; 6. provisions for training and technical support, as necessary; 7. duration of contract, including delineation of follow-up services;	

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	8. policies and procedures for sharing information; 9. methods for resolving disputes; 10. a plan and procedure for timely payment, and consequences for failure to pay; 11. necessary documentation and means of reporting to, funding or oversight bodies; and 12. conditions for termination of the contract. RPM 4.02 The organization has an information management system that: 1. gives personnel consistent, timely, and appropriate access to all types of electronic and paper records; and 2. supports continuity and integration of care across programs and services by giving timely access to information about persons served to practitioners across the organization, as appropriate. Interpretation: Organizations moving to electronic systems may need to develop procedures for maintaining both electronic and paper records including procedures for maintaining consistency between the two file types and ensuring the electronic record is comprehensive and complete. If there are components of paper records that cannot be accommodated electronically, the organization should consider how it will retain and document the existence of supplemental, paper-based portions of records. ICHH 3.03 The organization uses health information technologies to: 1. link services including shared access to the person's health information; 2. organize, track, and analyze critical program information including referrals and needed follow-up; and 3. satisfy applicable reporting requirements. ICHH 6.05 The care coordinator supports smooth transitions between care settings by:	

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	1. coordinating information sharing and service provision with providers and the person; 2. developing, or supporting the development of, a comprehensive discharge or transition plan with steps for follow-up; and 3. facilitating face-to-face interactions between providers, whenever possible.	
3.c.1 Care Coordination Partnerships The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.	ICHH Purpose Adults and children who receive integrated care experience improved health care quality, an improved client care experience, and improved clinical and non-clinical outcomes. ICHH Definition ICHH Definition: Integrated care is the systematic coordination of behavioral and physical health care in order to improve an individual's overall health. Behavioral health providers can offer integrated care by fully integrating primary care into their existing program, establishing written agreements with a primary care provider that is located on-site, or establishing written agreements with a primary care provider that is located in the community. MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures. MHSU 6.02	

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	The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services. MHSU 10.03 The organization supports the coordination of behavioral and physical health care to increase access to needed services by: 1. providing referrals to identified primary care providers; 2. communicating with the primary care doctor about treatment planning; and 3. linking individuals to providers that can help them navigate the health care system. RPM 6.03 Non-contractual service agreements include, as appropriate: 1. services exchanged or provided, and/or the goals and objectives of such collaborations; 2. roles and responsibilities of each organization including reporting responsibilities; 3. procedures for sharing information; 4. confidentiality protections including signed written consent forms; 5. assignment of case coordination responsibilities;	

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	6. service authorization procedures including accepting or rejecting cases; and 7. how to resolve communication difficulties. Interpretation: This standard applies to non-contractual arrangements, also known as Memorandums of Understanding (MOUs), in which organizations collaborate with service providers to deliver specific services to a person or persons. This could include, for example, a service in which a service provider voluntarily comes into the host organization's facility to provide weekly smoking cessation classes.	
3.c.2 Care Coordination Partnerships The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.	RPM 6.03 Non-contractual service agreements include, as appropriate: 1. services exchanged or provided, and/or the goals and objectives of such collaborations; 2. roles and responsibilities of each organization including reporting responsibilities; 3. procedures for sharing information; 4. confidentiality protections including signed written consent forms; 5. assignment of case coordination responsibilities; 6. service authorization procedures including accepting or rejecting cases; and 7. how to resolve communication difficulties. Interpretation: This standard applies to non-contractual arrangements, also known as Memorandums of Understanding (MOUs), in which organizations collaborate with service providers to deliver specific services to a person or persons. This could include, for example, a service in which a service provider voluntarily comes into the host organization's facility to provide weekly smoking cessation classes. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including:	The criterion is more prescriptive than the standard regarding what types of community providers the organization needs to have care coordination expectations with.

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Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover. Certifying states are encouraged to find ways to incentivize inpatient treatment facilities to partner with CCBHCs to establish protocols and procedures for transitioning individuals, including real time notification of discharge and record transfers that support the seamless delivery of care, maintain recovery, and reduce the risk of relapse and injury during transitions.	1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served. ICHH 6.05 The care coordinator supports smooth transitions between care settings by: 1. coordinating information sharing and service provision with providers and the person; 2. developing, or supporting the development of, a comprehensive discharge or transition plan with steps for follow-up; and 3. facilitating face-to-face interactions between providers, whenever possible.	
3.c.3 Care Coordination Partnerships The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships	RPM 6.03 Non-contractual service agreements include, as appropriate: 1. services exchanged or provided, and/or the goals and objectives of such collaborations;	

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support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: 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. Other social and human services CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following: Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders. Suicide and crisis hotlines and warmlines. Indian Health Service or other tribal programs. Homeless shelters. Housing agencies. Employment services systems. Peer-operated programs. Services for older adults, such as Area Agencies on Aging. Aging and Disability Resource Centers. State and local health departments and behavioral health and developmental disabilities agencies. Substance use prevention and harm reduction programs. Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers. Legal aid. Immigrant and refugee services. SUD Recovery/Transitional housing. Programs and services for families with young children, including Infants, Toddlers, WIC, Home Visiting Programs,	2. roles and responsibilities of each organization including reporting responsibilities; 3. procedures for sharing information; 4. confidentiality protections including signed written consent forms; 5. assignment of case coordination responsibilities; 6. service authorization procedures including accepting or rejecting cases; and 7. how to resolve communication difficulties. Interpretation: This standard applies to non-contractual arrangements, also known as Memorandums of Understanding (MOUs), in which organizations collaborate with service providers to deliver specific services to a person or persons. This could include, for example, a service in which a service provider voluntarily comes into the host organization's facility to provide weekly smoking cessation classes. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services.	

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Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs. Coordinated Specialty Care programs for first episode psychosis. Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food and transportation programs) In addition, the CCBHC has a care coordination partnership with the 988 Suicide Crisis Lifeline call center serving the area in which the CCBHC is located. Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.Certifying states may require CCBHCs to establish additional partnerships	MHSU 10.04 In collaboration with individuals and families, the organization coordinates with, as needed: 1. the child welfare system; 2. the justice system; 3. courts; and 4. the school system. Interpretation: The organization should coordinate with the justice system to advocate for continuous medication-assisted treatment with buprenorphine for individuals receiving office-based opioid treatment who are incarcerated or on probation or parole. Interpretation: Implementation of MSHU 10.04 should include collaboration with the referral source when families are referred and mandated to receive services by an agency with statutory responsibility. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served.	
3.c.4 Care Coordination Partnerships The CCBHC has partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type. Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the	RPM 6.03 Non-contractual service agreements include, as appropriate: 1. services exchanged or provided, and/or the goals and objectives of such collaborations; 2. roles and responsibilities of each organization including reporting responsibilities; 3. procedures for sharing information; 4. confidentiality protections including signed written consent forms; 5. assignment of case coordination responsibilities;	

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partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover	6. service authorization procedures including accepting or rejecting cases; and 7. how to resolve communication difficulties. Interpretation: This standard applies to non-contractual arrangements, also known as Memorandums of Understanding (MOUs), in which organizations collaborate with service providers to deliver specific services to a person or persons. This could include, for example, a service in which a service provider voluntarily comes into the host organization's facility to provide weekly smoking cessation classes. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a	

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	developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. MHSU 10.03 The organization supports the coordination of behavioral and physical health care to increase access to needed services by: 1. providing referrals to identified primary care providers; 2. communicating with the primary care doctor about treatment planning; and 3. linking individuals to providers that can help them navigate the health care system. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served. MHSU 11.01 The organization provides, either directly or by referral, necessary support services which may include, as appropriate: 1. basic needs, such as food, clothing, and housing; 2. work-related services and job placement; 3. transportation; 4. legal services; 5. financial counseling; 6. social skills training; 7. public benefits; 8. educational services; and 9. respite care. Interpretation: Service members and veterans should be linked to any services or benefits for which they may be eligible, including Veterans Affairs health services.	

<table>
<tr><th>SAMHSA CCBHC Criteria[i]</th><th>COA Accreditation Standards</th><th>Social Current Notes</th></tr>
<tr><td>3.c.5
Care Coordination Partnerships
The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge Transfer (ADT) system. The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and continues until the individual is linked to services or assessed to be no longer at risk.

Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement,</td><td>RPM 6.03
Non-contractual service agreements include, as appropriate:
1. services exchanged or provided, and/or the goals and objectives of such collaborations;
2. roles and responsibilities of each organization including reporting responsibilities;
3. procedures for sharing information;
4. confidentiality protections including signed written consent forms;
5. assignment of case coordination responsibilities;
6. service authorization procedures including accepting or rejecting cases; and
7. how to resolve communication difficulties.

Interpretation: This standard applies to non-contractual arrangements, also known as Memorandums of Understanding (MOUs), in which organizations collaborate with service providers to deliver specific services to a person or persons. This could include, for example, a service in which a service provider voluntarily comes into the host organization’s facility to provide weekly smoking cessation classes.

MHSU 3.02
Prompt, responsive intake practices:
1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
2. give priority to urgent needs and emergency situations including access to expedited service planning;
3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs;
4. support timely initiation of services; and
5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly.</td><td>The criterion is more prescriptive than the standard regarding what types of providers are included in the agreements. CRI 6.01 and 6.02 only apply when crisis services are provided directly.</td></tr>
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the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.	Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. CRI 6.01 To ensure rapid and efficient access, the organization establishes procedures for working with emergency responders including: 1. police and fire departments; 2. hospital emergency rooms; 3. mental and physical health crisis teams; and 4. child and adult protective services. CRI 6.02 The organization has formal arrangements with local social service, mental health, and medical resources to facilitate referrals and service coordination and ensure rapid or priority access to services. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care;	

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	11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services. MHSU 6.03 Individuals and their families, when appropriate, are connected with peer support services, either directly or by referral, appropriate to their request or need for service. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served. CRI 6.01 To ensure rapid and efficient access, the organization establishes procedures for working with emergency responders including: 5. police and fire departments; 6. hospital emergency rooms; 7. mental and physical health crisis teams; and 8. child and adult protective services. ICHH 6.05 The care coordinator supports smooth transitions between care settings by: 1. coordinating information sharing and service provision with providers and the person; 2. developing, or supporting the development of, a comprehensive discharge or transition plan with steps for follow-up; and 3. facilitating face-to-face interactions between providers, whenever possible.	

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3.d.1 Care Treatment Team, Treatment Planning, and Care Coordination Activities The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	MHSU 4 Individuals and their families, as appropriate to the program model and the age and expressed wishes of the person, participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support. Interpretation: Due to the importance of family involvement in achieving positive outcomes for children and youth, service planning and monitoring should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child. MHSU 7 Treatment decisions are guided by a qualified clinical team and are made in collaboration with persons served. MHSU 7.02 A licensed physician, or other qualified health professional, and a clinical team led by a licensed provider, collaborate with the individual to make decisions about level of care, treatment, and aftercare or discharge planning.	
3.d.2 Care Treatment Team, Treatment Planning, and Care Coordination Activities The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving	MHSU 7.02 A licensed physician, or other qualified health professional, and a clinical team led by a licensed provider, collaborate with the individual to make decisions about level of care, treatment, and aftercare or discharge planning. Examples: Clinical teams may include social work, medical, psychological, and psychiatric professionals with specialized training in mental health and/or substance use disorders.	

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services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. Note: See criteria 4.k relating to required treatment planning services for veterans.		
3.d.3 Care Treatment Team, Treatment Planning, and Care Coordination Activities 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.	MHSU 10 The organization coordinates services in order to promote continuity of care and whole-person wellness. Interpretation: The standards in MHSU 10 address the efforts an organization makes to promote information sharing and collaboration with the various systems touching the individual or family. Organizations are not required to provide integrated care to implement the standards in this section. Organizations that offer integrated behavioral health and primary care services (e.g., health homes) will complete the Integrated Care; Health Home (ICHH) standards.	
4.a.1 General Service Provisions Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or	This is a regulatory criterion that defines the scope of the CCBHC model. Please see how COA Accreditation Standards address the 9 core services of CCBHCs in relevant sections of this crosswalk.

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	service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location.	
4.a.2 General Service Provisions The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.	CR 1.04 Individuals provide consent prior to receiving services and have the right to: 1. participate in all service decisions; 2. be informed of the benefits, risks, side effects, and alternatives to planned services; 3. be offered the most appropriate and least restrictive or intrusive service alternative to meet their needs; 4. receive service in a manner that is free from harassment or coercion and that protects the person's right to self-determination; 5. refuse any service, treatment, or medication, unless mandated by law or court order; and 6. be informed about the consequences of such refusal, which can include discharge. Interpretation: In regard to element (d), organizations should ensure that services or interventions do not include strategies that are coercive, threatening, or harmful to an individual's overall wellbeing. Research shows that services and interventions that attempt to alter sexual orientation, gender identity, or gender expression (e.g., conversion or reparative therapies) are harmful and, as such, should be prohibited from agency practice.	
4.a.3 General Service Provisions With regard to either CCBHC or DCO services, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources.	

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	Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. CR 1.01 All persons served receive, and are helped to understand, information about their rights and responsibilities that is: 1. provided in writing; 2. distributed during their initial contact; 3. available in the major languages of the defined service population; 4. effectively and appropriately communicated to persons with special needs; and 5. posted in the reception or common area of each service delivery site or residential facility. Interpretation: If an organization provides services remotely using technology, client rights and responsibilities should be made available on the organization's public website and the organization must implement a system for assuring and documenting that clients receive and understand their rights and responsibilities. Interpretation: If a client is disoriented, suffering from impaired cognition, or in immediate crisis at initial contact, the summary	

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	of client rights and responsibilities should be provided at an appropriate time. CR 1.02 Written rights and responsibilities include, but are not limited to: 1. basic expectations for use of the organization's services including the responsibility to provide information needed to receive services; 2. hours in which services are available; 3. rules, behavioral expectations, and other factors that could result in discharge or termination; 4. the right of the person served to receive service in a manner that is non-coercive and that protects the person's right to self-determination; 5. the right of the person served, families, and/or legal guardians to participate in decisions regarding the services provided; and 6. basic information about how to lodge complaints, grievances, or appeals. CR 1.05 The organization maintains a formal mechanism through which applicants, clients, and other stakeholders can express and resolve grievances, including denial of service, which includes: 1. the right to file a grievance without interference or retaliation; 2. timely written notification of the resolution and an explanation of any further appeal, rights or recourse; and 3. at least one level of review that does not involve the person about whom the complaint has been made or the person who reached the decision under review.	
4.a.4 General Service Provisions DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates	RPM 6.02 Written contracts: 1. are reviewed by legal counsel or another qualified individual prior to signing; and	

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care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.	2. contain all significant terms and conditions in accordance with applicable law. Interpretation: "Significant terms" should include, as appropriate to the type of contract: *1.* roles and responsibilities of participating organizations; *2.* services to be provided; *3.* clearly defined performance goals; *4.* measurable outcomes; *5.* service authorization, including eligibility criteria; *6.* provisions for training and technical support, as necessary; *7.* duration of contract, including delineation of follow-up services; *8.* policies and procedures for sharing information; *9.* methods for resolving disputes; *10.* a plan and procedure for timely payment, and consequences for failure to pay; *11.* necessary documentation and means of reporting to, funding or oversight bodies; and *12.* conditions for termination of the contract. RPM 7.03 Contracts for social and human services include: 1. service quality, client satisfaction, and outcomes that accord with the organization's expectations; 2. criteria for evaluating vendor performance; 3. a process for remediating performance issues; and 4. protocols for routine communication of related data.	
4.b.1 Requirement of Person-Centered and Family-Centered Care The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services	RPM 7.03 Contracts for social and human services include: 1. service quality, client satisfaction, and outcomes that accord with the organization's expectations; 2. criteria for evaluating vendor performance; 3. a process for remediating performance issues; and 4. protocols for routine communication of related data. MHSU	

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and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach. Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.	Purpose Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. Interpretation: Services can be offered in a variety of settings within the community including outpatient clinics, schools, and in homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications. MHSU 4 Individuals and their families, as appropriate to the program model and the age and expressed wishes of the person, participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support. Interpretation: Due to the importance of family involvement in achieving positive outcomes for children and youth, service planning and monitoring should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child. MHSU 5 The organization provides trauma-informed clinical counseling services that: 1. provide an appropriate level and intensity of support and treatment; 2. recognize individual and family values and goals; 3. accommodate variations in lifestyle; 4. emphasize personal growth, development, and situational change; and 5. promote recovery, resilience, and wellness.	

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	Interpretation: Outpatient withdrawal management programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies), provided to persons served on an individual or group basis. Services aim to enhance the person's understanding of addiction, manage their withdrawal symptoms, and connect them with an appropriate level of care for ongoing substance use treatment. The delivery of services will vary and depends on the assessed needs of the person and his or her treatment progress.	
4.b.2 Requirement of Person-Centered and Family-Centered Care Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation, and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.	CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity. Examples: Fair and equitable treatment may include the provision of effective, equitable, understandable, and respectful services that are responsive to: 1. diverse cultural beliefs and practices, such as the freedom to express and practice religious and spiritual beliefs; 2. preferred languages; 3. and other communication needs. Other categories that should be protected from discrimination and disrespect include, but are not limited to: race and ethnicity, military status, age, sexual orientation, gender identity, and developmental level. One way organizations can be responsive to the unique, culturally-defined needs of persons and families being served is by ensuring that program information, signs, posters, printed material, electronic and multimedia major population groups	

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	served; and in a manner that is non-discriminatory and non-stigmatizing.	
4.c.1 Crisis Behavioral Health Services The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so. Certifying states must request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:Emergency crisis intervention services: The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC) systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care. 24-hour mobile crisis teams: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area	CRI Purpose Crisis Response and Information Services operate as part of the community's crisis response system to provide immediate, dependable responses and reliable information to promote safety and stability for the individual in crisis. Definition: Crisis Response and Information Services are immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual. Services may be provided via telephone 24-hours a day, on a walk-in basis during regular business hours, by mobile unit, or by telephone referral. Crisis Hotline Services establish immediate communication links and provide supportive interventions for people in critical or emergency situations. Interpretation: Stabilization is a combination of methods used to return the service recipient to his or her pre-crisis level of functioning, including: *1.* identifying the precipitating event; *2.* mobilizing support and resources; *3.* identifying coping skills; and *4.* developing plans to ensure safety. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention;	The criterion is more prescriptive than the standard regarding how crisis care should be provided within the context of the broader state-sanctioned crisis systems. When crisis services are provided directly, CRI will be assigned.

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including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan. Crisis receiving/stabilization: The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite	6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services. TS 2.03 Direct service personnel receive training on: 1. communicating respectfully and effectively with service recipients; 2. engaging service recipients, including building trust, establishing rapport, and developing a professional relationship; 3. understanding the science of trauma and the impact of trauma on individuals, families, and personnel; and 4. trauma-informed care, including screening, assessment, and service delivery practices. CR 1.02 Written rights and responsibilities include, but are not limited to: 1. basic expectations for use of the organization's services including the responsibility to provide information needed to receive services; 2. hours in which services are available; 3. rules, behavioral expectations, and other factors that could result in discharge or termination; 4. the right of the person served to receive service in a manner that is non-coercive and that protects the person's right to self-determination; 5. the right of the person served, families, and/or legal guardians to participate in decisions regarding the services provided; and	

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programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis CareServices provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises. Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.	6. basic information about how to lodge complaints, grievances, or appeals. CRI 6.01 To ensure rapid and efficient access, the organization establishes procedures for working with emergency responders including: 1. police and fire departments; 2. hospital emergency rooms; 3. mental and physical health crisis teams; and 4. child and adult protective services. MHSU 8.05 Organizations providing withdrawal management to individuals withdrawing from opioids: 1. counsel individuals on the importance of medication-assisted treatment (MAT) and the risks of relapse, overdose, and death following detoxification without transitioning to maintenance medication; 2. offer MAT following withdrawal management either directly or through linkages with MAT providers; 3. clearly document when clients refuse MAT; and 4. provide a naloxone kit or prescription for any individual who refuses MAT. Interpretation: Organizations that do not offer medication-assisted treatment should have MOUs with MAT providers to ensure timely initiation of treatment. Studies have shown the risk of relapse increases dramatically following withdrawal without ongoing treatment, with 25% of readmissions occurring within the first 7 days post discharge. MHSU 9.13 Individuals are maintained on opioid treatment medication as long as they desire and derive benefit from treatment, but when withdrawal from opioid treatment medication is needed or desired, the organization:	

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	1. documents the reason for discontinuation; 2. educates the person about the process including risk of relapse, overdose, and mortality; 3. assesses for pregnancy, when applicable; 4. conducts dose reduction at a rate well tolerated by the person and in accordance with accepted medical practices; 5. conducts periodic assessments of mental status; 6. discontinues withdrawal and resumes treatment in the event of impending relapse; 7. offers the person relapse prevention services including counseling, support, and education; 8. encourages the person to participate in continued monitoring and support beyond the point of discontinuation; 9. invites the person to re-enter treatment at any time if they fear or have experienced a return to opioid use; 10. provides the person with information about and referral or transfer to a suitable, alternative treatment program, whenever possible; and 11. provides the person with a naloxone kit or prescription.	
4.d.1 Screening, Assessment, and Diagnosis The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. Note: See program requirement 3 regarding coordination of services and treatment planning.	MHSU Purpose Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. Definition: Diagnosis, Assessment, and Referral programs provide individuals with evaluation, diagnosis, and referral to appropriate services. Interpretation: Services can be offered in a variety of settings within the community including outpatient clinics, schools, and in homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications.	Screening, assessment, and diagnosis are part of the MHSU service standard. The criterion is more prescriptive than the standard regarding this service being provided via telehealth when appropriate.

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	ICHH 4.05 The organization promptly provides or makes arrangements for specialized screenings, assessments, or tests as needed based on information collected during initial and ongoing assessments. MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.	

SAMHSA CCBHC Criteria[i]	COA Accreditation Standards	Social Current Notes
	Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service.	
4.d.2 Screening, Assessment, and Diagnosis Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 3.03	

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	Persons served, and families as appropriate, participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is: 1. completed within established timeframes; 2. appropriately tailored to meet the age and developmental level of persons served; 3. conducted through a combination of interviews, discussion, and observation; and 4. focused on information pertinent for meeting service requests and objectives. Interpretation: For an assessment to be trauma-informed, the organization understands and recognizes the role of traumatic life events in the development of mental health and/or substance use disorders. Personnel should focus on the experiences and strengths of the individual or family rather than deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially re-traumatize persons served.	
4.d.3 Screening, Assessment, and Diagnosis The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum: 1. Preliminary diagnoses 2. The source of referral 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services 5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications 6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful 7. The use of any alcohol and/or other drugs the person receiving services may be taking and	PRG 3.03 When individuals are receiving prescription medication: 1. qualified personnel obtain and/or update information about the medications the individual is taking at each visit; and 2. the prescribing clinician compares current medications the individual is taking at each visit, including vitamins or other non-prescription medications, with new or changed medication orders to identify possible adverse interaction of medications. ICHH 4.02 Assessments are conducted using a standardized assessment tool to identify: 1. basic needs including food, clothing, and shelter; 2. the person's behavioral health, physical health, and community and social support service needs and goals; 3. history of trauma; 4. relevant systems involvement;	See the contents of The Assessment Matrix - Private, Public, Canadian, Network for a full list of criteria for the comprehensive assessment.

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indication for any current medications 8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors 9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence 10. Assessment of need for medical care (with referral and follow-up as required) 11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services 12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice)	5. individual and family strengths, risks, and protective factors; 6. natural supports and helping networks; and 7. the impact of the individual's health care needs on the family unit. MHSU 3 The organization's intake and assessment practices ensure that individuals and families served receive prompt and responsive access to appropriate services. Interpretation: For withdrawal management programs, due to the physical and mental state of the person, family involvement in the intake and assessment process may not be appropriate. Therefore, the process will focus on the individual and his or her care needs, except when the person is a minor. Interpretation: Due to the importance of family involvement in achieving positive outcomes for children and youth, the assessment should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child. MHSU 3.03 Persons served, and families as appropriate, participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is: 1. completed within established timeframes; 2. appropriately tailored to meet the age and developmental level of persons served; 3. conducted through a combination of interviews, discussion, and observation; and 4. focused on information pertinent for meeting service requests and objectives. Interpretation: For an assessment to be trauma-informed, the organization understands and recognizes the role of traumatic	

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	life events in the development of mental health and/or substance use disorders. Personnel should focus on the experiences and strengths of the individual or family rather than deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially re-traumatize persons served. MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. Interpretation: When working with children and youth, the	

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	assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service. MHSU 10.05 Care coordination activities include: 1. linkages to community providers, as well as completed follow-up when possible; 2. communication with partnering providers both internally and externally; and 3. communication with persons served.	
4.d.4 Screening, Assessment, and Diagnosis A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs, and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include: 1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. 2. An	PRG 3.03 When individuals are receiving prescription medication: 1. qualified personnel obtain and/or update information about the medications the individual is taking at each visit; and 2. the prescribing clinician compares current medications the individual is taking at each visit, including vitamins or other non-prescription medications, with new or changed medication orders to identify possible adverse interaction of medications. PRG 4.02 For each individual, the organization: 1. assesses the appropriateness of technology-based service delivery based on established criteria and suitability factors; 2. monitors whether or not the service delivery model is effective; and	See the contents of The Assessment Matrix - Private, Public, Canadian, Network for a full list of criteria for the comprehensive assessment.

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overview of relevant social supports; social determinants of health; and health related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. 3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP. 4. Pregnancy and/or parenting status. 5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments. 6. Relevant medical history and major health conditions that impact current psychological status. 7. A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. 8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs). 9. Basic cognitive screening for cognitive impairment. 10. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. 11. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. 12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services). 13. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to	3. arranges for services to be delivered in-person when necessary. ICHH 4.02 Assessments are conducted using a standardized assessment tool to identify: 1. basic needs including food, clothing, and shelter; 2. the person's behavioral health, physical health, and community and social support service needs and goals; 3. history of trauma; 4. relevant systems involvement; 5. individual and family strengths, risks, and protective factors; 6. natural supports and helping networks; and 7. the impact of the individual's health care needs on the family unit. MHSU 3 The organization's intake and assessment practices ensure that individuals and families served receive prompt and responsive access to appropriate services. Interpretation: For withdrawal management programs, due to the physical and mental state of the person, family involvement in the intake and assessment process may not be appropriate. Therefore, the process will focus on the individual and his or her care needs, except when the person is a minor. Interpretation: Due to the importance of family involvement in achieving positive outcomes for children and youth, the assessment should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child. MHSU 3.03	

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social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. 14. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. 15. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.	Persons served, and families as appropriate, participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is: 1. completed within established timeframes; 2. appropriately tailored to meet the age and developmental level of persons served; 3. conducted through a combination of interviews, discussion, and observation; and 4. focused on information pertinent for meeting service requests and objectives. Interpretation: For an assessment to be trauma-informed, the organization understands and recognizes the role of traumatic life events in the development of mental health and/or substance use disorders. Personnel should focus on the experiences and strengths of the individual or family rather than deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially re-traumatize persons served. MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals;	

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	6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service. MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures.	

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	Interpretation: The nature of problems resulting from mental health and/or substance use disorders may require medical services to be available. The organization is not required to provide services directly, but the results of medical screens, tests, and services should be documented in the case record when available and incorporated into service planning and monitoring. Interpretation: Organizations providing treatment services for mental health and/or substance use disorders are expected to have a licensed physician or other qualified health professional with appropriate training and experience on staff or available through a contract or formal arrangement. See MHSU 7.01 for more information. All other services must have, at minimum, an established referral relationship with a licensed physician or other qualified health professional.	
4.d.5 Screening, Assessment, and Diagnosis Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix B of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix B as a reason not to provide clinically indicated behavioral health screening or assessment. The state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.4 or Appendix B. Criteria 5: The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services.. Appendix B Required Measures: Time to Services (I-SERV), Will include sub-measures of average time to: Initial Evaluation, Initial Clinical Services,	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical	See The Assessment Matrix - Private, Public, Canadian, Network for more information on data that is collected during the assessment.

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Crisis Services. Depression Remission at Six Months (DEP-REM-6). Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC). Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD). Screening for Social Drivers of Health (SDOH). Patient Experience of Care Survey SAMHSA n/a n/a. Youth/Family Experience of Care Survey SAMHSA n/a n/a. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD). Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD). Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH). Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD). Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD). Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD). Plan All-Cause Readmissions Rate (PCR-AD). Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH). Antidepressant Medication Management (AMM-BH). Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD). Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. PRG 1.02 Case records contain information necessary to provide services including: 1. demographic and contact information; 2. the reason for requesting or being referred for services; 3. up-to-date assessments; 4. the service plan including mutually developed goals and objectives; 5. copies of all signed consent forms; 6. a description of services provided directly or by referral; 7. routine documentation of ongoing services; 8. documentation of routine supervisory review; 9. discharge or aftercare plan; 10. recommendations for ongoing and/or future service needs and assignment of aftercare or follow-up responsibility, if needed; and 11. a closing summary entered within 30 days of termination of service. ICHH 4.02 Assessments are conducted using a standardized assessment tool to identify: 1. basic needs including food, clothing, and shelter; 2. the person's behavioral health, physical health, and community and social support service needs and goals; 3. history of trauma; 4. relevant systems involvement; 5. individual and family strengths, risks, and protective factors; 6. natural supports and helping networks; and 7. the impact of the individual's health care needs on the family unit. ICHH 4.03	

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	The assessment incorporates applicable information from a variety of sources, which include, but are not limited to: 1. the person; 2. the person's family; 3. medical and/or clinical case records; 4. the results of screening tools; 5. relevant content from assessments completed by partnering or referring providers; 6. other providers; and 7. members of the care planning team. MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of	

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	the Matrix can be tailored according to the needs of specific individuals or service design. Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service.	
4.d.6 Screening, Assessment, and Diagnosis The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.	TS 2.03 Direct service personnel receive training on: 1. communicating respectfully and effectively with service recipients; 2. engaging service recipients, including building trust, establishing rapport, and developing a professional relationship; 3. understanding the science of trauma and the impact of trauma on individuals, families, and personnel; and 4. trauma-informed care, including screening, assessment, and service delivery practices. Interpretation: Training on trauma should be tailored to the type of service being provided. For example, it may not be appropriate or necessary for assessments in an Early Childhood Education (ECE) setting to be trauma informed. It is up to the organization to assess the applicability of this standard for each of its programs and service population and design the training accordingly. MHSU 2.03	Evidence for MHSU 3: a. Assessment Tool(s)

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	Clinical personnel are trained on, or demonstrate competence in: 1. evidence-based practices and other relevant emerging bodies of knowledge; 2. psychosocial and ecological or person-in-environment perspectives; 3. criteria to determine the need for more intensive services; 4. methods of crisis prevention and intervention, including assessing for and responding to signs of suicide risk or other safety threats/risks; 5. understanding child development and individual and family functioning; 6. identifying and building on strengths and protective factors; 7. working with difficult to reach or disengaged individuals and families; 8. recognizing and working with individuals with co-occurring physical health, mental health, and substance use conditions; and 9. collaborating with other disciplines, systems, and services. ICHH 4.02 Assessments are conducted using a standardized assessment tool to identify: 1. basic needs including food, clothing, and shelter; 2. the person's behavioral health, physical health, and community and social support service needs and goals; 3. history of trauma; 4. relevant systems involvement; 5. individual and family strengths, risks, and protective factors; 6. natural supports and helping networks; and 7. the impact of the individual's health care needs on the family unit. MHSU 3.02 Prompt, responsive intake practices:	

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	1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 3.03 Persons served, and families as appropriate, participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is: 1. completed within established timeframes; 2. appropriately tailored to meet the age and developmental level of persons served; 3. conducted through a combination of interviews, discussion, and observation; and 4. focused on information pertinent for meeting service requests and objectives. Interpretation: For an assessment to be trauma-informed, the organization understands and recognizes the role of traumatic life events in the development of mental health and/or substance use disorders. Personnel should focus on the experiences and strengths of the individual or family rather than	

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	deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially re-traumatize persons served. MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. MHSU 3.05 The organization uses a comprehensive, evidence-based suicide risk assessment tool to assess the following when suicide risk is identified:	

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	1. suicidal desire; 2. capability; 3. intent; and 4. buffers/protective factors. MHSU 8.01 Qualified personnel determine the appropriate level of withdrawal management for the person using diagnostic criteria outlined in clinical decision support tools and clinical practice guidelines.	
4.d.7 Screening, Assessment, and Diagnosis The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.	ASE 3.03 The organization accommodates the written and oral communication needs of clients by: 1. communicating, in writing and orally, in the languages of the major population groups served; 2. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed; 3. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons; 4. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and 5. considering the person's literacy level. Examples: Examples of ways the organization can demonstrate standard implementation include, but are not limited to: 1. providing basic program information in languages representative of consumer groups; 2. proactively reaching out to ensure that all individuals can use its services and fully participate in planning; 3. hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery;	

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	4. ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload; 5. offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without depending upon children or other individuals unable to maintain the integrity of the client-provider relationship; and 6. using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate.	
4.d.8 Screening, Assessment, and Diagnosis If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC, or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1.	MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes:	MHSU 8 standards only apply when CCBHCs offer outpatient withdrawal management services directly.

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	1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. MHSU 8 Withdrawal management is provided based on the needs of the person. Interpretation: For individuals with opioid use disorder, withdrawal management without transitioning to ongoing medication-assisted treatment is not recommended. According to the American Society of Addiction Medicine, medication-assisted treatment in combination with individualized psychosocial supports and services is the standard of care for treatment of opioid use disorder. Detoxification from opioids is not required to initiate maintenance medication. See MHSU	

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	8.04 for more information on providing withdrawal management to this population and MHSU 9 for more information on Office-Based Opioid Treatment. MHSU 8.01 Qualified personnel determine the appropriate level of withdrawal management for the person using diagnostic criteria outlined in clinical decision support tools and clinical practice guidelines.	
4.e.1 Person-Centered and Family Centered Treatment Planning The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis planning (CCBHCs may work collaboratively with DCOs to complete these activities). Person-centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person receiving services involvement and self-direction. Note: See program requirement 3 related to coordination of care and treatment planning	MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.	

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	Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service. MHSU 4 Individuals and their families, as appropriate to the program model and the age and expressed wishes of the person, participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support. Interpretation: Due to the importance of family involvement in achieving positive outcomes for children and youth, service planning and monitoring should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child. MHSU 4.02 The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that: 1. is individualized and centered around strengths; 2. identifies individualized warning signs of a crisis;	

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	3. identifies coping strategies and sources of support that persons served can implement during a suicidal crisis, as appropriate; and 4. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization. Interpretation: For individuals who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that individuals can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal individuals cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required. Interpretation: For organizations serving children and youth, when safety issues are identified, the organization: *1.* involves supervisory personnel in reviewing safety concerns and plans; and *2.* reports safety concerns in accordance with mandated reporting requirements.	
4.e.2 Person-Centered and Family Centered Treatment Planning The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision	CR 1.04 Individuals provide consent prior to receiving services and have the right to: 1. participate in all service decisions; 2. be informed of the benefits, risks, side effects, and alternatives to planned services; 3. be offered the most appropriate and least restrictive or intrusive service alternative to meet their needs; 4. receive service in a manner that is free from harassment or coercion and that protects the person's right to self-determination; 5. refuse any service, treatment, or medication, unless mandated by law or court order; and	

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making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.	6. be informed about the consequences of such refusal, which can include discharge. Interpretation: In regard to element (d), organizations should ensure that services or interventions do not include strategies that are coercive, threatening, or harmful to an individual's overall wellbeing. Research shows that services and interventions that attempt to alter sexual orientation, gender identity, or gender expression (e.g., conversion or reparative therapies) are harmful and, as such, should be prohibited from agency practice. CR 2.01 When the organization receives a request for confidential information about a client, or when the release of confidential information is necessary for the provision of services, prior to releasing such information, the organization: 1. determines if the reason to release information is valid; 2. obtains informed, written authorization to release the information from the client and/or parent or legal guardian, as appropriate; and 3. maintains each authorization of consent in the case record and provides a copy to the client and/or parent or legal guardian. ICHH 5.01 An assessment-based care plan is developed in a timely manner with the full participation of the individual and his or her family and includes: 1. the person's behavioral health, physical health, and community and social support service needs and goals, including basic needs when applicable; 2. steps for working toward achievement of desired goals including timeframes where appropriate; 3. services and supports to be provided, and by whom; 4. possibilities for maintaining and strengthening family relationships and other informal social networks;	

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	5. agreed upon timelines for conducting regular case reviews; and 6. documentation of the individual's or family's involvement in care planning ICHH 6 All aspects of the person's treatment are coordinated and monitored in accordance with the care plan to ensure access to and coordination of needed behavioral health care, physical health care, and community and social support services. ICHH 6.01 The care planning team includes at a minimum: 1. a designated care coordinator with qualifications appropriate to the needs of the identified service population; 2. a primary care professional such as a physician's assistant or nurse practitioner with access to a physician for needed consultation; 3. a behavioral health professional such as a social worker, psychologist, or other licensed clinician with access to a psychiatrist for needed consultation; and 4. other providers and supports based on the needs of the individual. ICHH 6.03 The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by: 1. establishing partnerships and coordination procedures with direct service providers in the community; 2. establishing communication procedures with persons served and across disciplines, both internally and externally; 3. maintaining a comprehensive, up-to-date referral list; 4. removing barriers to the initiation of needed services including procedures for providing a warm hand off when	

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	needed services are provided directly by the program or on-site through a partnering provider; and 5. assisting the person with system navigation. Interpretation: The array of community and social support services and behavioral and physical health care services that should be made available to persons served include: 1. preventative and health promotion services; 2. mental health and substance use services; 3. comprehensive care management, care coordination, and transitional care; 4. chronic disease management, including self-management; 5. community, social support, and recovery services; 6. peer support services; and 7. long-term care supports and services. MHSU 4 Individuals and their families, as appropriate to the program model and the age and expressed wishes of the person, participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support. Interpretation: Due to the importance of family involvement in achieving positive outcomes for children and youth, service planning and monitoring should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom;	

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	3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. MHSU 4.03 The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess: 1. service plan implementation; 2. progress toward achieving service goals and desired outcomes; and 3. the continuing appropriateness of the agreed upon service goals. Interpretation: When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.	

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	MHSU 4.04 The worker and individual, and his or her family when appropriate: 1. review progress toward achievement of agreed upon service goals; and 2. sign revisions to service goals and plans.	
4.e.3 Person-Centered and Family Centered Treatment Planning The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.	MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. MHSU 4.03	

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	The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess: 1. service plan implementation; 2. progress toward achieving service goals and desired outcomes; and 3. the continuing appropriateness of the agreed upon service goals. Interpretation: When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.	
4.e.4 Person-Centered and Family Centered Treatment Planning Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.	MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is	

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	required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate	

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	military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery.	
4.e.5 Person-Centered and Family Centered Treatment Planning The treatment plan is comprehensive, addressing all services required, including recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.	CR 1.04 Individuals provide consent prior to receiving services and have the right to: 1. participate in all service decisions; 2. be informed of the benefits, risks, side effects, and alternatives to planned services; 3. be offered the most appropriate and least restrictive or intrusive service alternative to meet their needs; 4. receive service in a manner that is free from harassment or coercion and that protects the person's right to self-determination; 5. refuse any service, treatment, or medication, unless mandated by law or court order; and 6. be informed about the consequences of such refusal, which can include discharge. Interpretation: In regard to element (d), organizations should ensure that services or interventions do not include strategies that are coercive, threatening, or harmful to an individual's overall wellbeing. Research shows that services and interventions that attempt to alter sexual orientation, gender identity, or gender expression (e.g., conversion or reparative therapies) are harmful and, as such, should be prohibited from agency practice. MHSU 4.01	

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	An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. MHSU 4.03 The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess: 1. service plan implementation; 2. progress toward achieving service goals and desired outcomes; and 3. the continuing appropriateness of the agreed upon service goals.	

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	Interpretation: When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard. MHSU 4.04 The worker and individual, and his or her family when appropriate: 1. review progress toward achievement of agreed upon service goals; and 2. sign revisions to service goals and plans.	
4.e.6 Person-Centered and Family Centered Treatment Planning Where appropriate, consultation is sought during treatment planning as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking).	ICHH 4.05 The organization promptly provides or makes arrangements for specialized screenings, assessments, or tests as needed based on information collected during initial and ongoing assessments. ICHH 6.01 The care planning team includes at a minimum: 1. a designated care coordinator with qualifications appropriate to the needs of the identified service population; 2. a primary care professional such as a physician's assistant or nurse practitioner with access to a physician for needed consultation; 3. a behavioral health professional such as a social worker, psychologist, or other licensed clinician with access to a psychiatrist for needed consultation; and 4. other providers and supports based on the needs of the individual.	
4.e.7 Person-Centered and Family Centered Treatment Planning The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person	PRG 1.03 The case record contains essential medical and legal information including, as applicable: 1. orders for and results of psychological, medical, toxicological, diagnostic, or other evaluations;	

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receiving services. Consistent with the criteria in 4.e.1 through 4.e.7, certifying states should specify other aspects of person-centered and family-centered treatment planning they will require based upon the needs of the population served. Treatment planning components that certifying states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, tailored treatment to ensure cultural and linguistically appropriate services).	2. documentation of all prescribed and over-the-counter medications including copies of all written orders for medications, when applicable; 3. special treatment procedures, allergies, or adverse treatment responses; and 4. court reports, documents of guardianship or legal custody, birth or marriage certificates, and any legal directives related to the service being provided.	
4.f.1 Outpatient Mental Health and Substance Use Services The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or	CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity. DTX Purpose Individuals who receive Day Treatment Services improve psychosocial, educational, vocational, and cognitive functioning, and learn to manage their symptoms. Definition: Day Treatment Services are daytime programs that provide integrated, comprehensive treatment; and educational, vocational, and activity services to individuals with physical or mental disabilities, emotional disorders, behavioral disorders, and/or substance use conditions. Day treatment services also include therapeutic services for their families. Day Treatment Services are designed to prevent movement to a more intensive level of care or as transitional or maintenance services for those	COA Accreditation assigns ASAM Level 2.1 programs DTX. COA Accreditation assigns ASAM level 1 programs MHSU.

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specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. Note: See also program requirement 3 regarding coordination of services and treatment planning. Based upon the findings of the community needs assessment as required in program requirement 1, certifying 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 Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Long-acting injectable medications to treat both mental and substance use disorders; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management Training; Effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation. This list is not intended to be all inclusive. Certifying states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.	who have stepped down from more intensive levels of care. DTX providers may offer medication-assisted treatment for opioid use disorder under the Drug Addiction Treatment Act of 2000 as part of their intensive outpatient or partial hospitalization program(s). MHSU Purpose Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. Definition: Mental Health and/or Substance Use Services (MHSU) are comprehensive, community-based, and designed to help persons served with diagnosable conditions, including: mental health disorders; disorders relating to the use of alcohol, drugs, or other substances; and co-occurring mental health and substance use disorders. Based on the needs of the individual or family, services may address mental health symptoms, diagnoses, and associated functional impairments; resolve issues resulting from the use of alcohol, drugs, or other substances; help manage co-occurring mental health, substance use, and/or health conditions; or provide clinical support for psychosocial adjustments related to life cycle issues. Clinical counseling programs reviewed under Mental Health and/or Substance Use Services provide counseling, support, and education to address a range of issues related to behavioral health disorders. Services focus on the treatment of diagnosable conditions where therapeutic, evidence-based interventions are provided by appropriately trained, licensed, and/or credentialed personnel. Interpretation: Services can be offered in a variety of settings within the community including outpatient clinics, schools, and in homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions	

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	to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications. MHSU 3.02 Prompt, responsive intake practices: 1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary; 2. give priority to urgent needs and emergency situations including access to expedited service planning; 3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs; 4. support timely initiation of services; and 5. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly. Interpretation: Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management;	

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	9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services.	
4.f.2 Outpatient Mental Health and Substance Use Services Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC)25 to improve service outcomes.	TS 2.04 Training for direct service personnel addresses differences within the organization's service population, as appropriate to the type of service being provided, including: 1. interventions that address cultural and socioeconomic factors in service delivery; 2. the role cultural identity plays in motivating human behavior; 3. procedures for working with non-English speaking persons or individuals with communication impairments; 4. understanding explicit and implicit bias and discrimination; 5. recognizing individuals and families with special needs; 6. the needs of individuals and families in crisis, including recognizing and responding to a mental health crisis; 7. the needs of victims of violence, abuse, or neglect and their family members; and 8. basic health and medical needs of the service population. MH 5.04 If a service recipient is a trauma survivor or a victim of violence, abuse or neglect, the organization provides: 1. a protection or safety plan, as needed; 2. more intensive services; 3. trauma-informed care; 4. more frequent monitoring of progress toward service goals; and 5. a referral. Interpretation: Service members and veterans who are trauma survivors may need services uniquely tailored to their needs. Service members and veterans often experience a complex	

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	nexus of post-traumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), substance abuse, and intimate partner violence. MHSU 5 The organization provides trauma-informed clinical counseling services that: 1. provide an appropriate level and intensity of support and treatment; 2. recognize individual and family values and goals; 3. accommodate variations in lifestyle; 4. emphasize personal growth, development, and situational change; and 5. promote recovery, resilience, and wellness. Interpretation: Outpatient withdrawal management programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies), provided to persons served on an individual or group basis. Services aim to enhance the person's understanding of addiction, manage their withdrawal symptoms, and connect them with an appropriate level of care for ongoing substance use treatment. The delivery of services will vary and depends on the assessed needs of the person and his or her treatment progress.	
4.f.3 Outpatient Mental Health and Substance Use Services Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.	MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors;	

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	5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom;	

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	3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. MHSU 11.03 Individuals who have primary responsibility for children receive accommodations for, or assistance with: 1. childcare arrangements; 2. educational and recreational services for children; and 3. parenting workshops.	
4.g.1 Outpatient Clinic Primary Care Screening and Monitoring The CCBHC is responsible for outpatient 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. Prevention is a key component of primary care screening and monitoring	MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history;	

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services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions: • HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix B • Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population.	3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change; 7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures. Interpretation: The nature of problems resulting from mental health and/or substance use disorders may require medical services to be available. The organization is not required to provide services directly, but the results of medical screens, tests, and services should be documented in the case record	

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	when available and incorporated into service planning and monitoring. Interpretation: Organizations providing treatment services for mental health and/or substance use disorders are expected to have a licensed physician or other qualified health professional with appropriate training and experience on staff or available through a contract or formal arrangement. See MHSU 7.01 for more information.All other services must have, at minimum, an established referral relationship with a licensed physician or other qualified health professional. ICHH 6.03 The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by: 1. establishing partnerships and coordination procedures with direct service providers in the community; 2. establishing communication procedures with persons served and across disciplines, both internally and externally; 3. maintaining a comprehensive, up-to-date referral list; 4. removing barriers to the initiation of needed services including procedures for providing a warm hand off when needed services are provided directly by the program or on-site through a partnering provider; and 5. assisting the person with system navigation. Interpretation: The array of community and social support services and behavioral and physical health care services that should be made available to persons served include: 1. preventative and health promotion services; 2. mental health and substance use services; 3. comprehensive care management, care coordination, and transitional care; 4. chronic disease management, including self-management; 5. community, social support, and recovery services; 6. peer support services; and	

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	7. long-term care supports and services. ICHH 7.01 Health data for persons served is collected, aggregated, and analyzed to inform individual and organization-wide health promotion activities.	
4.g.2 Outpatient Clinic Primary Care Screening and Monitoring The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols will include: • Identifying people receiving services with chronic diseases; • Ensuring that people receiving services are asked about physical health symptoms; and • Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g. In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.	ICHH 4.03 The assessment incorporates applicable information from a variety of sources, which include, but are not limited to: 1. the person; 2. the person's family; 3. medical and/or clinical case records; 4. the results of screening tools; 5. relevant content from assessments completed by partnering or referring providers; 6. other providers; and 7. members of the care planning team. MHSU 3.04 The comprehensive assessment includes: 1. behavioral health needs and goals including an evaluation of mental health and substance use symptoms or disorders, their severity, and treatment history; 2. physical health needs and goals including a comprehensive medical history; 3. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated; 4. individual and family strengths, risks, and protective factors; 5. social factors that may influence treatment including natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals; 6. barriers to change;	MHSU 9 only applies when office-based opioid treatment is being provided directly to the individual by the CCBHC.

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	7. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and 8. a summary of symptoms and diagnoses based on a standardized diagnostic tool. Interpretation: The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design. Interpretation: When working with children and youth, the assessment of individual and family strengths, risks, and protective factors should include the following areas: *1.* the child's developmental history; *2.* a history of involvement in other systems including education, child welfare, and juvenile justice; *3.* individual family members' experiences and perspectives; *4.* family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and *5.* the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service. MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures. Interpretation: The nature of problems resulting from mental health and/or substance use disorders may require medical	

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	services to be available. The organization is not required to provide services directly, but the results of medical screens, tests, and services should be documented in the case record when available and incorporated into service planning and monitoring. Interpretation: Organizations providing treatment services for mental health and/or substance use disorders are expected to have a licensed physician or other qualified health professional with appropriate training and experience on staff or available through a contract or formal arrangement. See MHSU 7.01 for more information. ICHH 7.01 Health data for persons served is collected, aggregated, and analyzed to inform individual and organization-wide health promotion activities. MHSU 9.05 Early in treatment, each person receives a physical exam and laboratory testing in accordance with national practice guidelines that includes, but is not limited to: 1. screening for commonly co-occurring medical conditions, pregnancy and methods of contraception, acute trauma, and history of narcotic dependence and IV drug use; 2. evidence of current physical dependance; and 3. laboratory testing to identify existing medical conditions and current substance use. Interpretation: Completion of the physical exam and/or lab work should never delay the initiation of medication-assisted treatment. This standard requires that all individuals receiving office-based opioid treatment have an up-to-date physical exam that meets the requirements of the standard. If a current physical exam that satisfies these requirements is not present in the person's record, the prescriber should conduct the exam as part of the comprehensive assessment process or facilitate	

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	completion of the exam in partnership with the individual and applicable providers. MHSU 10.03 The organization supports the coordination of behavioral and physical health care to increase access to needed services by: 1. providing referrals to identified primary care providers; 2. communicating with the primary care doctor about treatment planning; and 3. linking individuals to providers that can help them navigate the health care system.	
4.g.3 Outpatient Clinic Primary Care Screening and Monitoring The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following: 1. ensuring individuals have access to primary care services; 2. ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions; 3. coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and 4. promoting a healthy behavior lifestyle. Note: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS. Note: See also program requirement 3 regarding coordination of services and treatment planning.Certifying states may elect to require specific other screening and monitoring to be provided by the CCBHCs in addition to the those described in 4.g.	MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures. Interpretation: The nature of problems resulting from mental health and/or substance use disorders may require medical services to be available. The organization is not required to provide services directly, but the results of medical screens, tests, and services should be documented in the case record when available and incorporated into service planning and monitoring. Interpretation: Organizations providing treatment services for mental health and/or substance use disorders are expected to have a licensed physician or other qualified health professional with appropriate training and experience on staff or available through a contract or formal arrangement. See MHSU 7.01 for more information.All other services must have, at minimum, an established referral relationship with a licensed physician or other qualified health professional.	

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	Interpretation: Individuals with both chronic pain and substance use disorder should receive integrated treatment from appropriate medical specialists. ICHH 6.03 The organization facilitates access to the full array of community and social support, behavioral health care, and physical health care services by: 1. establishing partnerships and coordination procedures with direct service providers in the community; 2. establishing communication procedures with persons served and across disciplines, both internally and externally; 3. maintaining a comprehensive, up-to-date referral list; 4. removing barriers to the initiation of needed services including procedures for providing a warm hand off when needed services are provided directly by the program or on-site through a partnering provider; and 5. assisting the person with system navigation. Interpretation: The array of community and social support services and behavioral and physical health care services that should be made available to persons served include: 1. preventative and health promotion services; 2. mental health and substance use services; 3. comprehensive care management, care coordination, and transitional care; 4. chronic disease management, including self-management; 5. community, social support, and recovery services; 6. peer support services; and 7. long-term care supports and services. ICHH 6.04 Individuals are assisted in making appointments for needed or requested services, and the care coordinator follows up to: 1. ensure the service was received; 2. identify any needed follow-up; and	

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	3. make needed changes to the care plan in partnership with the person and his or her family. ICHH 7.01 Health data for persons served is collected, aggregated, and analyzed to inform individual and organization-wide health promotion activities. ICHH 7.03 The organization offers individuals and their families health education on topics relevant to their needs that will empower them to manage their chronic conditions and promote wellness. MHSU 10.03 The organization supports the coordination of behavioral and physical health care to increase access to needed services by: 1. providing referrals to identified primary care providers; 2. communicating with the primary care doctor about treatment planning; and 3. linking individuals to providers that can help them navigate the health care system.	
4.h.1 Targeted Case Management Services a 4.H: Targeted Case Management Services26 4.h.1 The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC targeted case	MHSU 3.07 Reassessments are conducted as necessary, according to the needs of the individual or family. Interpretation: Certain events may heighten or trigger suicide risk, as could a new physical or mental health diagnosis, and should prompt a new suicide risk assessment as part of the reassessment. Once any potential suicide risk is identified, it may be important to conduct reassessments regularly even if these trigger events are not observed. Examples: Timeframes for reassessment depend on the service population and length of treatment, or may be delineated by regulatory requirements. The organization may conduct a reassessment during specific milestones in the treatment process, for example:	The criterion is more prescriptive than the standard regarding when targeted case management should be provided.

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management should also be used accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services. Based upon the needs of the population served, states should specify the scope of other CCBHC targeted case management services that will be required, and the specific populations for which they are intended.	1. after significant treatment progress; 2. after a lack of significant treatment progress; 3. after new symptoms are identified; 4. after changes in treatment strategy and/or medication; 5. when significant behavioral changes are observed; 6. when there are changes to a family situation; or 7. when significant environmental changes or external stressors occur. MHSU 4.03 The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess: 1. service plan implementation; 2. progress toward achieving service goals and desired outcomes; and 3. the continuing appropriateness of the agreed upon service goals. Interpretation: When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard. MHSU 4.04 The worker and individual, and his or her family when appropriate: 1. review progress toward achievement of agreed upon service goals; and 2. sign revisions to service goals and plans. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions;	

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	3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services.	
4.i.1 Psychiatric Rehabilitation Services The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to: • Participate in supported education and other	MHSU PURPOSE Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. MHSU Definition Mental Health and/or Substance Use Services (MHSU) are comprehensive, community-based, and designed to help persons served with diagnosable conditions, including: mental health disorders; disorders relating to the use of alcohol, drugs, or other substances; and co-occurring mental health and substance use disorders. Based on the needs of the individual or family, services may address mental health symptoms, diagnoses, and associated functional impairments; resolve issues resulting from the use of alcohol, drugs, or other substances; help manage co-occurring mental health, substance use, and/or health conditions; or provide clinical support for psychosocial adjustments related to life cycle issues. MHSU 5.01	

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educational services; • Achieve social inclusion and community connectedness; • Participate in medication education, self-management, and/or individual and family/caregiver psycho-education; and • Find and maintain safe and stable housing. Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management, Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers. Note: See program requirement 3 regarding coordination of services and treatment planning. Certifying states should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served above the minimum requirements described in 4.i.	Clinical counseling services promote whole-person wellness and help individuals and families to develop the knowledge, skills, and supports necessary to: 1. manage mental health and/or substance use disorders; 2. cultivate and sustain positive, meaningful relationships with peers, family members, and the community; and 3. develop self-efficacy. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care; 11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services. MHSU 6.03 Individuals, and their families when appropriate, are actively connected with peer support services, either directly or by referral, appropriate to their request or need for service. MHSU 11 Individuals and families receive support services that increase the likelihood of progress in treatment and positive change. MHSU 11.01	

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	The organization provides, either directly or by referral, necessary support services which may include, as appropriate: 1. basic needs, such as food, clothing, and housing; 2. work-related services and job placement; 3. transportation; 4. legal services; 5. financial counseling; 6. social skills training; 7. public benefits; 8. educational services; and 9. respite care. MHSU 11.02 The organization works with individuals and families to identify natural supports and social networks to cultivate and sustain a supportive community.	
4.j.1 Peer Supports, Peer Counseling, and Family/Caregiver Supports The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include: peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites28; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support. Note: See program requirement 3 regarding coordination of services and treatment planning. Certifying states should specify the scope of peer and family	CSE Purpose Individuals and families who participate in Coaching, Support, and Education Services identify and build on strengths, develop skills, gain experiential knowledge, access appropriate community and social supports and resources, and improve functioning in daily activities at home, at work, and in the community. MHSU 2.05 Individuals who provide peer support: 1. obtain certification, as defined by their state; 2. are willing to share their personal recovery stories; 3. have a job description and clearly understand the role of a peer support worker; and 4. have adequate supports in place and appropriate supervision, including mentoring and/or coaching from more experienced peers when indicated. MHSU 6.03	CSE standards would be assigned if the CCBHC was offering a peer-run program such as a wellness and recovery center. When peers are providing services as part of the treatment team, that will be captured in MHSU.

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services they will require based upon the needs of the population served.	Individuals, and their families when appropriate, are actively connected with peer support services, either directly or by referral, appropriate to their request or need for service. Interpretation: Connections to outside self-help/mutual aid groups should not be limited to providing the time and location for a meeting. Organizations can support the individual's acclimation to a new group by, for example, discussing meeting protocols and what to expect prior to attending, accompanying them to their first meeting, and encouraging them to make connections with peers while at the meeting.	
4.k.1 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans The CCBHC is responsible for providing directly, or through a DCO, intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook. Note: See program requirement 3 regarding coordination of services and treatment planning.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regards to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. MHSU	MHSU standards include interpretations throughout regarding considerations when delivering behavioral health services to veterans. The criterion is more prescriptive than the standard regarding the geographic radius to which services must be made available. The standards have not been compared to minimum mental health guidelines set by the Veterans Health Administration.

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	Purpose Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. Interpretation: Services can be offered in a variety of settings within the community including outpatient clinics, schools, and in homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications.	
4.k.2 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans 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	MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible. Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a	The criterion is more prescriptive than the standards regarding screening all individuals for U.S. military service.

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services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). Note: See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.	developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery.	
4.k.3 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.	MHSU 10.02 Individuals with co-occurring mental health and substance use disorders receive coordinated treatment either directly or through active involvement with a cooperating service provider. Interpretation: This standard is applicable to all programs regardless of the services offered. Organizations that only treat substance use disorders are expected to have the core capability to address co-occurring mental health conditions, and organizations that only treat mental health disorders are expected to have the core capability to address co-occurring substance use disorders. MHSU 10.03 The organization supports the coordination of behavioral and physical health care to increase access to needed services by: 1. providing referrals to identified primary care providers; 2. communicating with the primary care doctor about treatment planning; and 3. linking individuals to providers that can help them navigate the health care system.	
4.k.4 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans 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	CR Purpose The rights and dignity of clients are respected throughout the organization. Interpretation: COA recognizes that mandated clients and individuals receiving Adult Guardianship (AG) services may have	The criterion is more prescriptive than the standard regarding frequency of contact with the veteran.

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the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled: 1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required. 2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis. 3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity). 4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. 5. The treatment plan is revised, when necessary.29 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	a reduced level of rights. In addition, information provided to individuals who have been deemed incapacitated by the court, court order, and state law may vary based on an individual's assessed capacity to understand such information. Individuals should retain as much personal responsibility and self-determination as possible given their assessed capacity and individual rights may not be abridged unless superseded by legal mandate or court order. MHSU 2.10 The organization minimizes the number of workers assigned to persons served over the course of their contact with the organization by: 1. assigning a worker at intake or early in the contact; and 2. avoiding the arbitrary or indiscriminate reassignment of direct service personnel. MHSU 3.06 Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include: 1. medication monitoring and management; 2. physical examinations or other physical health services; 3. medical management of withdrawal symptoms; 4. laboratory testing and toxicology screens; or 5. other diagnostic procedures. MHSU 3.07 Reassessments are conducted as necessary, according to the needs of the individual or family. Interpretation: Certain events may heighten or trigger suicide risk, as could a new physical or mental health diagnosis, and should prompt a new suicide risk assessment as part of the reassessment. Once any potential suicide risk is identified, it may be important to conduct reassessments regularly even if these trigger events are not observed.	Documentation of participation in treatment planning and decision making satisfies the requirement of a client signature in MHSU 4.01.

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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.	Examples: Timeframes for reassessment depend on the service population and length of treatment, or may be delineated by regulatory requirements. The organization may conduct a reassessment during specific milestones in the treatment process, for example: 1. after significant treatment progress; 2. after a lack of significant treatment progress; 3. after new symptoms are identified; 4. after changes in treatment strategy and/or medication; 5. when significant behavioral changes are observed; 6. when there are changes to a family situation; or 7. when significant environmental changes or external stressors occur. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible.	

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	Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery. PRG 3.03 When individuals are receiving prescription medication: 1. qualified personnel obtain and/or update information about the medications the individual is taking at each visit; and 2. the prescribing clinician compares current medications the individual is taking at each visit, including vitamins or other non-prescription medications, with new or changed medication orders to identify possible adverse interaction of medications. MHSU 3.07 Reassessments are conducted as necessary, according to the needs of the individual or family. Interpretation: Certain events may heighten or trigger suicide risk, as could a new physical or mental health diagnosis, and should prompt a new suicide risk assessment as part of the reassessment. Once any potential suicide risk is identified, it may be important to conduct reassessments regularly even if these trigger events are not observed. Examples: Timeframes for reassessment depend on the service population and length of treatment, or may be delineated by regulatory requirements. The organization may conduct a reassessment during specific milestones in the treatment process, for example: 1. after significant treatment progress; 2. after a lack of significant treatment progress; 3. after new symptoms are identified; 4. after changes in treatment strategy and/or medication;	

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	5. when significant behavioral changes are observed; 6. when there are changes to a family situation; or 7. when significant environmental changes or external stressors occur. MHSU 4.03 The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess: 1. service plan implementation; 2. progress toward achieving service goals and desired outcomes; and 3. the continuing appropriateness of the agreed upon service goals. Interpretation: When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard. MHSU 4.04 The worker and individual, and his or her family when appropriate: 1. review progress toward achievement of agreed upon service goals; and 2. sign revisions to service goals and plans. MHSU 7.02 A licensed physician, or other qualified health professional, and a clinical team led by a licensed provider, collaborate with the individual to make decisions about level of care, treatment, and aftercare or discharge planning.	
4.k.5 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans Behavioral health services are recovery-oriented. The VHA adopted the National Consensus Statement on Mental	CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner;	

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Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery: • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect As implemented in VHA recovery, the recovery principles also include the following: • Privacy • Security • Honor Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.	2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity. MHSU MHSU Purpose Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. MHSU Definition: Mental Health and/or Substance Use Services (MHSU) are comprehensive, community-based, and designed to help persons served with diagnosable conditions, including: mental health disorders; disorders relating to the use of alcohol, drugs, or other substances; and co-occurring mental health and substance use disorders. Based on the needs of the individual or family, services may address mental health symptoms, diagnoses, and associated functional impairments; resolve issues resulting from the use of alcohol, drugs, or other substances; help manage co-occurring mental health, substance use, and/or health conditions; or provide clinical support for psychosocial adjustments related to life cycle issues. Interpretation: Services can be offered in a variety of settings within the community including outpatient clinics, schools, and in homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications. MHSU 5 The organization provides trauma-informed clinical counseling services that:	

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	1. provide an appropriate level and intensity of support and treatment; 2. recognize individual and family values and goals; 3. accommodate variations in lifestyle; 4. emphasize personal growth, development, and situational change; and 5. promote recovery, resilience, and wellness. Interpretation: Outpatient withdrawal management programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies), provided to persons served on an individual or group basis. Services aim to enhance the person's understanding of addiction, manage their withdrawal symptoms, and connect them with an appropriate level of care for ongoing substance use treatment. The delivery of services will vary and depends on the assessed needs of the person and his or her treatment progress. MHSU 5.01 Clinical counseling services promote whole-person wellness and help individuals and families to develop the knowledge, skills, and supports necessary to: 1. manage mental health and/or substance use disorders; 2. cultivate and sustain positive, meaningful relationships with peers, family members, and the community; and 3. develop self-efficacy. MHSU 5.02 Personnel assist individuals and families to: 1. explore and clarify the concern or issue; 2. voice the goals they wish to achieve; 3. identify successful coping or problem-solving strategies based on their strengths, formal and informal supports, and preferred solutions; and 4. realize ways of maintaining and generalizing gains. MHSU 5.03	

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	Clinical personnel: 1. determine the optimal level and intensity of care, including clinical and community support services; 2. follow up when an evaluation for psychotropic medications and medication-assisted treatment is recommended; and 3. use written criteria to determine when the involvement of a psychiatrist is indicated. MHSU 6 Persons served receive ongoing, coordinated, trauma-informed therapeutic services based on their assessed needs and goals. MHSU 6.01 Persons served receive psychosocial, therapeutic, and educational interventions that are: 1. matched with the person's assessed needs, readiness for change, age, developmental level, and personal goals; and 2. 2. provided in individual, family, and/or group format. Interpretation: For withdrawal management programs, therapeutic and educational interventions may be limited given the length of treatment and the person's treatment progress. MHSU 6.02 The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including: 1. psychotherapy; 2. illness management and psychoeducation interventions; 3. coping skills training; 4. alternative therapies; 5. relapse prevention; 6. acute care; 7. support groups and self-help referrals; 8. withdrawal management; 9. detoxification; 10. inpatient care;	

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	11. intensive outpatient care; 12. medical care; 13. psychiatric services; and 14. case management and other supportive services. MHSU 6.03 Individuals, and their families when appropriate, are actively connected with peer support services, either directly or by referral, appropriate to their request or need for service. Interpretation: Connections to outside self-help/mutual aid groups should not be limited to providing the time and location for a meeting. Organizations can support the individual's acclimation to a new group by, for example, discussing meeting protocols and what to expect prior to attending, accompanying them to their first meeting, and encouraging them to make connections with peers while at the meeting. MHSU 10 The organization coordinates services in order to promote continuity of care and whole-person wellness. Interpretation: The standards in MHSU 10 address the efforts an organization makes to promote information sharing and collaboration with the various systems touching the individual or family. Organizations are not required to provide integrated care to implement the standards in this section. Organizations that offer integrated behavioral health and primary care services (e.g., health homes) will complete the Integrated Care; Health Home (ICHH) standards.	
4.k.6 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans All behavioral health care is provided with cultural competence. 1. Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of	TS 1.01 A personnel development plan: 1. is reviewed annually and revised in accord with an assessment of the organization's training needs; 2. incorporates a variety of educational methods; 3. is responsive to the history, cultural backgrounds, and related needs of personnel;	

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those who have served their country. 2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.	4. outlines specific competency expectations for each job category; 5. provides opportunities for personnel to fulfill the continuing education requirements of their respective professions; 6. provides opportunities to support advancement within the organization and profession; and 7. provides opportunities for personnel to practice cultural humility. CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity. Examples: Fair and equitable treatment may include the provision of effective, equitable, understandable, and respectful services that are responsive to: diverse cultural beliefs and practices, such as the freedom to express and practice religious and spiritual beliefs; preferred languages; and other communication needs. Other categories that should be protected from discrimination and disrespect include, but are not limited to: race and ethnicity, military status, age, sexual orientation, gender identity, and developmental level. One way organizations can be responsive to the unique, culturally-defined needs of persons and families being served is by ensuring that program information, signs, posters, printed material, electronic and multimedia communications, and trainings are available and presented: in the language(s) of the major population groups served; and in a manner that is non-discriminatory and non-stigmatizing.	

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	TS 2.04 Training for direct service personnel addresses differences within the organization's service population, as appropriate to the type of service being provided, including: 1. interventions that address cultural and socioeconomic factors in service delivery; 2. the role cultural identity plays in motivating human behavior; 3. procedures for working with non-English speaking persons or individuals with communication impairments; 4. understanding explicit and implicit bias and discrimination; 5. recognizing individuals and families with special needs; 6. the needs of individuals and families in crisis, including recognizing and responding to a mental health crisis; 7. the needs of victims of violence, abuse, or neglect and their family members; and 8. basic health and medical needs of the service population. MHSU 2.03 Clinical personnel are trained on, or demonstrate competence in: 1. evidence-based practices and other relevant emerging bodies of knowledge; 2. psychosocial and ecological or person-in-environment perspectives; 3. criteria to determine the need for more intensive services; 4. methods of crisis prevention and intervention, including assessing for and responding to signs of suicide risk or other safety threats/risks; 5. understanding child development and individual and family functioning; 6. identifying and building on strengths and protective factors; 7. working with difficult to reach or disengaged individuals and families;	

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	8. recognizing and working with individuals with co-occurring physical health, mental health, and substance use conditions; and 9. collaborating with other disciplines, systems, and services. Interpretation: When the organization serves military or veteran populations, it is essential that staff have the competencies needed to effectively support and assist service members, veterans, and their families, including sufficient knowledge regarding: military culture, values, policies, structure, terminology, unique barriers to service, traumas and signature injuries, applicable regulations, benefits, and other relevant issues. When providers possess the requisite military competency, they are capable of supporting improved communication and more effective care. Signature injuries and co-occurring conditions often found in this population include post-traumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), substance use, and intimate partner violence, which could subsequently increase the risk for suicide. Personnel serving military and veteran populations should have the competencies to identify, assess, and develop a treatment plan for these injuries and conditions.	
4.k.7 Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans 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	CR 1.04 Individuals provide consent prior to receiving services and have the right to: 1. participate in all service decisions; 2. be informed of the benefits, risks, side effects, and alternatives to planned services; 3. be offered the most appropriate and least restrictive or intrusive service alternative to meet their needs; 4. receive service in a manner that is free from harassment or coercion and that protects the person's right to self-determination; 5. refuse any service, treatment, or medication, unless mandated by law or court order; and	

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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.	6. be informed about the consequences of such refusal, which can include discharge. Interpretation: In regard to element (d), organizations should ensure that services or interventions do not include strategies that are coercive, threatening, or harmful to an individual's overall wellbeing. Research shows that services and interventions that attempt to alter sexual orientation, gender identity, or gender expression (e.g., conversion or reparative therapies) are harmful and, as such, should be prohibited from agency practice. MHSU Purpose Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness. Definition: Mental Health and/or Substance Use Services (MHSU) are comprehensive, community-based, and designed to help persons served with diagnosable conditions, including: mental health disorders; disorders relating to the use of alcohol, drugs, or other substances; and co-occurring mental health and substance use disorders. Based on the needs of the individual or family, services may address mental health symptoms, diagnoses, and associated functional impairments; resolve issues resulting from the use of alcohol, drugs, or other substances; help manage co-occurring mental health, substance use, and/or health conditions; or provide clinical support for psychosocial adjustments related to life cycle issues. Clinical counseling programs reviewed under Mental Health and/or Substance Use Services provide counseling, support, and education to address a range of issues related to behavioral	

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	health disorders. Services focus on the treatment of diagnosable conditions where therapeutic, evidence-based interventions are provided by appropriately trained, licensed, and/or credentialed personnel. Diagnosis, Assessment, and Referral programs provide individuals with evaluation, diagnosis, and referral to appropriate services. Interpretation: Services can be offered in a variety of settings within the community including outpatient clinics, schools, and in homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications. MHSU 4.01 An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes: 1. agreed upon goals, desired outcomes, and timeframes for achieving them; 2. services and supports to be provided, and by whom; 3. possibilities for maintaining and strengthening family relationships and other informal social networks; 4. procedures for expedited service planning when crisis or urgent need is identified; and 5. the person's or legal guardian's signature. Interpretation: For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the person. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible.	

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	Interpretation: Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery.	
5.a.1 Data Collection, Reporting, and Tracking The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Appendix B. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards. Note: See criteria 3.b for requirements regarding health information systems.	PQI 3 The organization identifies measures and outcomes related to: 1. the impact of services on clients; 2. quality of service delivery; and 3. management and operations performance. PQI 3.01 The organization identifies key outputs and outcomes, and related: 1. measurement indicators; 2. performance targets; and 3. data sources including data collection tools or instruments for each identified output and outcome. Interpretation: Organizations are encouraged to use standardized or recognized outcomes evaluation tools when such tools are available and appropriate. Interpretation: Program outputs and client outcomes must be identified in the logic model submitted in the Person-Centered Logic Model Core Concept in each assigned Service Standard. Examples:Outputs are what the program delivers. Examples of program outputs include:number of educational or clinical sessions provided;total number of clients served over a specified period of time; andnumber of housing placements made. Outcomes are the observable and measurable effects of a program's activities on its service recipients. Examples include:improved functioning as measured by the Children's Functional Assessment Rating Scale (CFARS);number/percent of	

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	homeless and runaway youth that are reunited with family during past quarter;reduction in criminal justice system involvement; andimproved family/community involvement. For some programs, outcomes, outputs, indicators, tools, etc. may be established by contractual and/or funding requirements. RPM 4.03 The organization's electronic information systems are capable of: 1. capturing, tracking, and reporting financial, compliance, and other business information; 2. longitudinal reporting and comparison of performance and outcomes over time; and 3. the use of clear and consistent formats and methods for reporting and disseminating data. Interpretation: “Electronic information systems” are used for collecting, storing, analyzing, and disseminating information electronically. An electronic information system may consist of a single desktop or larger network of computers, laptops, and/or devices. Organizations are not required to implement robust electronic information systems; rather they must have systems that are appropriate for supporting their administrative operations and service delivery. ICHH 3.03 The organization uses health information technologies to: 1. link services including shared access to the person's health information; 2. organize, track, and analyze critical program information including referrals and needed follow-up; and 3. satisfy applicable reporting requirements.	
5.a.2 Data Collection, Reporting, and Tracking Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to:	This criterion is specific to the regulation and oversight of CCBHCs and not directly addressed by

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beginning in 2022, must collect and report the Clinic-Collected quality measures identified as required in Appendix B. Reporting is annual and, for Clinic Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA.States participating in the Section 223 Demonstration must report State-Collected quality measures identified as required in Appendix B. The State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications. Certifying states also may require certified CCBHCs to collect and report any of the optional Clinic-Collected measures identified in Appendix B. Section 223 Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State-Collected or Clinic-Collected). Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12) months after the end of the measurement year, as that term is defined in the technical specifications. States participating in the Section 223 Demonstration program are expected to share the results from the State-Collected measures with their Section 223 Demonstration program CCBHCs in a timely fashion. For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship	1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources. Interpretation: In regard to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes. Interpretation: If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location. PQI 5.01 Procedures for collecting, reviewing, and aggregating data include: 1. cleaning data to ensure data integrity including accuracy, completeness, timeliness, uniqueness, and outliers; 2. protecting personal identifiable information (PII) in data reports; 3. aggregating data quarterly; and 4. developing reports for analysis and interpretation. Interpretation: Data should be collected, aggregated, and reviewed at least quarterly at all three levels of performance measurement as addressed in PQI 3.03, PQI 4, and the Person-Centered Logic Model Core Concept in each assigned Service Standard. Interpretation: The aggregation of data reduces the risk of	an accreditation standard. Some of the more relevant standards have been included here.

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with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report. Note: CCBHCs may be required to report on quality measures through DCOs as a result of participating in a state CCBHC program separate from the Section 223 Demonstration, such as a program to support the CCBHC model through the state Medicaid plan.	disclosing PII in most instances; however, risk of disclosure still exists particularly when data is being disaggregated and unique or easily observable characteristics might allow someone to be identified in the data set. As such, data collection and reporting procedures should include mechanisms for avoiding such disclosure such as data suppression, rounding, reporting in ranges rather than exact counts, combining sub-groups into larger groups, etc. PQI 5.03 Reports of PQI findings are: 1. shared and discussed with board members, staff, and stakeholders; and 2. distributed in timeframes and formats that facilitate review, analysis, interpretation, and timely corrective action.	
5.a.3 Data Collection, Reporting, and Tracking In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and		See above

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the national evaluation contractor annually. To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and, as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.		
5.a.4 Data Collection, Reporting, and Tracking CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS. Note: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.		See above
5.b.1 Continuous Quality Improvement (CQI) Plan In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved	PQI 1.01 A written PQI plan and procedures cover each program or service area and, if necessary, outline any variances between regions or sites, and: 1. articulate the organization's approach to quality improvement and methods used; 2. describe the PQI system's structure, functions, and activities; 3. define staff roles and assign responsibility for implementing and coordinating the PQI program (PQI 2); 4. identify what is being measured and why (PQI 3, PQI 4, Service Standards); and	The criterion is more prescriptive than the standard regarding who needs to be involved in coordinating the CQI system.

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patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.	5. include procedures for reporting findings and monitoring results (PQI 5). PQI 2 The organization has sufficient qualified staff, representing different departments and levels of the organization, to conduct and sustain its PQI system. PQI 2.01 Staff responsible for implementing and coordinating the organization's PQI system are competent to: 1. identify indicators of quality practice; 2. implement internal and external evaluation methods, such as benchmarking, as appropriate to the programs being evaluated; 3. ensure proper data entry and data integrity; 4. collect, analyze, and interpret data; and 5. communicate evidence and findings to staff in a manner that facilitates their active engagement. PQI 2.02 Staff receive support, as appropriate to their responsibilities, on: 1. inputting data into the data management system; 2. using data collection tools and forms; 3. reading and interpreting reports; and 4. using data to improve performance. PQI 3.01 The organization identifies key outputs and outcomes, and related: 1. measurement indicators; 2. performance targets; and 3. data sources including data collection tools or instruments for each identified output and outcome. Interpretation: Organizations are encouraged to use standardized or recognized outcomes evaluation tools when	

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	such tools are available and appropriate. Interpretation: Program outputs and client outcomes must be identified in the logic model submitted in the Person-Centered Logic Model Core Concept in each assigned Service Standard. PQI 5.02 The organization analyzes disaggregated PQI data to: 1. track and monitor identified measures; 2. identify patterns and trends; and 3. compare performance over time. Interpretation: Organizations should disaggregate data to identify patterns of disparity or inequity that can be masked by aggregate data reporting. Common characteristics used to disaggregate data include: *1.* race and ethnicity/country of origin; *2.* generation status; *3.* immigrant/refugee status; *4.* age group; *5.* sexual orientation; and *6.* gender/gender identity. PQI 5.04 The organization: 1. reviews PQI findings and stakeholder feedback and takes action, when indicated; and 2. monitors the effectiveness of actions taken and modifies implemented improvements, as needed. MHSU 1.02 The logic model identifies individual and/or family outcomes in at least two of the following areas: 1. change in clinical status; 2. change in functional status; 3. health, welfare, and safety; 4. permanency of life situation;	

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	5. quality of life; 6. achievement of individual service goals; and 7. other outcomes as appropriate to the program or service population. Interpretation: Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.	
5.b.2 Continuous Quality Improvement (CQI) Plan The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.	RPM 2 The organization identifies and reduces potential loss and liability by: 1. conducting prevention and risk reduction activities; and 2. monitoring and evaluating risk prevention and management effectiveness. RPM 2.01 The organization conducts a quarterly review of immediate and ongoing risks that includes a review of incidents, critical incidents, accidents, and grievances including the following, as appropriate to the program or service: 1. facility safety issues; 2. serious illness, injuries, and deaths; 3. situations where a person was determined to be a danger to himself/herself or others; 4. service modalities or other organizational practices that involve risk or limit freedom of choice; and 5. the use of restrictive behavior management interventions, such as seclusion and restraint. RPM 2.02 The organization conducts a review of each incident, serious occurrence, accident, and grievance that involves the threat of or actual harm, serious injury, or death; and review procedures: 1. require that the investigation be initiated within 24 hours of the incident and/or accident being reported and establish timeframes for completing the review;	

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	2. require solicitation of statements from all involved individuals; 3. ensure an independent review; 4. require timely implementation and documentation of all actions taken; 5. address ongoing monitoring if actions are required and assessing their effectiveness; and 6. address applicable reporting requirements. PQI 3.03 The organization identifies measures for management and operational performance to: 1. measure progress toward achieving its mission and strategic and annual goals; 2. evaluate operational functions that influence the capacity to deliver services and meet the needs of persons served; and 3. identify and mitigate risk. Examples: Examples of operations and management performance measures can include: *1.* efficiency in the allocation and utilization of its human and financial resources to further the achievement of organizational objectives; *2.* effectiveness of risk prevention measures; *3.* effectiveness at retaining a competent and qualified workforce through staff retention/turnover and satisfaction; *4.* costs versus benefits of fundraising efforts; *5.* achievement of budgetary objectives; *6.* effectiveness of community education and outreach; and *7.* efforts to diversify the governing body, leadership, or workforce. MHSU 1.02 The logic model identifies client outcomes in at least two of the following areas: 1. change in clinical status; 2. change in functional status;	

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	3. health, welfare, and safety; 4. permanency of life situation; 5. achievement of individual service goals; and 6. other outcomes as appropriate to the program or service population. Interpretation: Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.	
5.b.3 Continuous Quality Improvement (CQI) Plan The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.	PQI 3 The organization identifies measures and outcomes related to: 1. the impact of services on clients; 2. quality of service delivery; and 3. management and operations performance. PQI 3.01 The organization identifies key outputs and outcomes, and related: 1. measurement indicators; 2. performance targets; and 3. data sources including data collection tools or instruments for each identified output and outcome. Interpretation: Organizations are encouraged to use standardized or recognized outcomes evaluation tools when such tools are available and appropriate. Interpretation: Program outputs and client outcomes must be identified in the logic model submitted in the Person-Centered Logic Model Core Concept in each assigned Service Standard. PQI 5 The organization systematically collects, aggregates, analyzes, and maintains data. PQI 5.01	The criterion is more prescriptive than the standard regarding what data must be tracked.

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	Procedures for collecting, reviewing, and aggregating data include: 5. cleaning data to ensure data integrity including accuracy, completeness, timeliness, uniqueness, and outliers; 6. protecting personal identifiable information (PII) in data reports; 7. aggregating data quarterly; and 8. developing reports for analysis and interpretation. Interpretation: Data should be collected, aggregated, and reviewed at least quarterly at all three levels of performance measurement as addressed in PQI 3.03, PQI 4, and the Person-Centered Logic Model Core Concept in each assigned Service Standard. PQI 5.02 The organization analyzes disaggregated PQI data to: 1. track and monitor identified measures; 2. identify patterns and trends; and 3. compare performance over time. Interpretation: Organizations should disaggregate data to identify patterns of disparity or inequity that can be masked by aggregate data reporting. Common characteristics used to disaggregate data include: *1.* race and ethnicity/country of origin; *2.* generation status; *3.* immigrant/refugee status; *4.* age group; *5.* sexual orientation; and *6.* gender/gender identity. PQI 5.04 The organization: 1. reviews PQI findings and stakeholder feedback and takes action, when indicated; and	

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	2. monitors the effectiveness of actions taken and modifies implemented improvements, as needed. MHSU 1.02 The logic model identifies individual and/or family outcomes in at least two of the following areas: 1. change in clinical status; 2. change in functional status; 3. health, welfare, and safety; 4. permanency of life situation; 5. quality of life; 6. achievement of individual service goals; and 7. other outcomes as appropriate to the program or service population. Interpretation: Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.	
6.a.1 General Requirements of Organizational Authority and Finances 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,		Organization type and legal authorization to operate are confirmed during the application process as they are part of the COA Accreditation eligibility criteria. Standards for private organizations and public authorities are available. For-profits are currently accredited by COA Accreditation and would not be eligible for CCHBC accreditation per this criterion.

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county, region, or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.		
6.a.2 General Requirements of Organizational Authority and Finances To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs shall reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.	GOV 3.03 The organization collaborates with community members and persons served to advocate for issues of mutual concern consistent with the organization's mission, such as: 1. improvements to existing services; 2. filling gaps in service to offer a full array of community supports; 3. the full and appropriate implementation of applicable laws and regulations regarding issues concerning the service population; 4. improved supports and accommodations for individuals with special needs or marginalized communities; 5. solutions to community-specific needs including racial equity and cultural and linguistic diversity; 6. service coordination; 7. a coordinated community response to public health emergencies. CR 1.03 People have the right to ethical and equitable treatment including: 1. the right to receive services in a non-discriminatory manner; 2. the consistent enforcement of program rules and expectations; and 3. the right to receive inclusive services that are respectful of, and responsive to, cultural and linguistic diversity. Examples: Ethical and equitable treatment may include the provision of effective, equitable, understandable, and respectful services that are responsive to: diverse cultural beliefs and practices, such as the freedom to express and practice religious and spiritual beliefs; preferred languages; and other communication needs.	The criterion is more prescriptive than the standard regarding developing arrangements with American Indian/Alaska Native organizations and tribes.

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6.a.3 General Requirements of Organizational Authority and Finances An independent financial audit is performed annually for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.	FIN 1 The organization's governing body or designated committee of the governing body, as appropriate: 1. approves the annual budget and any revisions to the budget; 2. reviews quarterly and annual financial statements/summaries provided by management; 3. reviews accounting policies and procedures; 4. reviews recommendations of the organization’s auditors, and management's response to the recommendations; 5. annually evaluates the executive director’s management of the organization’s financial affairs; and 6. reviews and approves the IRS Form 990. Interpretation: Minutes of governing body and its committee meetings should reflect active oversight of the organization's finances. FIN 5 The organization receives an audit or review of its financial statements that is conducted within 180 days of the end of each fiscal year by an independent, certified public accountant.	The standard allows for a review of financial statements in place of an audit. An audit would be required for CCBHC accreditation per this criterion.
6.b.1 Governance CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial	PQI 1.02 The PQI plan: 1. defines the organization's stakeholders; and 2. specifies how important internal and external stakeholder groups will be involved in the PQI process. Interpretation: Stakeholder involvement is fundamental to a well-designed, useful PQI system. Ideally, a broad range of internal and external stakeholders including staff from all levels of the organization, the organization's governing body, persons served, and other external stakeholders have a role in the organization's PQI system. GOV 3.02	The criterion is more prescriptive than the standard regarding what percentage of the board must be made up of individuals with lived experience and their families.

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number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making. CCBHCs reflect substantial participation by one of two options: Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families. Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board. Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into: 1. Identifying community needs and goals and objectives of the CCBHC Service development, quality improvement, and the activities of the CCBHC 3. Fiscal and budgetary decisions 4. Governance (human resource planning, leadership recruitment and selection, etc.) Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual	The organization conducts ongoing community outreach and education to: 1. communicate its mission, role, functions, capacities, and scope of services; 2. provide information about the strengths, needs, and challenges of the individuals, families, and groups it serves; 3. build community support and presence and maintain effective partnerships; and 4. elicit feedback as to unmet needs in the community that can be addressed by the organization as its top advocacy priorities. GOV 3.03 The organization collaborates with community members and persons served to advocate for issues of mutual concern consistent with the organization's mission, such as: 1. improvements to existing services; 2. filling gaps in service to offer a full array of community supports; 3. the full and appropriate implementation of applicable laws and regulations regarding issues concerning the service population; 4. improved supports and accommodations for individuals with special needs or marginalized communities; 5. solutions to community-specific needs including racial equity and cultural and linguistic diversity; 6. service coordination; 7. a coordinated community response to public health emergencies. GOV 3.04 The governing body: 1. reflects the demographics of the community it serves; 2. represents the interests of the community it serves; 3. serves as a link between the organization and the public or community; and	

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summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website.	4. is sufficiently diverse in strengths and capabilities to plan and deliver appropriate services to its defined community. Interpretation: COA recognizes that Board recruitment is a significant challenge for many organizations and that meeting the standard may be a long-term process. In the interim, an organization can establish a stakeholder advisory group that is representative of the community and include strategies for plan for strengthening its Board in its long-term or strategic plan.	
6.b.2 General Requirements of Organizational Authority and Finances If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so. If option 2 is chosen, for CCBHCs not certified by the state, the federal grant funding agency will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.For certifying states, if option 2 is chosen then states will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.		See 6.b.1
6.b.3 General Requirements of Organizational Authority and Finances To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6.b.1.		See 6.b.1

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6.b.4 General Requirements of Organizational Authority and Finances Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry	GOV 3.04 The governing body: 1. reflects the demographics of the community it serves; 2. represents the interests of the community it serves; 3. serves as a link between the organization and the public or community; and 4. is sufficiently diverse in strengths and capabilities to plan and deliver appropriate services to its defined community. Interpretation: COA recognizes that Board recruitment is a significant challenge for many organizations and that meeting the standard may be a long-term process. In the interim, an organization can establish a stakeholder advisory group that is representative of the community and include strategies for plan for strengthening its Board in its long-term or strategic plan. Examples: The governing body should reflect a wide range of skills, abilities, community knowledge, and professions. Examples of board member strengths and capabilities may include: *1.* governance expertise, including leadership ability and policy development skills; *2.* relevant business experience; *3.* financial expertise; *4.* knowledge of consumer issues and trends; *5.* familiarity with and access to community leaders, political representatives, and other -relevant local organizations; *6.* public recognition and respect; and *7.* commitment and ability to fundraise or to connect the organization with potential resources, as applicable. GOV 7 The organization prevents the enrichment of insiders and other abuses through the adoption and enforcement of a conflict-of-interest policy. GOV 7.01	The criterion is more prescriptive than the standard regarding what percentage of the board can come from the health care industry but does have clear guidance on handling conflicts of interest.

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	A conflict-of-interest policy is tailored to the organization's specific needs and characteristics, and: 1. defines conflict of interest; 2. identifies groups of individuals within the organization covered by the policy; 3. addresses policy enforcement; 4. provides a framework for evaluating situations that may constitute a conflict; and 5. invests management with developing procedures that facilitate disclosure of information to prevent and manage potential and apparent conflicts of interest. GOV 7.02 The conflict-of-interest policy requires governing body members, advisory group members, personnel, and consultants who have a financial interest in the organization's assets, business transactions, leases, or professional services to: 1. disclose this information; and 2. not participate in any discussion or vote taken with respect to such interests. Interpretation: Governing body members who receive compensation for professional services they provide as consultants cannot be part of the organization's audit review process.	
6.c.1 Accreditation The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements.	RPM 1 The organization has a process for annually reviewing compliance with applicable federal, state, and local laws, codes, and regulations, including those related to: 1. licensure; 2. facilities; 3. accessibility; 4. health and safety; 5. finances; and 6. human resources.	A current license is a requirement to pursue COA Accreditation.

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Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.		
6.c.2 Accreditation CCBHCs must be certified by their state as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services. CCBHC expansion grant recipients are encouraged to seek state certification if they are in a state that certifies CCBHCs. State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. Certifying states may use an independent accrediting body as a part of their certification process as long as it meets state standards for the certification process and assures adherence to the CCBHC Certification Criteria.		This criterion outlines CCBHC designation options and is not included in an accreditation review.
6.c.3 Accreditation States are encouraged to require accreditation of the CCBHCs by an appropriate independent accrediting body (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean "deemed" status		Not applicable to an accreditation review.

Updated 06/28/2023

[i] Substance Abuse and Mental Health Services Administration. (2023, February). *Certified Community Behavioral Health Center (CCBHC) Certification Criteria*. Retrieved April 21, 2023 from Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA.