

## Oregon Standards for Certified Community Behavioral Health Clinics (CCBHCs)

[Senate Bill 832](#) directed the Oregon Health Authority (OHA) to develop standards for “achieving integration of behavioral health services and physical health services in Patient-Centered Primary Care Homes (PCPCH) and Behavioral Health Homes (BHH).” OHA relied upon the expertise of the [PCPCH Standards Advisory Committee](#) (committee) to advise in the development of integration standards. The committee developed [BHH](#) model with over 40 specific measures that provides a framework for integrating physical health services into behavioral health care settings. At this time there is no BHH recognition from the state akin to PCPCH recognition. Therefore, to align this work with the CCBHC demonstration, **organizations applying to become a CCBHC in Oregon must meet 9 Oregon Standards for CCBHCs which have adapted from the BHH model in addition to the federal CCBHC standards.**

1. **Telephone and Electronic Access** - CCBHC provides continuous access to behavioral health advice by telephone.
2. **Performance and Clinical Quality** – CCBHC tracks one quality metric from the core or menu set of PCPCH Quality Measures. See appendix for list of measures.
3. **Provision of Services** – CCBHC reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation.
4. **Coordination and Integration with Primary Care** – CCBHC has primary care services onsite at least 20 hours a week and has a process to insure patients can access primary care services during the hours onsite primary care is not available.
5. **Organization of CCBHC Information** – CCBHC maintains a health record for each consumer that contains at least the following elements: problem list, medication list, medication list, allergies, basic demographic information, preferred language, and updates this record as needed at each visit.
6. **Specialized Care Setting Transitions**- CCBHC has a written agreement with its usual hospital providers or directly provides routine hospital care.
7. **Care Coordination** – CCBHC demonstrates that members of the health care team have defined roles in care coordination for consumers and tell each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care.
8. **End of Life Planning** – CCBHC has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from them.
9. **Language and Cultural Interpretation** – CCBHC offers and/or uses either providers who speak a consumer’s and family’s language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice.

## **1. Telephone and Electronic Access** - CCBHC provides continuous access to behavioral health advice by telephone.

### **Intent**

Access to behavioral health advice outside of in-person office visits is an important Certified Community Behavioral Health Clinic function associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that CCBHC consumers, caregivers and families can obtain behavioral health advice via telephone from a live person at all times.

### **Specifications**

To meet this standard the CCBHC must have 24 hour a day, 7 days a week access to a live person via telephone for behavioral advice for all consumers of the clinic. Clinic must have documented policy and procedures, including provider expectations for workflow and EHR access (if applicable) to ensure all after hours telephone encounters are documented in the EHR or paper chart within 24 hours of the call. It is not required that the person receiving the call or giving clinical advice has real-time access to the consumer's medical record, although this would be ideal.

### **Examples**

Practice strategies meeting the intent of this standard:

- Business and after-hours phone calls answered by a live person and referred to a behavioral health clinician for clinical advice as appropriate.
- Business and after-hours phone calls answered by an on-call provider
- Business and after-hours phone calls answered by a live answering service with triage of appropriate call to an on-call clinician

Practice strategies NOT meeting the intent of this standard:

- Routine use of an answering machine to answer phone calls during or after business hours with no options for patients to access behavioral health advice from a live person.
- Use of an automated message referring patients to the emergency room or an urgent care practice during or after business hours.
- Use of non-clinical staff (e.g. receptionist) to answer phone calls if staff do not have real time access to a clinician as dictated by appropriate protocols.

## **2. Performance and Clinical Quality** – CCBHC tracks one quality metric from the core or menu set of PCPCH Quality Measures.

### **Intent**

Measuring and improving on clinical quality is a foundation element of Certified Community Behavioral Health Clinics. The intent of this standard is to demonstrate the CCBHCs have the capacity to monitor clinical quality data and improve their performance where appropriate.

### **Specifications**

See appendix at end of this document for list of eligible quality measures. Detailed specifications for each measures can be found in the PCPCH Quality Measures section of the [PCPCH Technical Assistance Guide](#). The CCBHC can track any one of the 29 measures listed.

CCBHCs may collect quality data either by querying an EHR or by manual audit of an electronic or paper chart (a chart review). CCBHCs can also use quality measures produced from claims data by a 3<sup>rd</sup> party (IPA, health plan, etc.). CCBHC must aggregate the data across all providers and consumers in the practice.

CCBHCs must use the exact specifications for calculating and reporting their data. When auditing charts manually or by query of an EHR, clinics must include in the sample all eligible patients during the sample period.

**3. Provision of Services** – CCBHC reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation.

**Note:** This standard aligns with CCBHC Program Requirement 4 - Scope of Services with some key differences. CCBHC standards requires that clinics either directly provide these services or provide them through referral with relationships with other providers, while the BHH standard, as currently written, require the clinic to directly provide the services listed. Another difference is that the CCBHC criteria include additional services not required by the BHH standard such as provision of substance use services, crisis mental health services, peer support and counselor services, etc.

**4. Coordination and Integration with Primary Care** – CCBHC has primary care services onsite at least 20 hours a week and has a process to insure patients can access primary care services during the hours onsite primary care is not available.

**Intent** – Many Oregonians with a behavioral health condition are not accessing primary care services. Integrating behavioral health with primary care opens the door to both physical and behavioral health care in a setting that is familiar to a person with a behavioral health condition. A consumer that chooses a Certified Community Behavioral Health Clinic as their “home” should have all their healthcare needs provided at that home.

To meet this standard, there needs to a high level of collaboration and integration between behavioral health and primary care providers. The behavioral health and physical health providers function as a team with frequent personal communication. The team actively seeks system solutions as it recognizes the barriers to care integration for a broader range of consumers. Providers understand the different roles team members need to play and have started to change their practice and structure of care to achieve consumer goals. Consumers view the operation as a single health system treating the whole person. (From Center for Integrated Health Solutions)

Collaboration and integration is defined in the AHRQ lexicon for behavioral health and primary care as the integration as a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

**Specifications** – CCBHC has primary care providers (PCP) onsite at least 20 hours a week offering services for physical health, disease prevention and treatment. PCP can be contracted. Categories of service should include:

- Acute care for minor illnesses and injuries
- Ongoing management of chronic diseases including coordination of care
- Office based procedures and diagnostic tests
- Patient education, prevention and wellness support services
- Care management, understood as individualized, person-centered planning and coordination to increase consumer participation and follow-up with all PC screening, assessment and treatment services

Rural clinics with critical access shortages may be able to substitute a portion of the required 20 hours of on-site primary care using telehealth. Please contact the program for more information.

CCBHC must demonstrate evidence of collaborative provider relationships and care coordination for patients receiving primary care services off-site during hours that primary care providers are not available at the CCBHC.

CCBHC has a registry/tracking system for physical health needs/outcomes.

**Examples:**

Practice strategies meeting the intent of this standard:

- Primary care physician (MD, DO, ND) Physician Assistant (PA), or Medical Nurse Practitioners (NP) are available at least 20 hours a week to provide primary care services.
- CCBHC providers names of primary care providers commonly used by the CCBHC and documentation in the medical record detailing collaboration with these providers such as telephone encounters, discussing particular patients, shared protocols for medical management or regular meeting times.
- Examples of regular two-way communication with these providers in patient charts demonstrating active coordination of patient care.

Practice strategies NOT meeting the intent of this standard:

- BH and PC providers work at separate facilities and have separate communication systems.
- Providers view each other as resources and communicate periodically about shared consumers and it is driven by specific issues or provider's need for specific information about a mutual consumer. (e.g. PCP requests a copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis).
- BH and PC are co-located in the same facility and providers still use separate systems or are starting to use some shared systems. Communication is more regular due to proximity of providers with an occasional meeting to discuss shared consumers. Movement of consumers between practices is most often through a referral process. There is some attempt for BH and PC providers to work as a team but how the team operates is not clearly defined leaving most decisions about consumer care to be made independently by individual providers.

**5. Organization of CCBHC Information** – CCBHC maintains a health record for each consumer that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, and updates this record as needed at each visit.

**Intent**

Certified Community Behavioral Health Clinics must maintain comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as consumers move throughout the health care system. Maintaining a health record with up-to-date information is an essential prerequisite to managing safe transitions of care between providers. This measure does require standardized collection of the above elements, but is not intended to require an electronic health record. CCBHC standards do require clinics to have an electronic health record.

**Specifications**

Clinics must be able to provide examples of all of the required elements and be able to demonstrate a process for how these elements are regularly assessed and updated by practice staff. Documentation of each element must be standardized across all consumer records. Clinics are not expected to calculate the percentage of complete consumer records or demonstrate that every element is complete in each record.

**Examples**

Examples of strategies meeting the intent of this standard include:

- Required elements are located in a consistent place in paper charts or in discrete fields in an EMR.
- Practice has a clear process and demonstrates the above data elements are reviewed and updated regularly (e.g. provider reviews medications at each visit, front desk staff verifies demographic information at check-in)

**6. Specialized Care Setting Transitions-** CCBHC has a written agreement with its usual hospital providers or directly provides routine hospital care.

**Intent**

Care coordination and communication during care transitions is an important aspect of patient safety, especially between inpatient and outpatient care settings. CCBHCs should take responsibility for facilitating appropriate transitions of care by developing working relationships with their usual providers of hospital care.

**Specifications**

Definition of Usual Hospital Providers -The hospital(s) or hospitalist group(s) that most frequently cares for the Certified Community Behavioral Health Clinic’s consumer population when admitted to a hospital or visiting the Emergency Room.

Clinics meeting the intent of this standard must be able to identify the usual providers of hospital care for their consumers (e.g. a specific hospital(s) or hospitalist group(s)) and have a written agreement in place with the usual hospital providers so that the Certified Community Behavioral Health Clinic is notified when consumers are admitted and discharged. Written agreements with usual providers of hospital care should contain the following types of information:

- Process for requesting hospital admission
- Process and performance expectations for communication at the time of hospital admission
- Process for sharing of patient medical records at the time of hospital admission
- Process and performance expectations for communication at the time of hospital discharge
- Process and performance expectations for scheduling after-hospital follow up appointments

Note: CCBHCs that have clinicians providing their own hospital care routinely for clinic patients do not need to have a written agreement in place. However, if a clinic is part of a system that includes a hospital, the clinic must still have a written agreement unless clinicians at the CCBHC clinic provide hospital care routinely for their consumer population.

**7. Care Coordination** – CCBHC demonstrates that members of the health care team have defined roles in care coordination for consumers and tell each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care.

**Intent**

Care coordination is an essential feature of a Certified Community Behavioral Health Clinic. The intent of this standard is to ensure that Certified Community Behavioral Health Clinics deliberately consider care coordination functions, explicitly assign these functions to specific staff members, take extra steps to coordinate the care of consumers with complex care needs and communicate clearly to consumers who they can contact at the clinic to help coordinate their care.

CCBHC must be able to identify person(s) responsible for care coordination, provide a written description of their role/functions and a method for notifying patients of who is responsible for coordinating their behavioral health and primary health care.

**Specifications**

This standard requires both clear assignment of care coordination responsibilities to practice staff and clear communication to consumers about how to obtain these services. All care coordination functions within the practice do not need to be assigned to a single person. Some care coordination activities may be performed by clinical staff (e.g. motivational interviewing, support of behavior change, patient education) while others may be performed by non-clinical staff (follow up on referral and test results). However, consumers should be informed of who is responsible for their coordination needs.

**Examples**

A CCBHC could demonstrate meeting this standard through the following kinds of activities:

- Written job descriptions assigning certain care coordination functions to particular staff
- Demonstration that certain staff members perform care coordination (e.g staff member X maintains a log tracking test results)
- Clear verbal or written instructions are provided to consumers on who to contract to follow-up or obtain needed services.

- 8. End of Life Planning** – CCBHC has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from them.

**Intent**

Arranging for culturally appropriate end-of-life and palliative care is an important aspect of care coordination for consumers, caregivers, and families. This standard is intended to ensure that Certified Community Behavioral Health Clinics engage their consumers, caregivers, and families in end of life discussions, routinely assess consumers’ need and eligibility for hospice or palliative care when appropriate, and refer consumers for these services or coordinate services within the clinic. It is also important for clinics to ensure consumers wishes are documented in advance directive forms available in the consumer’s medical record or through provider orders recorded in the medical record (i.e. POLST) which reflect the consumer’s wishes for their end-of-life care

**Specifications**

POLST – Physician Orders for Life-Sustaining Treatment

CCBHCs are not required to directly provide hospice or palliative care, but must have a process in place to refer and coordinate those service when consumers and families need them.

**Examples**

Activities meeting the intent of this standard could include:

- List of usual referral provider for hospice or palliative care (including admission criteria for these providers) and examples of consumers referred to hospice or palliative care
- Examples of encounters for consumers regarding hospice or palliative care referral
- Examples of hospice or palliative care plans developed or approved by CCBHC providers

- 9. Language and Cultural Interpretation-** CCBHC offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice.

**Intent**

Cultural and linguistic proficiency is a core component of person and family centered care. The intent of this standard is to ensure that Certified Community Behavioral Health Clinics communicate with consumers, caregivers, and families in their language of choice using trained medical interpreters. Further, there is a strong evidence base supporting the benefits of translating written materials.

**Specifications**

Clinics must be able to produce a list of interpreter services used at the clinic and written guidelines for providing services to consumers in the language of their choice.

Interpretation services should be offered either on-site or telephonically for all consumers at the clinic that speak languages other than English and must be provided free of charge to consumers. Interpretation services should be offered and available during the consumers' entire office visit and for telephone encounters. Consumers may decline the use of interpreters, but should be informed that interpreters are available free of charge and have distinct advantages. Some clinics ask consumers who refuse interpretation services to sign a waiver.

**Examples**

The following kinds of activities would meet the intent the standard:

- Use of bilingual staff to communicate with consumers or family members in their language(s) of choice throughout their entire office visit and during telephone encounters.
- Use of a real-time telephonic interpreter (e.g., Passport to Languages, Pacific Interpreters, Language Line Solutions, etc.) to communicate with consumers in their language of choice throughout their entire office visit and/or during telephone encounters.
- Use of an in-person interpreter to communicate with consumers in their language of choice throughout their entire office visit and/or during telephone encounters.

The following kinds of activities would NOT meet the intent the standard:

- Routine use of consumer family members to act as interpreters for non-English speaking patients.
- Interpreter services, providers, or other employees acting as translators, available at some times during clinic business hours, but not available at other times and the clinic does not have a strategy to provide alternative options for interpreter services the times when the employee(s) or services are unavailable and for consumers languages for which the providers or employee(s) cannot offer proficient interpretation.

## Overview of PCPCH Core and Menu Set Quality Measures

<b>Adult Core Quality Measure Set</b>						
<b>Measure #</b>	<b>Source</b>	<b>Measure</b>	<b>UDS (FQHCs)</b>	<b>OHA State Performance Measure</b>	<b>Meaningful Use</b>	<b>Benchmark</b>
1	NQF0421	BMI Screening and Follow-up	X		X	47%
2	NQF0028	Tobacco Use: Screening and Cessation Intervention	X		X	93%
3	NQF0509	Reminder System for Mammograms			X	TBD
4	NQF0032	Cervical cancer screening	X			73%
5	OHA State Performance Measure (NQF 0034)	Colorectal cancer screening	X	X		47%
6	OHA State Performance Measure (NQF 0057)	Comprehensive Diabetes Care: Hemoglobin A1c testing		X		86%
7	NQF0575	Comprehensive Diabetes Care: HbA1c control	X			60%
8	OHA State Performance Measure (NQF 0018)	Controlling High Blood Pressure		X		64%

## Pediatrics Core Quality Measure Set

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
9	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X		X	43%
10	OHA State Performance Measure (NQF0038)	Childhood Immunization Status	X	X		82%
11	NQF0036	Use of Appropriate Medications for People with Asthma	X			91%
12	OHA State Performance Measure (NQF1399)	Developmental screening in the first 3 years of life		X		50%
13	OHA State Performance Measure (NQF 1392)	Well child care (0 – 15 months)		X		77%
14	NQF 1516	Well child care (3 – 6 years)				74%
15	OHA State Performance Measure (CHIPRA Core Measure #12)	Adolescent well-care (12-21 years)		X		53%

## Menu Quality Measure Set<sup>1</sup>

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
16	OHA State Performance Measure (NQF 0418)	Screening for clinical depression		X		25%
17	OHA State Performance Measure (NQF 1517)	Prenatal and Postpartum Care – Prenatal Care Rate		X		69%
18	OHA State Performance Measure (NQF1517)	Prenatal and Postpartum Care – Postpartum Care Rate	X	X		66%
19	OHA State Performance Measure (NQF0002)	Appropriate testing for children with pharyngitis		X		76%
20	NQF0043	Pneumonia vaccination status for older adults				TBD
21	NQF0044	Pneumonia Vaccination				TBD
22	NQF0041	Influenza Immunization				TBD
23	NQF0066, 67,70, 74	Chronic Stable Coronary Disease				NQF 0070, 83%
24	OHA State Performance Measure	Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse		X		13%
25	NQF0061	Comprehensive Diabetes Care: Blood Pressure Control	X			67%
26	NQF0064	Comprehensive Diabetes Care: LCL-C Control	X			40%

<sup>1</sup> Note: Any additional adult or pediatric core measure that a practice tracks can be used as a menu set measure.

27	OHA State Performance Measure (NQF0108)	Follow-up care for children prescribed ADHD medication		X		Initiation: 51% Continuation & Maintenance: 63%
28	OHA State Performance Measure (NQF 1407)	Adolescent immunizations up to date at 13 years old		X		70%
29	OHA State Performance Measure (NQF0063)	Comprehensive Diabetes Care: Lipid LDL-C Screening		X		80%

