Oregon Certified Community Behavioral Health Clinic (CCBHC) Program Requirements Manual

Version 1

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Preface A: The Purpose and Function of the "Oregon CCBHC Program Requirements Manual"

The "Oregon Certified Community Behavioral Health Clinic (CCBHC) Criteria Manual - Version 1" must be used as the primary source outlining compliance and duties. Should there be a perceived conflict between the rule and the manual, CCBHCs and applicants should defer to the "Oregon Certified Community Behavioral Health Clinic (CCBHC) Program Requirements Manual - Version 1".

Per **OAR 309-009-0040(3),** CCBHCs must meet the criteria outlined in this manual to become certified and maintain certification.

Certification of Certified Community Behavioral Health Clinics

Applicant Requirements (OAR 309-009-0040)

CCBHCs must meet the following requirements:

1. CCBHCs must conform to at least one of the following criteria for organizational authority:
    a. Is a non-profit organization exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code
    b. Is part of a local government behavioral health authority. An applicant is considered part of a local government behavioral health authority when a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services
    c. 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.)
    d. Is an urban Indian organization pursuant to a grant or contract with the Indian Health Services, under Title V of the Indian Health Care Improvement Act (25 U.S.C 1601 et seq.)

2. Meet designation requirements for “Ready to certify” or “Mostly ready to certify, with assistance” as defined in OAR 309-009-0050

3. Meet state criteria outlined in the document titled “Oregon CCBHC Program Requirements Manual - Version 1”

4. Per **OAR 309-009-0030(3)(b)(A),** CCBHCs must have the following certifications through Chapter 309 Division 08 rules:
    a. Outpatient mental health (Chapter 309 Division 19)
    b. ASAM 0.5 (OAR 309-019-0181)
    c. ASAM 1 (OAR 309-019-0182)
    d. ASAM 2.1 (OAR 309-019-0183)
    e. If directly providing mobile crisis services, Mobile Crisis Intervention Services and Crisis Stabilization Services (Chapter 309 Division 72)

5. Provide directly or through designated collaborating organization (DCO), all required services:
    (a) 24-hour crisis behavioral health services, including mobile crisis outreach;
    (b) Screening, assessment, and diagnosis;
    (c) Person-centered and family-centered treatment planning;
    (d) Outpatient mental health and substance use disorder services;
    (e) Primary care screening and monitoring;
    (f) Targeted case management;
    (g) Psychiatric rehabilitation services;
    (h) Peer and family support services;
    (i) Intensive, community-based mental health care for members of the armed forces and veterans

6. Agree to site visit and follow up activities with the CCBHC site review team.

7. Applicants that are not a community mental health program (CMHP) must submit a finalized written agreement between the applicant and CMHP, meeting the requirements outlined in the “CMHP-CCBHC Written Agreement Guidance,” found on the CCBHC website. If the non-CMHP and CMHP are unable to reach a mutual agreement on the coordination of services, either entity is permitted to request a meeting with the Authority.

Application and Certification Process (OAR 309-009-0030)

General Requirements

An applicant seeking initial certification, certification renewal, or changes to existing certification must submit an Oregon Health Authority (Authority) designated application to the Authority.

An applicant with multiple facility locations under the same management must have each facility approved for CCBHC certification. Each facility location is independently considered for CCBHC certification. An applicant must submit documentation with the application sufficient for the Authority to evaluate each facility location. A separate application for each facility location is not required as long as the provider structure, including but not limited to policies and procedures, governs all locations.

Applicants seeking certification renewal or changes to existing certification must submit application 90 days prior to the desired effective date and must receive approval via certification prior to the change being implemented. Changes to certification include:

1. Changing the scope of services provided at any certified CCBHC facility location, including access facilities and qualified satellite facilities
2. Changes to designated collaborating organizations (DCO)
3. Relocating a certified CCBHC facility location
4. Adding or removing a facility location from the current CCBHC certification, including satellite facilities and/or access facilities

A qualified satellite facility is a facility owned and operated by a CCBHC that does not provide all required CCBHC services, but does provide at minimum:

1. Crisis services, except mobile crisis
2. Screening, diagnosis, and risk assessment
3. Service planning
4. Outpatient mental health and substance use services

A CCBHC access facility is an outpatient setting owned and operated by a CCBHC and subject to approval by the Authority that provides low barrier services that facilitate engagement and access to care within the scope of CCBHC. Access facilities offer unscheduled, voluntary services. Access facilities are distinct from satellite facilities, which must provide the specified set of required services.

All qualified satellite and access facilities must be located within the service area of the CCBHC, appropriately certified and/or licensed for the services provided, and ensure that people receiving services at that facility have access to all CCBHC services not provided at the qualified satellite or access facility.

Initial Certification

For initial certification, applicants must complete the following:

1. Attend a Certified Community Behavioral Health Clinic (CCBHC) orientation hosted by the Authority

2. Complete and submit the preliminary application provided by the Authority, including a community needs assessment plan
    a. If not already certified in any of the required certifications per **OAR 309-009-0030(3)(b)(A),** the applicant must first submit an application following Chapter 309 Division 08 rules
    b. If applicant intends to partner with a Designated Collaborating Organization (DCO), they must include:
        i. A draft or finalized Memorandum of Understanding (MOU) with each DCO
        ii. Documentation of each DCO's applicable certifications and Medicaid provider enrollments authorizing the DCO to provide the services outlined in the MOU
    c. Applicants that are not a community mental health program (CMHP) must enter into a written agreement with the CMHP in their service area regarding the coordination of services that are provided by both organizations, following the provided "CMHP-CCBHC Written Agreement Guidance". Applicants who are not CMHPs must submit either:
        i. Documentation of outreach to the CMHP within their service area notifying the CMHP of intent to apply for CCBHC; or
        ii. A draft or finalized written agreement between the applicant and CMHP, meeting the requirements outlined in the "CMHP-CCBHC Written Agreement Guidance," found on the CCBHC website
3. The Authority must review the preliminary application within 30 days of its submission to determine whether it is accurate, complete, and meets the certified requirements:

a. If the application is found not complete and/or does not demonstrate compliance, the Authority must provide written notice of the incomplete or noncompliant application, describing any necessary amendments to the application. The applicant must submit an amended application to the Authority within 14 calendar days of receipt of the Authority's notice
b. If the Authority determines the applicant has met the requirements of these rules, the Authority must inform applicant in writing that the preliminary application has been approved as a potential CCBHC, send the full application form to be completed and submitted by the applicant, and send information regarding site visit planning

4. Complete the full application form, including:
    a. The formal application provided by the Authority
    b. A community needs assessment and staffing plan
    c. Applicants that are not a community mental health program (CMHP) must submit a finalized written agreement with the CMHP in their service area, meeting the requirements outlined in the document "CMHP-CCBHC Written Agreement Guidance," found on the CCBHC website.
        i. If the non-CMHP and CMHP are unable to reach a mutual agreement on the coordination of services, either entity is permitted to request a meeting with the Authority
    d. Supporting documents as required by the Authority

5. Complete a site visit

6. If required by the Authority, complete a Site Improvement Plan

Renewal Certification

For renewal certification, the applicant must:

1. Complete a full application form for all certifications, including:
    a. The formal application provided by the Authority
    b. Community needs assessment and staffing plan
    c. Applicants that are not a community mental health program (CMHP) must submit a finalized written agreement with the CMHP in their service area, meeting the requirements outlined in the document

"CMHP-CCBHC Written Agreement Guidance," found on the CCBHC website, when changes have been made to the agreement

d. Supporting documents as required by the Authority

2. Complete a site visit

3. If required by the Authority, complete a Site Improvement Plan

CCBHC renewal certification will be aligned with outpatient behavioral health provider or community mental health program renewal certification, as applicable and feasible.

Denial of Application

The Authority may deny CCBHC certification if an applicant does not meet the requirements of these rules, including the requirements outlined in "Oregon Certified Community Behavioral Health Clinic (CCBHC) Program Requirements Manual - Version 1". An applicant may request that the Authority reconsider the denial of CCBHC certification.

1. A request for reconsideration must be submitted in writing to the Authority within 30 days of the date of the denial or approval letter and must include a detailed explanation of why the applicant believes the Authority's decision is in error along with any supporting documentation.
2. The Authority must inform the applicant in writing whether it has reconsidered its decision.

Level of Readiness (OAR 309-009-0050) & Types of Certifications (OAR 309-009-0055

Level of Readiness Definitions

Ready to certify: The applicant demonstrates substantial conformance to the criteria, their current operation has capacity to be maintained and/or improved, and they demonstrate ongoing quality improvement. The applicant may require a Site Improvement Plan (SIP) for only a few criteria.

Mostly ready to certify, with assistance: The applicant demonstrates conformance to many of the criteria, they have significant areas for improvement but there is evidence of the organization's capability to improve and their commitment to

progress. Requires a SIP for multiple criteria to achieve compliance.

Not ready to certify: The applicant does not demonstrate sufficient conformance to the criteria.

Certification Types

Full certification is given when CCBHC receives a level of readiness designation of "ready to certify". Full certification is effective for 3 years.

Provisional certification is given when the CCBHC receives a level of readiness designation of "Mostly ready to certify, with assistance". Provisional certification is effective for 1 year.

CCBHCs with full certification must submit a recertification application to the Authority in conjunction with their Chapter 309 Division 08 certifications. The Authority will use the level of readiness tool to review each application and verify CCBHC certification.

Site Improvement Plan (SIP) and Monitoring (OAR 309-009-0055)

A Site Improvement Plan (SIP) is a written plan, using the provided template on the CCBHC website, which addresses deficiencies to CCBHC requirements. The SIP must address steps the applicant is taking to become compliant, a timeframe in which compliance will be achieved, and supports needed to achieve compliance. When the Authority identifies deficiencies during certification, the Authority will require CCBHCs to submit a SIP. CCBHCs will have 30 calendar days to submit a Site Improvement Plan (SIP) for achieving compliance.

1. When access or care to persons served is a serious issue, the CCBHC site may be given a much shorter period to initiate SIPs, and this condition may be established, in writing, as part of the Authority findings.
2. If the Authority identifies an issue that places a person served in imminent risk to health or safety, the Authority may require immediate response based on risk.

The Authority will review the SIP, seek clarifying or additional information from the CCBHC site as needed, and issue a response within 30 calendar days of receipt.

Provisional Certification

For provisional certification, the SIP must not exceed a duration of 12 months.

The Authority will take steps to monitor the CCBHC site's implementation of the SIP as part of performance monitoring, including but not limited to conducting quarterly virtual meetings over 12 months.

1. Following 12 months, if the CCBHC site still fails to meet requirements for full certification, provisional certification will continue for an additional six (6) months of monitoring with quarterly virtual meetings required.
2. If deficiencies are resolved, and full certification criteria has been met by the CCBHC at the conclusion of the SIP process, the CCBHC is given a full certification.

Full Certification

For full certification, a SIP must not exceed a duration of 3 years.

The Authority will take steps to monitor the CCBHC site's implementation of the SIP as part of performance monitoring, including, but not limited to, annual virtual meetings over the 3-year period.

Variances (OAR 309-009-0060)

The Authority may grant a variance to a CCBHC applicant or provider if:

1. There is a lack of resources to meet the criteria required in these rules, or
2. Implementation of the proposed alternative services, methods, concepts, or procedures would result in improved outcomes for the individual.

CCBHC applicants must submit the variance request directly to the CCBHC project team using the approved "Application for Continued Variance" form.

The authority must approve or deny the request for a variance and must notify the provider in writing of the decision to approve or deny the requested variance, within 30 days of receipt of the variance.

Granting a variance for one request does not set a precedent that must be followed by the Authority when evaluating subsequent requests for variance. Variances are approved for a specific duration of time as established in the variance approval.

Program Requirement 1: Staffing

1.A: Community Needs Assessment

1.a.1. The community needs assessment must inform the Certified Community Behavioral Health Clinic's (CCBHC) service delivery and operations.

1.a.2. The community needs assessment must be completed and submitted with the application for certification.

1.a.3. The CCBHC is permitted to use regional assessments completed within 3 years of the required CCBHC community needs assessment to fulfill the community needs assessment requirement. CCBHCs who submit regional needs assessments must also submit the following:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCHC, including through DCOs
2. Identification of health disparities if not identified within regional needs assessment or if those identified are outside scope of CCBHC
3. Current strengths and challenges
4. A plan of action

1.a.4. CCBHCs completing their own community needs assessment must include the following components:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose
3. Economic factors and social drivers of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to

transportation, nutrition, and stable housing
4. Cultures and languages of populations residing in service area
5. Identification of underserved population(s)
6. A description of how the staffing plan does and/or will address findings
7. Current strengths and challenges
8. Plan of action

1.a.5. The community needs assessment or submitted regional assessment must include input regarding:

1. Cultural, linguistic, physical health, and behavioral health treatment needs
2. Developmentally appropriate evidence-based and promising practices and behavioral health crisis services
3. Access and availability of CCBHC services including days, times, and locations, and telehealth options
4. Potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages

1.a.6. Clinics must attempt to obtain input from the following entities in the service area to incorporate within the community needs assessment and action plan:

1. People with lived experience of mental and substance use conditions, parents/caregivers of children, youth, and young adults with serious social and emotional needs, and persons who have received/are receiving services from the clinic
2. Crisis response providers or systems
3. Health centers (including FQHCs)
4. Local health departments (Note: these departments also develop community needs assessments that may be helpful)
5. Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics
6. One or more Department of Veterans Affairs facilities
7. Jails, courts, and juvenile justice systems
8. Representatives from local K-12 school systems
9. Early Learning Hubs

10. Local System of Care
11. Other community partners

1.B: Staffing Plan

1.b.1. The CCBHC staff (both clinical and non-clinical) must be appropriate in size and composition and provide services appropriate for the population served, as identified in the community needs assessment.

1.b.2. The staffing plan for medical and clinical staff must be approved by the medical director.

1.b.3. The staffing plan includes clinical, traditional health workers, and other core staff comprised of employed and contracted staff, as needed.

1.C: General Staffing Requirements

1.c.1. The CCBHC must have a psychiatrist or psychiatric nurse practitioner as a medical director. The medical director need not be a full-time employee but must be employed or contracted by the clinic.

1.c.2. The CCBHC's management team includes a chief executive officer (CEO)/program director/or equivalent and a medical director.

1.c.3. The CEO or equivalent of the CCBHC maintains a fully staffed management team appropriate for the needs and size of the clinic, as determined by the current needs assessment and staffing plan.

1.c.4. The medical director provides guidance regarding behavioral health clinical service delivery, ensures the quality of the medical component of care, and provides guidance to foster the integration and coordination of behavioral health and primary care.

1.c.5. If the medical director is not experienced in the assessment and diagnosis of substance use disorder; substance intoxication and withdrawal; pharmacological management of substance use

disorders, including intoxication and withdrawal; ambulatory withdrawal management; outpatient addiction treatment; toxicology testing; and pharmacodynamics of commonly used substances, the CCBHC has 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.

1.c.6. If the medical director does not have experience providing services to early childhood, youth, young adults, and families, the CCBHC has experienced staff or arrangements that ensure access to consultation on psychiatric service for early childhood, youth, and young adults for the medical director and clinical staff. CCBHCs are encouraged to use the Oregon Psychiatric Access Line – Kids (OPAL-K) for consultation.

1.c.7. The CCBHC has 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.

1.c.8. If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it refers to an opioid treatment program (if any exist in the CCBHC service area) and provides care coordination to ensure access to methadone.

1.c.9. The CCBHC has staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists.

1.c.10. The CCBHC has staff with expertise in addressing trauma and promoting the recovery of children, youth, and young adults with serious social and emotional needs and adults with serious mental illness.

1.c.11. The CCBHC supplements its core staff as necessary in order to adhere to Program Requirement 3 (Care Coordination), Program

Requirement 4 (Scope of Services), and individual service plans, through arrangements with, and referrals to, other providers.

1.c.12. Staffing satisfies the requirements of criteria 4.K for services to veterans.

1.D: Liability/Malpractice Insurance

1.d.1. The CCBHC maintains adequate liability/malpractice insurance, as required in OAR 309-008-0400 [Certification of Behavioral Health Treatment Services > The Application Process]

1.E: Licensure and Credentialing of Providers

1.e.1. Clinics are held to all rules in Chapter 309, Division 8 [Certification of Behavioral Health Treatment Services] for licensure and credentialing.

1.e.2. CCBHC practitioners providing direct services furnish them within their scope of practice in accordance with all applicable federal, state, and local laws and regulations, including Medicaid billing regulations or policies.

1.e.3. All CCBHC staff must meet the requirements relevant to their position as included in OAR 309-019-0125 [Staffing Qualifications].

1.e.4. Appropriate supervision must be provided for CCBHC providers that are working towards licensure.

1.F: Staff Training

1.f.1. All staff must meet the training requirements for their job title, certification, or licensure as described in OAR 309-019-0125 [Staff Qualifications].

1.f.2. The CCBHC has a training plan for all employees and contract staff who have direct contact with people receiving services or their families.

1.f.3. During staff onboarding, and at reasonable intervals, the CCBHC provides training on:

1. Person-centered and family-centered, recovery-oriented planning and services
2. Cultural responsiveness
3. Trauma-informed care
4. The clinic's policy and a continuity plan for operations/disasters
5. The clinic's policy and procedures for integration and coordination with primary care and care for co-occurring mental health and substance use disorders

1.f.4. During staff onboarding, and annually thereafter, the CCBHC provides training on:

1. Risk assessment
2. Suicide and overdose prevention and postvention
3. The roles of family members and peer staff

1.f.5. Individuals providing training to CCBHC staff have the qualifications to do so as evidenced by their education, training, and experience.

1.f.6. Staff will regularly receive training for developmentally appropriate evidence-based and/or promising practices specific to their role and the populations they serve. A certificate of completion must be acquired through this training.

1.f.7. Trainings are aligned with the 15 National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate inequities.

1.f.8. CCBHC staff who work with children, youth, and young adults will receive training on age and developmentally appropriate care.

1.f.9. CCBHC staff who work with people receiving CCBHC services who are active-duty military or veterans will receive training on military culture.

1.G: Skills and Competence Policies

1.g.1. Clinics must maintain written service delivery policies and procedures regarding personnel qualifications, credentialing, and training; trauma-informed service delivery; and the provision of culturally and linguistically appropriate services according to all requirements of OAR 309-019-0110 [Provider Policies].

1.g.2. The CCBHC regularly assesses and has written policies and procedures that describe the methods used for assessing skills and competencies of providers and keeps track of training provided for each employee.

1.g.3. Clinics must ensure that all training is completed and documented according to the requirements of OAR 309-019-0130 [Personnel Documentation, Training, and Supervision].

1.g.4. CCBHC policies have explicit provisions for ensuring that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), patient privacy requirements specific to care for minors, and other state and federal laws.

Program Requirement 2: Availability and Accessibility of Services

2.A: General Requirements of Access and Availability

2.a.1. Services are provided at locations and times that facilitate accessibility and meet the needs of the population, including some services in evening hours and weekend.

2.a.2. CCBHCs must offer transportation or transportation vouchers to facilitate access to CCBHC services.

2.a.3. In accordance with the person receiving services' preference and as clinically appropriate, CCBHCs must provide telehealth video conferencing, remote patient monitoring, asynchronous intervention, and other technologies to facilitate access to services.

1. Telehealth must be provided in accordance with all applicable rules in OAR 410-120-1990 [Telehealth].

2.a.4. The CCBHC must conduct outreach, engagement, and retention activities to support inclusion and access for persons seeking services and populations affected by health inequities.

2.a.5. The CCBHC must have a continuity of operations plan in the event of an emergency that disrupts services.

1. The plan must ensure the CCBHC is able to notify staff, people receiving services, and community partners when services are disrupted.
2. The CCBHC, to the extent feasible, must identify alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters.
3. The plan must address health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.

2.a.6. The CCBHC provides a safe, functional, clean, sanitary, welcoming, and trauma-informed environment for people receiving services and staff, conducive to the provision of services identified in program requirements. CCBHCs must follow all applicable rules in OAR 309-019-0205 [Building Requirements in Behavioral Health Programs].

2.a.7. CCBHC services conform to state or county/municipal court standards for the provision of voluntary and court-ordered services.

2.B: Language Accessibility

2.b.1. The clinic must ensure that all information given to the person receiving services be provided in a format or language appropriate to the person's need, in accordance with OAR 309-019-0115 [Individual Rights].

1. Documents or messages 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, ideally written at an 5th grade reading level, can be provided in alternative formats, and are provided in a timely manner at intake and throughout the time a person is served by the CCBHC.

2.b.2. The clinic must ensure that they demonstrate compliance with Title II of the Americans with Disabilities Act of 1990, as is required in OAR 309-019-0110 [Provider Policies], which includes that all communications with persons with disabilities be as effective as communications with others, including providing auxiliary aids, accessible formats, and adapted technology.

1. CCBHC auxiliary aids and services are available, ADA compliant, and responsive to the needs of people with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletype [TTY] lines) receiving services.

2.b.3. The CCBHC provides interpretation and/or translation services and translated documents to people with Limited English Proficiency (LEP) or with language-based disabilities.

1. Interpretation and/or translation services are readily available, timely, and appropriate for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters or translators are used, such service providers are trained to function in a medical and, preferably, a behavioral health setting.

2.b.4. The community needs assessment has informed which languages require language assistance.

2.C: General Requirements for Timely Access to Services

2.c.1. All people new to receiving services will receive a preliminary triage and risk screening to determine acuity of needs at the time of first contact. The preliminary triage may occur in-person, by telephone, or through other remote communication. Based on the level of acuity determined in the preliminary triage, services must be provided within the following timeframes:

1. If the preliminary triage identifies an emergency/crisis need, appropriate action is taken immediately including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.
2. If the preliminary triage identifies an urgent need, clinical services and initial evaluation are to be provided within one business day of the time the request is made.
3. If the preliminary triage identifies routine needs, services are to be provided, and the initial evaluation completed, within seven business days.

2.c.2. The initial evaluation may be done telephonically for persons presenting with emergency or urgent needs. For those who continue to receive services from the CCBHC, an initial evaluation conducted telephonically must be reviewed in person once the emergency is resolved.

2.c.3. All new people receiving services receive a comprehensive evaluation to be completed within 90 calendar days of the first request for services. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 90-day period.

2.c.4. If a person already receiving services from the CCBHC presents with a need for services or requests an appointment, the acuity of their need determines the timeframe in which services must be provided.

1. If the person already receiving services from the CCBHC presents with an emergency/crisis need, the CCBHC takes appropriate and immediate action that is consistent with the needs of the person receiving services, including immediate crisis response.
2. If the person presents with an urgent, non-emergency need, clinical services are provided within one business day of the request, unless the preference of the person receiving services is for a later time.
3. If the person is seeking routine outpatient clinical service, appointments occur within ten business days from when the request for appointment is made, unless the preference of the person receiving services is for a later time.

2.D: No Refusal of Service

2.d.1. The CCBHC must ensure no person seeking CCBHC services is denied behavioral health care services because of a person's inability to pay for such services, place of residence, experiencing houselessness, or a lack of a permanent address.

2.d.2. The CCBHC has published sliding fee discount schedule(s) on the CCBHC website, posted in the CCBHC waiting room, and readily accessible to people receiving services and their families.

1. The fee schedule(s) is based on locally prevailing rates or charges and includes reasonable costs of operation.
2. The CCBHC has written policies and procedures describing

eligibility for and implementation of the sliding fee discount schedule and are applied equally to all persons seeking services.

2.d.3. The CCBHC must have policies/protocols addressing services for those who do not live close to or within the CCBHC service area.

1. The CCBHC must provide, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of the person requesting service's area of residence.
2. The CCBHC has protocols that address management of the person receiving service's on-going treatment needs beyond crisis services. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track persons seeking non-crisis services to the CCBHC or other clinics serving the person's area of residence.

2.d.4. Persons seeking services are considered for services without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, intellectual and/or developmental disability, IQ score, or physical disability.

Program Requirement 3: Care Coordination

3.A: General Requirements of Care Coordination

3.a.1 The Certified Community Behavioral Health Clinic (CCBHC) must establish care coordination partnerships with community partners, including inpatient and outpatient physical and behavioral health care providers and non-medical services and supports. The CCBHC must have written protocols establishing care coordination expectations with local physical health providers, substance use disorder providers, inpatient and residential providers, emergency department, Veteran's Affairs or other veteran services providers, Indian Health service youth regional treatment centers, Fidelity Wraparound providers (if not offered by the CCBHC), and other community providers offering services/supports in the service area, including those serving children, youth, and families.

3.a.2 In accordance with the person receiving services' preference, the CCBHC must provide services/supports to assist persons and families in gaining access to and maintaining resources, including but not limited to: Medicaid, Social Security benefits, general assistance, Supplemental Nutrition Assistance Program (SNAP), vocational rehabilitation, and housing.

3.a.3 The CBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.

3.a.4 The CCBHC coordinates with systems serving children, youth, and families, including criminal and juvenile justice and child welfare.

3.a.5 The CCBHC has procedures to coordinate care in collaboration with the family/caregiver of the person receiving services.

3.a.6 When a person continuing to receive services from the CCBHC is referred to an external provider for a service~~s~~ outside of the scope of the CCBHC, the CCBHC must assist the person or their guardian in obtaining an appointment; document attempts to confirm the outcome of the referral within the client record; acquire a release of information, as needed for ongoing coordination of care with external partner; and document within the client record ongoing care coordination, including but not limited to, records requests, consultation requests, and other coordination services as applicable.

3.a.7 When a CCBHC is unable to serve a person, due to a need for specialized or intensive care outside of the CCBHC's scope or capability or by the person's choice, the CCBHC must provide a referral and document in the client's record follow-up with the referred provider or the person attempting to confirm that the person seeking services is established in care. Coordination of care remains the responsibility of the CCBHC until the person has established care with the referred provider or the person disengages from participation.

3.a.8 CCBHC agreements for care coordination do not limit the freedom of a person receiving services to choose their provider within the CCBHC, its DCOs, or an unaffiliated entity. People receiving services are not required to provide a reason for choosing or changing any provider.

3.a.9 Before prescribing medications, the CCBHC must document attempts to determine any medications prescribed by other providers, including consulting the Prescription Drug Monitoring Program. With consent, the CCBHC must provide this information to external providers to the extent necessary for safe and quality care.

3.a.10 The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA, 42 CFR Part 2, requirements specific to minors, and other privacy and confidentiality requirements of state or federal law addressing care coordination and in interactions with the DCOs.

3.a.11 The CCBHC has procedures to coordinate care for medication reconciliation with other providers.

3.a.12 The CCBHC obtains 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.

3.a.13 If the CCBHC is unable to obtain consent for any care coordination activity specified in Program Requirement 3, attempts to do so are documented and revisited periodically.

3.a.14 A referral to Fidelity Wraparound must be offered to eligible youth enrolled in CCBHC at the time of entry and throughout enrollment in services as applicable.

1. If a youth is enrolled in Fidelity Wraparound, the Wraparound Care Coordinator must continue to provide care coordination for the youth/young adult during the time they are enrolled in the CCBHC.
2. If the youth is a participant in Fidelity Wraparound, the CCBHC team may be included in the regular scheduled Wraparound meeting. The CCBHC provider must ensure that all CCBHC documentation requirement are met.

3.B: Care Coordination Agreements

3.b.1 The CCBHC must have written protocols establishing care coordination expectations with Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), health departments, and/or other primary care providers. Written protocols include:

1. Procedures for sharing relevant treatment information such as treatment related to the screening and monitoring of physical health conditions, in accordance with individual preferences
2. Coordination of screening monitoring physical health conditions, including lab work
3. Documented follow-up in client record after referrals are provided

3.b.2 The CCBHC must have written protocols establishing care coordination expectations for the following SUD providers as applicable to the CCBHC's service area and scope of services: Opioid treatment programs, medical withdrawal management facilities and providers, and tribally operated mental health and SUD providers. Written protocols include:

1. Procedures for transitioning individuals between levels of care, including provision of peer services or other supports
2. Sharing relevant treatment information such as prescriptions, in accordance with individual preference
3. Follow-up procedures after discharge from higher levels of care
4. A plan for suicide prevention and/or overdose prevention plan (if clinically indicated)

3.b.3 The CCBHC must have written protocols establishing care coordination expectations with emergency departments, inpatient psychiatric facilities, acute care hospitals, residential SUD treatment, and children and youth psychiatric residential treatment facilities. Written protocols include:

1. Tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged
2. Transfer of health records of services received (including prescriptions), in accordance with individual preference
3. Active follow-up after discharge
4. A plan for suicide prevention and safety and/or overdose prevention (as clinically indicated)
5. A plan for provision of peer support services or other supports to help facilitate transition of care
6. A plan to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge
7. The CCBHC receives notification of relevant inpatient and outpatient facilities through EDIE/Collective Platform, for people receiving CCBHC services

3.b.4 The CCBHC must have written protocols establishing care coordination expectations with Veteran Affairs medical centers, independent clinics, drop-in centers, other facilities of the Department of Veterans Affairs, or other community services and/or providers serving members of the U.S. Armed Forces and Veterans. Written protocols include:

1. Processes for identifying/assigning the Principle Behavioral Health Provider and acquiring necessary documentation to coordinate with the Principle Behavioral Health Provider
2. Processes for sharing information in accordance with the person receiving services
3. Protocols for tracking referrals.

3.b.5 The CCBHC must have written protocols establishing care coordination expectations with community partners. Written protocols identify referral processes, sharing of treatment in accordance with the preferences of person being served by the CCBHC, on-going care coordination, and other relevant care coordination needs as applicable to each partner. Required community partners (as available within service area) are:

1. Schools
2. Child welfare agencies
3. Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
4. Indian Health Service youth regional treatment centers
5. State licensed and national accredited child place agencies for therapeutic foster care services
6. Fidelity Wraparound (if CCBHC is not a Fidelity Wraparound provider)
7. Local Intellectual/Developmental Disabilities Departments
8. Shelters and housing services providers

3.C: Treatment Team

3.c.1. The CCBHC must designate an interdisciplinary team responsible for cooperatively supporting the needs of the person receiving CCBHC services, as appropriate and desired, in a culturally and linguistically appropriate manner.

3.c.2. The interdisciplinary treatment team is responsible for directing, coordinating, and managing care and services.

3.c.3. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of people receiving services, including traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.

Program Requirement 4: Scope of Services

4.A: General Service Provisions

4.a.1. CCBHCs must ensure access to nine required services: crisis services; screening, assessment, and diagnosis; service planning; outpatient mental health and substance use disorder services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer-delivered services; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

1. CCBHCs must provide directly the following services: outpatient mental health and substance use disorder services; crisis services, except for mobile crisis; screening, assessment, and diagnosis; and service planning.
2. CCBHCs may enter into an agreement with a designated collaborating organization (DCO) for mobile crisis services, outpatient primary care screening and monitoring, targeted case management, psychiatric rehabilitation, peer-delivered services, and intensive community-based outpatient care for members of the U.S. Armed Forces and veterans.

4.a.2. All CCBHC services must be provided in a manner aligned with the requirements of Section 2401(a) of the Affordable Care Act, including, but not limited to, being person- and family-centered, developmentally appropriate, and culturally and linguistically responsive.

4.a.3. CCBHCs must practice measurement-based care.

1. This must include regular measurement of symptoms, function, patient experience of treatment, and/or clinician relationships.
2. This data must be used to inform treatment decisions and promote patient-centered, responsive care.

APA.org: Measurement-Based Care – Recommended Readings and Resources

4.a.4. The CCBHC provides services that are person and family centered; recovery oriented; respectful of the needs, preferences, and values of the person receiving CCBHC services; and ensure both involvement of the person receiving CCBHC services and self-direction of the services received.

4.a.5. CCBHC services are responsive to the to race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography, and social class of the person receiving CCBHC services and are culturally, linguistically, and ethnically appropriate, as indicated in the needs assessment. 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.

4.a.6. The CCBHC provides, or makes available through a formal arrangement, traditional practices and treatment.

4.a.7. Services address culturally sensitive requirements for care provided to active-duty service members or veterans.

4.a.8. The services that the CCBHC provide for children, youth, and young adults are family-centered, youth-guided, and developmentally appropriate.

4.a.9. The CCBHC must develop grievance procedures in compliance with OAR 309-019-0215 [Grievances and Appeals].

4.a.10. People receiving CCBHC services will be informed of and have access to CCBHC grievance procedures.

4.B: Designated Collaborating Organizations

4.b.1. The relationship between a Certified Community Behavioral Health Clinic (CCBHC) and its designated collaborating organization (DCO) must be established through a contract or other formal, legal written agreement.

4.b.2. A DCO is permitted to provide mobile crisis through a non-fiscal arrangement with the CCBHC. All other DCO agreements must be fiscal arrangements.

4.b.3. The CCBHC retains responsibility for care coordination and is responsible for ensuring access to all required CCBHC services.

4.b.4. DCO-provided services must adhere to all CCBHC requirements for those services and meet the same quality standards as those provided directly by the CCBHC. The DCO must be certified by the Authority for the services it provides on behalf of the CCBHC.

4.b.5. The CCBHC's health IT system must support coordinated care between the CCBHC and its DCOs, including but not limited to, integrating treatment records generated by the DCO into the CCBHC health record.

4.b.6. DCOs must be legally authorized in accordance with federal, state, and local laws and act within the scope of their respective state licenses, certifications, or registrations.

4.b.7. People receiving services from a DCO will be informed of and have access to the CCBHC's existing grievance procedures.

4.b.8. Services received through a DCO must be part of a coordinated package with other CCBHC services and not experienced as if accessing services through another provider organization.

4.b.9. The DCO agreement must reduce administrative burden on people receiving services and their family members when accessing DCO

services.

4.b.10. Nothing about a CCBHC's agreements with their DCO(s) can limit the freedom of a person receiving services to choose their provider within the CCBHC, its DCOs, or any other provider.

4.b.11. The CCBHC must ensure that all standard privacy and confidentiality requirements are met, including obtaining consent from people receiving services from a DCO.

4.b.12. Metrics, quality measures, and reporting required of CCBHCs may relate to services that persons receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data upon creation of the relationship with DCOs.

4.C: Crisis Behavioral Health Services

4.c.1. CCBHCs must provide mobile crisis services directly or through a designated collaborating organization in accordance with OAR 309-072-0140. The CCBHC or DCO must be certified to Chapter 309, Division 72 [Mobile Crisis Intervention Services and Stabilization Services].

4.c.2. CCBHCs must directly provide crisis stabilization services in accordance with OAR 309-019-0105(53), which must include, at minimum, walk-in mental health and substance use disorder services for voluntary individuals. Walk-in services 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.

4.c.3. For children and families in crisis, CCBHCs must provide crisis stabilization services directly or through a designated collaborating organization in accordance with OAR 309-072-0160.

4.c.4. The CCBHC must provide directly or coordinate 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 in accordance with OAR 309-019-0300 through OAR 309-019-0305.

4.c.5. Ideally, crisis stabilization services are available to persons of any level of acuity, whether the person presents on their own, with a concerned person, such as a family member, or with a human service worker and/or law enforcement in accordance with state and local laws, however, facilities need not manage the highest acuity persons in this ambulatory setting. CCBHCs must have procedures in place for minors presenting in crisis without a caregiver/guardian.

4.c.6. Crisis services include suicide prevention, intervention, and postvention 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 person is medically stable.

4.c.7. CCBHCs provide overdose prevention activities, including making available naloxone.

4.c.8. The CCBHC educates persons served by the CCBHC about crisis planning; psychiatric advanced directives; how to access crisis services, including the 988 Suicide & Crisis Lifeline and other area hotlines and warmlines; and overdose prevention.

4.c.9. The CCBHC must create, maintain, and follow crisis plans to prevent and de-escalate future crisis situations, in conjunction with the person receiving services following a psychiatric emergency or crisis.

4.c.10. 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.

4.c.11. Protocols are established for CCBHC staff to address the needs of

CCBHC people receiving services in psychiatric crisis who come to emergency departments.

4.c.12. The CCBHC has policies or procedures in place requiring communication to the public of the methods for providing a continuum of crisis prevention, response, and postvention services.

4.c.13. The CCBHC has an established protocol specifying the role of law enforcement during the provision of crisis services.

4.c.14. Protocols with law enforcement are in place to reduce delays for initiating services during and following a behavioral health crisis.

4.D: Behavioral Health Screening, Assessment, and Diagnosis

4.d.1. The Certified Community Behavioral Health Clinic (CCBHC) must directly provide screening, assessment, and diagnosis, including risk assessment for behavioral health conditions.

1. When specialized screening, assessment, or diagnostic services outside of the scope of the CCBHC are required, the CCBHC must refer the person receiving services to an appropriate provider to receive these services.

4.d.2. All persons requesting CCBHC services must be asked whether they have ever served in the US military or are a caregiver or family member of someone who has served in the US military.

4.d.3. Screening, assessment, and diagnosis are conducted in a timeframe 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.

4.d.4. CBHCs are encouraged to conduct an initial evaluation for all people seeking services, but an initial evaluation is not required to begin providing services if all information required in the initial evaluation is gathered during a comprehensive evaluation at a later time.

4.d.5. An initial evaluation must conform to all requirements in OAR 309-

019-0135 [Entry and Assessment].

4.d.6. All people receiving CCBHC services receive a comprehensive evaluation. The comprehensive evaluation should, in a manner consistent and appropriate for the person's presenting circumstances and symptomology, gather information that is commensurate with the complexity of their specific needs and prioritize the preferences of people receiving services with respect to the depth of evaluation and their treatment goals.

4.d.7. The comprehensive evaluation conforms to all requirements in OAR 309-019-0135 [Entry and Assessment]. The comprehensive evaluation must include:

1. An overview of relevant social supports; social determinants of health and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. For children and youth receiving services, assessment of education needs and supports and assessment of systems involvement, such as child welfare and juvenile justice. Necessary referrals are provided to social services when clinically indicated.
2. 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.
3. Pregnancy and/or parenting status.
4. 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.
5. Relevant medical history and major health conditions that impact current psychological status. 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.
6. A medication list including prescriptions, over-the counter

medications, herbal remedies, and dietary supplements.

7. Allergies including medication allergies.
8. An exam that includes current mental status and basic cognitive screening for cognitive impairment.
9. Mental health, including depression screening, and other tools that may be used in ongoing measurement-based care.
10. Substance use disorders, including tobacco, alcohol, and other drugs, and problem gambling and/or gaming.
    a. If screener identifies unhealthy alcohol or substance use, a developmentally appropriate brief intervention should be provided, and a full assessment and treatment offered.
11. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services, including preferences regarding the use of technologies such as telehealth/telemedicine.

4.d.8. Screening and assessments conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program metric reporting requirements. The CCBHC should not take non-inclusion of a specific metric as a reason not to provide clinically indicated behavioral health screening or assessment. Required screenings per metric reporting requirements are:

1. PHQ-9 for persons receiving services 12 years and older with a diagnosis of depression (Depression Remission Six Months)
2. Validated depression screener for children and youth 12-17 and adults 18+ (Screening for Clinical Depression and Follow-Up)
3. AUDIT, AUDIT-C, or the Single Question Screening for adults (Unhealthy Alcohol Use: Screening and Brief Counseling)
4. Validated social determinants of health screener identifying needs related to food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (Screening for Social Drivers of Health)

4.d.9. The CCBHC uses standardized and validated screening and assessment tools appropriate for the person.

4.E Service Planning

4.e.1. CCBHCs must directly provide service planning. The CCBHC must develop a personalized, integrated service plan that addresses the person's prevention, medical, and behavioral health needs, as clinically appropriate.

4.e.2. The service plan conforms to all requirements in Chapter 309, Division 19, OAR 309-019-0140 [Service Plan and Service Notes] and OAR 309-019-0115 [Individual Rights].

4.e.3. Service planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services or their family if appropriate.

4.e.4. The service plan must be an integrated plan addressing the full breadth of behavioral health needs for the person receiving services, including both mental health and substance use services if clinically indicated, in the least restrictive setting possible.

4.e.5. The CCBHC seeks consultation where appropriate during service planning (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking.

4.e.6. All necessary releases of information are obtained and included in the health record as a part of the development of the initial service plan.

4.e.7. 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.

4.e.8. When a person receiving services is a veteran, verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

4.F: Outpatient Mental Health and Substance Use Services

4.f.1. The Certified Community Behavioral Health Clinic (CCBHC) must directly provide outpatient behavioral health care, including mental health care, substance use disorder services, and psychopharmacological treatment.

1. The CCBHC must provide evidence-based practices and/or promising practices for treating behavioral health conditions.
2. Substance use disorder treatment and services must be provided as described in ASAM Level 0.5, 1 and 2.1 in accordance with OAR 309-019-0181 [Early Intervention ASAM Level 0.5], OAR 309-019-0182 [Outpatient Substance Use Disorder Services ASAM Level 1] and OAR 309-019-0183 [Intensive Outpatient Substance Use Disorder Services ASAM Level 2.1].
3. Outpatient substance use disorder services must include treatment of tobacco use disorders.

4.f.2. The CCBHC must provide a developmentally appropriate evidence-based or promising practice for each of the following categories: Suicide prevention; trauma; families; early childhood and youths; young adults; older adults; psychosis; intellectual and developmental disabilities; substance use disorder; physical health and chronic disease management; psychiatric rehabilitation; supported employment; supportive housing; peer support services; and culturally specific care.

4.f.3. Promising or evidence-based services are delivered by staff trained in treating the specific population being served.

4.f.4. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental health 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.

4.f.5. When a specialist provider is not available to provide direct care to a person receiving CCBHC services, the CCBHC clinicians may consult with appropriate specialists for highly specialized treatment needs.

4.f.6. The CCBHC provides or makes available through a formal arrangement traditional practices or treatment as appropriate for the people receiving services served in the CCBHC area.

SAMHSA: Evidence-Based Practices Resource Center

(Please note, clinics are not restricted to the practices included on this site)

4.G: Outpatient Clinic Primary Care Screening and Monitoring

4.g.1. CCBHCs must provide directly or through a designated collaborating organization ongoing monitoring of health conditions as clinically indicated for the person receiving services, including but not limited to:

1. Ensuring people receiving services have access to primary care services
2. Ensuring ongoing, periodic laboratory testing and measurement of physical 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
4. Promoting healthy lifestyle behaviors

4.g.2. The medical director must establish organizational protocols to ensure that screenings for common physical health conditions are provided. Established protocols must conform to screening recommendations with scores of A and B of the United States Preventive Services Task Force Recommendations for the following conditions:

1. HIV and viral hepatitis

2. Primary care screening pursuant to CCBHC metric reporting requirements:
    a. Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
    b. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
3. Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the medical director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population

4.g.3. Screening protocols must include:

1. Identifying people receiving services with chronic diseases. Screening is permitted to include self-report. Chronic diseases to screen for include but are not limited to:
    a. Diabetes/pre-diabetes
    b. Cardiovascular disease
    c. COPD/Asthma
    d. Chronic pain
    e. HIV/Hepatitis
2. Ensuring that people receiving services are asked about physical health symptoms
3. Establishing systems for collection and analysis of laboratory samples

4.g.4. The CCBHC must 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. CCBHCs are encouraged to collect biological samples onsite. CCBHCs who refer persons receiving services offsite for collection of biological samples must provide transportation or coordinate transportation, according to the preferences of the person receiving services.

4.g.5. The CCBHC must 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 lab tests that address the health conditions included in the CCBHCs screening and monitoring protocols.

4.H: Targeted Case Management Services

4.h.1. CCBHCs must directly or through a designated collaborating organization provide targeted case management services in accordance with Oregon Administrative Rules Chapter 410, Division 138.

4.h.2. Targeted case management must provide an intensive level of support that goes beyond the care coordination expectations of CCBHCs.

4.h.3. Targeted case management services must assist people receiving services in sustaining recovery, and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports.

4.h.4. Targeted case management must include supports for people deemed at high risk of suicide or overdose, particularly during times of transition, such as changing treatment levels or environments or leaving a carceral setting; persons receiving services with complex or serious mental health or substance use conditions; and persons receiving services who have a short-term need for support in a critical period, such as an acute episode or while experiencing houselessness.

4.I: Psychiatric Rehabilitation Services

4.i.1. The CCBHC must directly or through a designated collaborating organization provide rehabilitation services for mental health and substance use disorders.

4.i.2. Psychiatric rehabilitation services must support people receiving services in participating in supported education or other educational services; achieving social inclusion and community connectedness; participating in medication education, self-management, and/or individual and family psychoeducation; and finding and maintaining safe and stable housing.

4.i.3. Psychiatric rehabilitation services must include supportive employment programs.

4.i.4. employment programs must be designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment.

4.J: Peer-Delivered Services

4.j.1. The Certified Community Behavioral Health Clinic (CCBHC) must provide peer-delivered services directly or through a designated collaborating organization. Peer-delivered services may be provided by peer support specialists or peer wellness specialists, including youth support specialists and family support specialists, in accordance with OAR 309-019-0125 [Staff Qualifications], or a certified recovery mentor credentialed by the Mental Health and Addiction Certification Board of Oregon (MHACBO).

4.j.2. At minimum, the CCBHC must ensure that peer-delivered services are provided by peer staff who self-identify as currently or formerly receiving mental health services, peer staff who self-identify as currently or formerly receiving substance use services or self-identify as in recovery from a substance use disorder, and youth support or family support specialists.

4.j.3. The CCBHC must that ensure that peer staff have access to a peer-delivered services supervisor.

1. Peer staff must be supervised in accordance with OAR 309-019-0130 [Personnel Documentation, Training, and Supervision], with the exception of OAR 309-019-0130(3)(c)(D), which allows for peer supervision to be provided only *when available*. CCBHCs must ensure that one of the two hours of required monthly supervision to program staff providing direct peer delivered services be provided by a peer-delivered services supervisor, defined as a qualified program staff with at least one year of experience as a peer support specialist or peer wellness specialist in behavioral health services, who is responsible for evaluating and guiding peer staff in the delivery of peer-delivered services and supports. Peer-delivered services supervision may be provided in partnership with a peer-led organization.

4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

4.k.1. The Certified Community Behavioral Health Clinic (CCBHC) must directly or through a designated collaborating organization provide intensive, community-based behavioral health care for Members of the U.S Armed Forces located more than 50 miles or one hour's drive time from a Military Treatment Facility and veterans living more than 40 miles from a VA medical facility or as otherwise required by federal law.

4.k.2. For those affirming current or former service in the U.S. military, CCBHCs either directs them to care or provides care through the CCBHC. Assistance will be provided in the following manner:

1. Current Military Personnel:
    a. 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.
    b. 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.

c. 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.

2. Veterans:

a. Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics).

4.k.3. Every veteran and Member of the U.S. Armed Forces seen for behavioral health services must be assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider must be made clear to the veteran and identified in the health record.

4.k.4. The Principal Behavioral Health Provider ensures that care provided to veterans and Members of the U.S Armed Forces is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including those contained in the

Uniform Mental Health Services Handbook. Additionally, they ensure:

1. Regular contact is maintained with the veteran as clinically indicated, if ongoing care is required.
2. A psychiatrist or other independent prescriber as satisfies the requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles psychiatric medications on a regular basis.
3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity).
4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
5. The treatment plan is revised, when necessary.
6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care.
    a. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures
    a. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the

veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

4.k.5. The CCBHC provides behavioral health services for veterans that are recovery-oriented and adhere to principles in SAMHSA's Working Definition of Recovery, in addition to VHA guidelines. These include clinical guidelines contained in the Uniform Mental Health Services Handbook from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics.

Program Requirement 5: Quality and Other Reporting

5.A: Health Information Systems

5.a.1. The Certified Community Behavioral Health Clinic (CCBHC) must establish and/or maintain a health information technology (IT) system that includes, but is not limited to, electronic health records.

5.a.2. The CCBHC must use its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct quality improvement, quality measurement, and reporting. The CCBHC uses its secure health IT system and related technology tools to conduct activities such as population health management, disparity reduction, outreach, and research.

5.a.3. The CCBHC must use technology that has been certified to current criteria under the ONC Health IT Certification Program to meet the following requirements:

1. Capture health information, including demographic information such as to race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography, and social class (as feasible)
2. Support care coordination by sending and receiving summary of care records
3. 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
4. Provide evidence-based clinical decision support
5. Conduct electronic prescribing

5.B: Data Collection, Reporting, and Tracking

5.b.1. The CCBHC must have the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to:

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
9. Outcomes of people receiving services

5.b.2. CCBHCs must report encounter, clinical outcome, quality data and any other such data as the Authority requires.

5.b.3. The CCBHC collects and reports the following Clinic-Collected quality measures for all people receiving CCBHC services. CCBHCs report quality measures nine (9) months after the end of the calendar year.

Measure	**Steward**
Time to Services (I-SERV)	SAMHSA
Depression Remission at Six Months (DEP-REM-6)	MN Comm Measure
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA
Screening for Social Drivers of Health (SDOH)	CMS
Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)	CMS

5.b.4. The state collects and reports the following State-Collected quality measures for all people receiving CCBHC services. The state reports quality measures 12 months after the end of the calendar year.

Measure	Steward
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)	NCQA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	NCQA
Plan All-Cause Readmissions Rate (PCR-AD)	NCQA
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA
Antidepressant Medication Management (AMM-BH)	NCQA
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	NCQA
Children and Adolescents on Antipsychotics (APP-CH)	NCQA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA

5.C: Continuous Quality Improvement (CQI) Plan

5.c.1. The CCBHC must develop, implement, and maintain a continuous quality improvement (CQI) plan for the services provided. The CQI plan must include explicit actions to identify, track and improve outcomes for populations facing health inequities.

5.c.2. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that improves the quality and timeliness of services.

5.c.3. 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.c.4. The CQI plan includes an explicit focus on improving outcomes and

services for those who experience health inequities due to race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography, and social class. The CQI addresses how the CCBHC uses disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health inequities.

5.c.5. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance.

5.c.6. The CQI plan is data-driven, incorporating quantitative and qualitative data. The CQI plan addresses how the CCBHC reviews 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
5. At least one Key Performance Indictor (KPI) identified in the Community Needs Assessment.
6. At least one measure from the clinic's chosen measurement-base care tool.
7. Clinic-Collected Quality Measures

Program Requirement 6: Organizational Authority and Governance

6.A: General Requirements of Organizational Authority and Finances

6.a.1. The Certified Community Behavioral Health Clinic (CCBHC) must have an independent financial audit 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.

6.a.2. To the extent the CCBHC is not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, the CCBHC has reached out to such entities within their geographic service area and offered arrangements with those entities to assist in the provision of services to tribal community members and to inform the provision of services to tribal community members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities, as a whole, satisfy the requirements of these criteria.

6.B: Governance

6.b.1. CCBHC governance must be informed by representatives of persons being served by the CCBHC in terms of geographic area, race, ethnicity, language, immigration status, sexual orientation, sex, gender identity, disability, age, social class, and in terms of health and behavioral health needs. The CCBHC must 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.

6.b.2. To ensure governance is informed by representatives of the persons being served by the CCBHC, the CCBHC must:

1. Option 1: Have a governing board with 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.
    a. No more than one half (50 percent) of governing board members may derive no more than 10 percent of their income from the health care industry.
2. Option 2: Or the CCBHC must have an advisory board or other approach approved by the Oregon Health Authority. 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 in identifying community needs, goals, and objectives of the CCBHC; service development; quality improvement; fiscal and budgetary decisions; and governance (human resource planning, leadership recruitment and selection, etc.).
    a. The governing board must establish protocols for incorporating input from individuals with lived experience and family members.
    b. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement are entered into the formal board record.
    c. A member or members of the alternate arrangement must be invited to board meetings.
    d. 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.
    e. The CCBHC provides staff support for posting an annual summary of the recommendations from the alternate arrangement on the CCBHC website.

6.b.3. Members of the governing board or advisory boards must be selected for 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.

Definitions

1) "Access facility" means an outpatient setting owned and operated by a CCBHC and subject to approval by the Authority that provides low barrier services that facilitate engagement and access to care within the scope of CCBHC. Access facilities offer unscheduled, voluntary services.

2) "Authority" means the Oregon Health Authority.

3) "Applicant" means an organization seeking certification as a Certified Community Behavioral Health Clinic.

4) "ASAM" means the American Society of Addiction Medicine (OAR 309-019-0105(8)). ASAM Levels of Care 0.5 (Early Intervention), 1 (Outpatient Substance Use Disorder Services), and 2.1 (Intensive Outpatient Substance Use Disorder Services) refer to discrete intensities of services and supports within a substance use disorders program, as described in The ASAM Criteria, Third Edition (OAR 309-019-0105(14)(a-c)).

5) "CCBHC directly provides" means the employees or contract employees within the management structure and, under direct supervision of the CCBHC deliver services.

6) "Certification" means the process which the Authority uses to determine if a practice has met the criteria in the document titled "Oregon Certified Community Behavioral Health Clinic (CCBHC) Program Requirements" found on the Oregon CCBHC website.

7) "Certified" means that the Authority has affirmed that an organization substantially meets the Oregon Certified Community Behavioral Health Clinic (CCBHC) Program Requirements."

8) "Certified recovery mentor" means a person who is in recovery from substance use dependence, has met the necessary training and additional requirements, and holds a credential through the Mental Health and Addiction Certification Board of Oregon (MHACBO) to provide peer-

delivered services.

9) "Community mental health program (CMHP)" means an entity that is responsible for planning and delivery of safety net services for persons with behavioral health conditions in a specific geographic area of the state under a contract with the Authority or a local mental health authority and pursuant to OAR Chapter 309, Division 14.

10) "Crisis stabilization services" means providing evaluation and treatment to individuals experiencing a crisis. Crisis services may be provided prior to completion of an intake. These services are intended to stabilize the individual in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available (OAR 309-019-0105(53)).

11) "Culturally responsive" means services that are respectful of and relevant to the beliefs, practices, cultures, and linguistic needs of diverse populations and communities whose members identify as having particular cultural or linguistic affiliations. Cultural responsiveness describes the capacity to respond to the issues of diverse communities and requires knowledge and capacity at different levels of intervention: systemic, organizational, professional, and individual (OAR 309-019-0105(55)).

12) "Designated collaborating organization" is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship to deliver one or more of the required services.

13) "Evidence-based practices" means significant and relevant practices based on scientifically-based research (OAR 309-072-0110(4)). Evidence-based practices can be found at the Substance Abuse and Mental Health Services Administration's (SAMHSA) Evidence-Based Practices Resource Center, however, clinics are not restricted to the practices included on these sites.

14) "Family support" means the provision of peer-delivered services to people defined as family to the individual (OAR 309-019-0105(68)).

15) "Family support specialist" means a peer support specialist or a peer wellness specialist who, based on similar life experiences, provides support services to and has experience parenting a child who is a current or former consumer of mental health or addiction treatment or who is facing or has faced difficulties in accessing education, health, or wellness services due to mental health or behavioral health barriers (OAR 950-060-0010(10)).

16) "Fidelity Wraparound" means a voluntary and definable care planning process that results in a unique set of community services and supports individualized for a youth and family to achieve a positive set of outcomes (OAR 309-019-0162(16)). A "Wraparound provider" is a certified entity that hires and trains staff to provide coordination and facilitation of Fidelity Wrapround for youth and families (OAR 309-019-0162(21)). The "Wraparound care coordinator" is a member of the Wraparound team specifically trained to coordinate and facilitate the components of a Wraparound team meeting for an individual family (OAR 309-019-0162(17)).

17) "Measurement-based care" means an evidence-based practice using systematic and routine assessment of the person's receiving services perspective through self-reported progress and outcome measures. This can include regular measurement of symptoms and functioning, as well as person's experience of treatment and clinician relationship. This data is used to inform treatment decisions and promotes person-centered, responsive care.

18) "Memorandum of Understanding (MOU)" means an agreement between two parties that is not legally binding, but which outlines the responsibilities of each of the parties to the agreement (OAR 309-072-0110(7)).

19) "Mental Health and Addiction Certification Board of Oregon (MHACBO)" means a board with the mission of certifying behavioral health professionals through competency-based evaluation of education, experience, and exams, the primary purpose of which is an assurance that behavioral health workers have met minimum standards of competence, are ethically accountable to the general public at-large, and have

contemporary knowledge evidenced through continuing education.

20) "Mobile crisis services" means mental health services for individuals in crisis provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration (OAR 309-019-0105(102)).

21) "Oregon CCBHC website" means http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Community-BH-Clinics.aspx.

22) "Peer" means program staff supporting an individual or the individual's family member who has similar life experience, either as a current or former recipient of substance use, problem gambling, or mental health services, or as a family member of an individual who is a current or former recipient of substance use, problem gambling, or mental health services (OAR 309-019-0105(113)).

23) "Peer-delivered services" are community-based services and supports provided by peers, peer support specialists, and peer wellness specialists to individuals or family members with similar lived experience. These services are intended to support individuals and families to engage individuals in ongoing treatment and to live successfully in the community (OAR 309-019-0105(114)).

24) "Peer-delivered services supervisor" means qualified program staff, with at least one year of experience as a peer support specialist (PSS) or peer wellness specialist (PWS) in behavioral health services, who is responsible for evaluating and guiding PSS and PWS program staff in the delivery of peer-delivered services and supports (OAR 309-019-0105(115)).

25) "Peer support specialist" means a qualified program staff providing peer-delivered services to an individual or family member with similar life experience under the supervision of a qualified clinic supervisor and a

qualified peer-delivered services supervisor (OAR 309-019-0105(116)).

26) "Peer wellness specialist" means program staff who support an individual in identifying behavioral health service and support needs through community outreach, assisting individuals with access to available services and resources, addressing barriers to services, and providing education and information about available resources and behavioral health issues in order to reduce stigma and discrimination toward consumers of behavioral health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness under the supervision of a qualified clinical supervisor and a qualified peer-delivered services supervisor (OAR 309-019-0105(118)).

27) "Postvention" means an organized response in the aftermath of a suicide to accomplish any one or more of the following: facilitate the healing of individuals from the grief and distress of suicide loss, mitigate other negative effects of exposure to suicide, and/or prevent suicide among people who are at high risk after exposure to suicide (Suicide Prevention Resource Center and Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines)

28) "Program director" means program staff with appropriate professional qualifications and experience who is designated to manage the operation of a program (OAR 309-019-0105(123))

29) "Promising practice" means a practice, an approach, a tool, or a training that demonstrates, based on preliminary information, potential for becoming an evidence-based practice (OAR 309-072-0110(11)).

30) "Satellite facility" means a facility owned and operated by the CCBHC that does not provide all required CCBHC services, but does provide, at minimum: Crisis services, except mobile crisis; screening, diagnosis, and risk assessment; service planning; and outpatient mental health and substance use services.

31) "Site Improvement Plan (SIP)" means a written plan, using the provided template on the CCBHC website, which addresses deficiencies to CCBHC

requirements. The SIP must address steps the applicant is taking to become compliant, a timeframe in which compliance will be achieved, and supports needed to achieve compliance.

32) "Traditional health worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon (OAR 950-060-0010(19)).

33) "Trauma informed care/services" means services that reflect the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health, substance use, or problem gambling services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services (OAR 309-019-0105(162)).

34) "Trauma-informed design" means integrating the principles of trauma-informed care into design. The goal is to create physical spaces that promote safety, well-being, and healing (Trauma-Informed Design Society).

35) "Youth support specialist" means either a peer support specialist or a peer wellness specialist who, based on a similar life experience, provides supportive services to an individual who is not older than 30 years old and is a current or former consumer of mental health or addiction treatment or is facing or has faced difficulties in access education, health, and wellness services due to mental health or behavioral health barriers (OAR 950-060-0010(22)).