Behavioral Health Policies and Procedures Deliverable Evaluation

CCO Name:	
Date of Review:	
Reviewer:	

Behavioral Health Policies and Procedures ***OHA Health Plan Services CCO 2.0 Contract, Exhibit M***		
Category	**Required Components**	**Score**
Behavioral Health Access	**The CCO has written policies and procedures related to timely access to care that address:**	
Exhibit M(1) *OAR 410-141-3515*	1. Members having timely access to care in accordance with 410-141-3515, including Exhibit B, Part 4 of the OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
Comments:		
Integration, Transition, and Collaboration with Partners	**The CCO has written policies and procedures related to integration, transition, and collaboration with partners that address:**	
Exhibit M(3) *OAR 309-019-0275 through OAR 309-019-0295*	2. Ensuring that members who are ready to transition to a community placement are placed in the most integrated setting appropriate for the member.	Y ☐ N ☐
	3. Ensuring that members transitioning to another health care setting are placed consistent with the member's treatment goals, clinical needs, and informed choice.	Y ☐ N ☐
	4. CCO oversight, care coordination, transition planning and management of the behavioral health needs of members to ensure culturally and linguistically appropriate behavioral health services are provided in a way that members are served in the most natural and integrated environment possible and that minimizes the use of institutional care.	Y ☐ N ☐
	5. Engaging with local law enforcement, jail staff and courts to improve outcomes and mitigate additional health and safety impacts for members who have criminal justice involvement related to their behavioral health conditions. Key outcomes include reductions in member arrests, jail admissions, lengths of jail stay and recidivism along with improvements in stability of employment and housing.	Y ☐ N ☐
	6. Working with providers of physical health and behavioral health services in the jail(s) in CCO's service area to ensure timely transfer of appropriate clinical information for members and potential members who have been previously incarcerated and have Enrolled with, or will be Enrolled with CCO, after release from jail. Information shall include but is not be limited to behavioral health diagnoses, level of functional impairment, medications and prior history of services.	Y ☐ N ☐
	7. Providing access to and documents all efforts to provide supported employment services for all adult members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295.	Y ☐ N ☐

Behavioral Health Policies and Procedures *OHA Health Plan Services CCO 2.0 Contract, Exhibit M*		
Category	**Required Components**	**Score**
Comments:		
Referrals, Prior Authorizations, and Approvals	**The CCO has written policies and procedures related to referrals, prior authorizations, and approvals that address:**	
Exhibit M(5) *OAR 410-141-3515*	8. Ensuring members have access to behavioral health screenings and referrals for services at multiple health system or health care entry points.	Y ☐ N ☐
	9. How the CCO does not require prior authorization for outpatient behavioral health services or behavioral health peer delivered services as required in the applicable section of Ex. B, Part 2, Sec. 3, Para., Sub. Para. (6) of the OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
	10. Permitting members, in accordance with Ex. B, Part 2, Sec. 3, Para. b, Sub. Para. (5), to obtain medication-assisted treatment for substance use disorders (SUD), including opioid and opiate use disorders, for up to thirty (30) days without first obtaining prior authorization for payment.	Y ☐ N ☐
	11. Ensuring prior authorization for behavioral health services comply with mental health parity regulations in 42 CFR part 438, subpart K and the requirements set forth in Ex. E, Sec. 22 of the OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
	12. Making a prior authorization determination within three (3) days of a request for non-emergent behavioral health hospitalization or residential care.	Y ☐ N ☐
	13. Not requiring members to obtain approval of a primary care physician in order to access Behavioral Health Assessment and evaluation services. Members shall have the right to refer themselves to behavioral health services available from the provider network.	Y ☐ N ☐
	14. Ensuring members receive services from non-participating providers for behavioral health services if those services are not available from participating providers or if a member is not able to access services within the timely access to care standards in OAR 410-141-3515.	Y ☐ N ☐
	15. The CCO's responsibility for coordinating behavioral health services with non-participating providers.	Y ☐ N ☐
	16. The CCO's responsibility for reimbursing for such services, including those provided outside the state when such services cannot be provided within the timely access to care standards as required under OAR 410-141-3515.	Y ☐ N ☐
Comments:		
Screening Members	**The CCO has written policies and procedures related to referrals, prior authorizations, and approvals that address:**	

Behavioral Health Policies and Procedures *OHA Health Plan Services CCO 2.0 Contract, Exhibit M*		
Category	**Required Components**	**Score**
Exhibit M(6) *OAR 309-019-0135*	17. Using a comprehensive Behavioral Health Assessment tool, in accordance with OAR 309-019-0135, to assist in adapting the intensity and frequency of behavioral health services to the behavioral health needs of the member.	Y ☐ N ☐
	18. Screening members for adequacy of supports for the family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs, and home visiting).	Y ☐ N ☐
	19. Screening members for, and provide, medically appropriate and evidence-based treatments for members who have both mental illness and SUD.	Y ☐ N ☐
	20. Assessing for opioid use disorders for populations at high risk for severe health outcomes, including overdose and death, including pregnant members and members being discharged from residential, acute care, and other institutional settings.	Y ☐ N ☐
	21. Screening members and provide prevention, early detection, brief intervention and referral to behavioral health services in any of the following circumstances: a. At an initial contact or during a routine physical exam. b. At an initial prenatal exam. c. When the member shows evidence of SUD or abuse. d. When the member over-utilizes covered services. e. When a member exhibits a reassessment trigger for Intensive care coordination.	Y ☐ N ☐
Comments:		
Substance Use Disorders	**The CCO has written policies and procedures related to the provision of SUD that address:**	
Exhibit M(7) *OAR 410-141-3585*	22. The provision of SUD services to members, which include outpatient, intensive outpatient, medication assisted treatment including opiate substitution services, and residential, and withdrawal management services, consistent with OAR Chapter 309, Divisions 18, 19 and 22 and Chapter 415, Divisions 20 and 50.	Y ☐ N ☐
	23. Informing all members, using culturally and linguistically appropriate means, that SUD services are covered services consistent with OAR 410-141-3585	Y ☐ N ☐
	24. Providing culturally and linguistically appropriate alcohol, tobacco, and other drug abuse prevention/education and information that reduce members' risk to SUD. CCO's prevention program shall meet or model national quality assurance standards. The CCO shall have mechanisms to monitor the use of its preventive programs and assess their effectiveness on members.	Y ☐ N ☐
	25. Providing culturally and linguistically appropriate SUD services for any member who meets the most current American Society of Addiction Medicine (ASAM) placement criteria for:	Y ☐ N ☐

Behavioral Health Policies and Procedures *OHA Health Plan Services CCO 2.0 Contract, Exhibit M*		
Category	**Required Components**	**Score**
	a. Outpatient, intensive outpatient, residential, withdrawal management, and medication assisted treatment including opiate substitution treatment, regardless of prior alcohol or other drug treatment or education. b. Specialized programs in each service area in the following categories: drug court referrals, Child Welfare referrals, Job Opportunities and Basic Skills ("JOBS") referrals, and referrals for persons with co-occurring disorders.	
	26. Ensuring that specialized, trauma informed, SUD services are provided in environments that are culturally and linguistically appropriate, designed specifically for the following groups: a. Adolescents, taking into consideration adolescent development; b. Women, and women's specific issues; c. Ethnically and racially diverse groups; d. Intravenous drug users; e. Individuals involved with the criminal justice system; f. Individuals with co-occurring disorders; g. Parents accessing residential treatment with any accompanying dependent children; and h. Individuals accessing residential treatment with Medication Assisted Therapy.	Y ☐ N ☐
	27. Providing withdrawal management in a non-hospital facility, where medically appropriate, ensuring all such facilities or programs providing withdrawal management services must have a certificate of approval or license from OHA in accordance with OAR Chapter 415, Division 12.	Y ☐ N ☐
	28. For members receiving SUD services, to the extent of available community resources and as medically appropriate, how the CCO provides information and referral to community services which may include but are not limited to: child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.	Y ☐ N ☐
	29. How the CCO complies with federal confidentiality laws and regulations (42 CFR Part 2) governing the identity and medical/client records of members who receive SUD services, in addition to any other confidentiality requirements described in the OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
Comments:		
Assertive community Treatment	**The CCO has written policies and procedures related to assertive community treatment that address:**	
Exhibit M(8) *OAR 410-141-3515*	30. Provider or care coordinator requirements to meet with the member face-to-face to discuss ACT services and provide information to support the member in making an informed decision regarding participation. This must include a description of ACT services and how to access them, an explanation of the role of the ACT	Y ☐ N ☐

Behavioral Health Policies and Procedures *OHA Health Plan Services CCO 2.0 Contract, Exhibit M*		
Category	**Required Components**	**Score**
OAR 309-019-0225 through OAR 309-019-0255	team, how supports can be individualized based on the member's self-identified needs, and ways that ACT can enhance a member's care and support independent community living.	
	31. Engaging with all eligible members who decline to participate in ACT in an attempt to identify and overcome barriers to the member's participation, and: a. Documents efforts to provide ACT to individuals who initially refuse ACT services and efforts to accommodate their concerns. b. Provides alternative evidence-based intensive services if member continues to decline participation in ACT, which must include coordination with an intensive care coordinator.	Y ☐ N ☐
	32. When the CCO lacks providers to provide ACT services, the CCO shall notify OHA and develop a plan to develop additional providers in accordance with OAR 410-141-3515. a. Lack of capacity shall not be a basis to allow members who are eligible for ACT to remain on the waitlist. b. No member on a waitlist for ACT services shall be without such services for more than thirty (30) days.	Y ☐ N ☐
	33. For members with Severe and Persistent Mental Illness (SPMI), how the CCO ensures that: a. Members are assessed to determine eligibility for ACT. b. ACT services are provided in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255. c. Additional ACT capacity is created within CCO's Service Area as services are needed in accordance with OAR 410-141-3515.	Y ☐ N ☐
	34. Ensuring all denials of ACT services are: a. Based on established, Evidence-Based medical necessity criteria. b. Recorded and compiled in a manner that allows denials to be accurately reported out as Medically Appropriate or inappropriate. c. Follow the Notice of Adverse Benefit Determination process for all denials in accordance with the applicable sections of Ex. I of OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
	35. Providing to OHA via Administrative Notice, any and all documentation related to ACT obligations set forth in this Sec. 8 of Ex. M within five (5) Business Days of request by OHA.	Y ☐ N ☐
Comments:		
Peer Delivered Services and Outpatient Behavioral Health Services	**The CCO has written policies and procedures related to peer delivered services (PDS) and outpatient behavioral health services that address:**	

Behavioral Health Policies and Procedures *OHA Health Plan Services CCO 2.0 Contract, Exhibit M*		
Category	**Required Components**	**Score**
Exhibit M(9) *OAR 309-019-0105*	36. Informing members of and encourages utilization of peer delivered services, including peer support specialist, peer wellness specialist, family support specialist, youth support specialist, or other peer specialist, in accordance with OAR 309-019-0105.	Y ☐ N ☐
	37. Encouraging utilization of PDS by providing members with information, which must include a description of PDS and how to access it, a description of the types of PDS providers, an explanation of the role of the PDS provider, and ways that PDS can enhance members' care.	Y ☐ N ☐
	38. How the CCO may use PDS in providing other behavioral health services such as ACT, crisis services, warm handoffs from hospitals, and services at Oregon State Hospital.	Y ☐ N ☐
	39. Provide outpatient behavioral health services that include, but are not limited to: a. Specialty programs which promote resiliency and rehabilitative functioning for individual and family outcomes. b. Assertive Community Treatment (ACT), enhanced care services, enhanced care outreach services, wraparound, behavioral supports, crisis care, respite care, and intensive outpatient services and support, and IINHT	Y ☐ N ☐
	40. Outpatient behavioral health services must be provided by CCO, regardless of location, frequency, intensity or duration of services, and as medically appropriate: a. Include assessment, evaluation, treatment planning, supports and delivery b. Be trauma informed c. Include strategies to address environmental and physical factors, social determinants of health and equality, and neuro-developmental needs that affect behavior.	Y ☐ N ☐
Comments:		
Behavioral Health Crisis Management	**The CCO has written policies and procedures related to behavioral health crisis management that address:**	
Exhibit M(10) *OAR 410-141-3840* *OAR 309-019-0105* *OAR 309-019-0300* *through* *OAR 309-019-0320*	41. The CCO's crisis management system, including post stabilization services and urgent care services available for all members on a twenty-four (24)-hour, seven (7)-day-a-week basis consistent with OAR 410-141-3840, 42 CFR 438.114, and the applicable section of Ex. B, Part 2 of the OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
	42. How the CCO's crisis management system provides an immediate, initial and limited duration response for potential behavioral health emergency situations or emergency situations that may include behavioral health conditions, including: a. Screening to determine the nature of the situation and the member's immediate need for covered services.	Y ☐ N ☐

Behavioral Health Policies and Procedures *OHA Health Plan Services CCO 2.0 Contract, Exhibit M*		
Category	**Required Components**	**Score**
	b. Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing a crisis situation. c. Development of a written initial services plan at the conclusion of the Behavioral Health Assessment. d. Provision of covered services and outreach needed to address the urgent or crisis situation. e. Linkage with public sector crisis services, such as mobile crisis services and diversion services.	
	43. Access to mobile crisis services and crisis hotline for all members in accordance with OAR 309-019-0105, and 309-019-0300 to 309-019-0320 to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care facility.	Y ☐ N ☐
Comments:		
Behavioral Health care coordination / ICC	**The CCO has written policies and procedures related to behavioral health care coordination/ICC that address:**	
Exhibit M(11) *OAR 410-141-3860* *OAR 410-141-3870*	44. Providing care coordination and ICC services for members with behavioral health disorders in accordance with OARs 410-141-3860 and 410-141-3870 and the applicable sections in Ex. B, Parts 2 and 4 of the OHA Health Plan Services CCO 2.0 Contract.	Y ☐ N ☐
	45. How the CCO ensures all care coordinators work with provider team members to coordinate integrated care. This includes but is not limited to coordination of physical health, behavioral health, intellectual and developmental disability, DHS, Oregon Youth Authority, social determinants of health, and ancillary services. *[Oral health is not included in this portion of the contract but is included in the proposed rules.]*	Y ☐ N ☐
	46. Coordination and appropriate referral to ICC services to ensure that the member's rights are met and there is post-discharge support (including member discharges from Oregon State Hospital).	Y ☐ N ☐
	47. Authorization and reimbursement for ICC Services, in accordance with OAR 410-141-3860 and 410-141-3870.	Y ☐ N ☐
	48. Tracking and coordinating for ICC reassessment triggers and ensuring there are multiple rescreening points for members based on reassessment triggers for ICC.	Y ☐ N ☐
Comments:		
Community Mental Health Program	**The CCO has written policies and procedures related to its Community Mental Health Program that address:**	
Exhibit M(12)	49. Coordination and collaboration on the development of the Community Health Improvement Plan with the local CMHP for the delivery of mental health services in accordance with ORS 430.630.	Y ☐ N ☐

Comments:		
Oregon State Hospital	**The CCO has written policies and procedures related to its Community Mental Health Program that address:**	
Exhibit M(13) *OAR 309-019-0000* *through* *OAR 309-019-0050*	50. Coordination with applicable subcontractors as needed regarding discharges for all adult members with SPMI.	Y ☐ N ☐
	51. Coordination of care for members during discharge planning for the return to home CCO or to the receiving CCO if member will be discharged into a different service area when member has been deemed ready to transition.	Y ☐ N ☐
	52. Arranging for both physical and behavioral health care services care coordination.	Y ☐ N ☐
	53. Providing case management services, care coordination and discharge planning for timely follow up to ensure continuity of care.	Y ☐ N ☐
	54. Coordinating with OHA regarding members who are presumptively or will be retroactively enrolled in Oregon Health Plan upon discharge.	Y ☐ N ☐
	55. Arranging for all services to be provided post-discharge in a timely manner.	Y ☐ N ☐
	56. Providing access to evidence-based intensive services for adult members with SPMI discharged from OSH who refuse ACT services.	Y ☐ N ☐
	57. Ensuring discharges from OSH shall not be to a secure residential treatment facility unless Medically Appropriate.	Y ☐ N ☐
	58. Ensuring no member shall be discharged to a secure residential treatment facility without the expressed prior written approval of the Director of OHA or the Director's designee.	Y ☐ N ☐
	59. Ensuring a member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet member's needs.	Y ☐ N ☐
Comments:		
Emergency Department Utilization	**The CCO has written policies and procedures related emergency department utilization that address:**	
Exhibit M(14)	60. Behavioral health services in the following key areas: a. Reducing visits to emergency departments. b. Reducing repeat visits to emergency departments. c. Reducing the length of time members spend in emergency departments. d. Ensuring members are contacted and offered services to prevent utilization of emergency departments. e. Ensuring members with SPMI have appropriate connection to community-based services after leaving an emergency department and will have a follow-up visit from Intensive Care Coordinator or other relevant provider within three (3) days.	Y ☐ N ☐

	61. Individualized Management Plans for members that have two (2) or more visits to an emergency department within a six (6)-month period	Y ☐ N ☐
	62. Working with hospitals to obtain data on emergency department utilization for behavioral health reasons and length of time in the emergency department.	Y ☐ N ☐
	63. Developing remediation plans with hospitals with significant numbers of emergency department stays longer than 23 hours.	Y ☐ N ☐
	64. Working with hospitals on strategies to reduce emergency department utilization by members with behavioral health disorders.	Y ☐ N ☐
	65. Working collaboratively with OHA and CMHPs to develop and implement plans to better meet the needs of members in less institutional community settings and to reduce recidivism to emergency departments for behavioral health reasons.	Y ☐ N ☐
Comments:		
Involuntary Psychiatric Care	**The CCO has written policies and procedures related to involuntary psychiatric care that address:**	
Exhibit M(15) *OAR 309-033-0200* *through* *OAR 309-033-0740*	66. Making a reasonable effort to provide covered services on a voluntary basis and consistent with current declaration for mental health treatment as provided at: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9550.pdf in lieu of involuntary treatment	Y ☐ N ☐
	67. Employing the use of emergency Psychiatric Holds consistent with ORS 426.130 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the member and the behavior of the member meets legal standards for the use of an Emergency Psychiatric Hold.	Y ☐ N ☐
	68. How the CCO only uses psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0740	Y ☐ N ☐
	69. Compliance with ORS Chapter 426 and OAR 309-033-0200 through 309-033-0740 for involuntary Civil Commitment of those members who are civilly committed under ORS 426.130.	Y ☐ N ☐
	70. How the CCO ensures that any involuntary treatment provided under the OHA Health Plan Services CCO 2.0 Contract is provided in accordance with ORS Chapter 426 and OAR 309-033-0200 through 309-033-0440 and coordinates with the CMHP Director in CCO's service area in assuring that all legal requirements are met. The CCO shall work with the CMHP Director in assigning a civilly committed member to any placement and participate in circuit court hearings related to planned placements, if applicable.	Y ☐ N ☐
	71. Working with secure residential treatment facilities to expeditiously move civilly committed adult members with SPMI who no longer need placement in an SRTF to a community placement in the most integrated setting appropriate for that person. Discharge shall be to housing consistent with the member's treatment goals, clinical needs, and informed choice. The member's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably and medically accommodated in light of cost, availability, and the other factors stated above.	Y ☐ N ☐

Comments:		
Long Term Psychiatric Care	**The CCO has written policies and procedures related to long term psychiatric care (LTPC) that address:**	
Exhibit M(16)		Y ☐ N ☐
		Y ☐ N ☐
	72. How a member is appropriate for LTPC, which is when: a. Member needs either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State Facility or extended care program or extended and specialized medication adjustment in a secure or otherwise highly supervised environment.	Y ☐ N ☐
	73. If CCO identifies a member, age 18 or older, as appropriate for LTPC, the CCO shall request a LTPC determination from the OSH extended care coordinator as described in the procedure from LTPC determinations on the CCO contract forms website.	
	74. When a member is ultimately determined appropriate for LTPC, the effective date of such determination will be: a. Three (3) business days after the date that the OSH extended care coordinator receives the clinical review packet from CCO; or. . b. In cases where OHA and the CCO mutually agree on a date other than as identified in (a) above, the date mutually agreed upon. c. In cases where the Clinical Reviewer determines a date other than a date described above, the date determined by the OSH Clinical Reviewer.	Y ☐ N ☐
	75. Requesting, within three (3) Business Days of receiving notice of the LTPC determination, a review by an independent OSH Clinical Reviewer in the event Contractor and OSH admissions office staff disagrees about whether a member is appropriate for LTPC. The determination of the Clinical Reviewer should be deemed the determination of OHA.	Y ☐ N ☐
	76. Working with the appropriate OHA team or designee in managing admissions, discharges and transitions from LTPC for members who require LTPC at a state facility, to ensure that members are served in and transition into the most appropriate, independent, and integrated community-based setting possible.	Y ☐ N ☐
	77. For members, including those in the long-term neuropsychiatric care at the state facility, how the CCO works with the member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated community-based setting possible consistent with member choice.	Y ☐ N ☐
	78. For members age seventeen (17) or younger identified as appropriate for LTPC referral, how the CCO: a. Requests a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for members 17 and Under. b. Works with the HSD Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC Secure Children's Inpatient Program and Secure Adolescent Inpatient Program.	Y ☐ N ☐

	c. Is responsible for care coordination for the entire length of stay, including admission determination and planning, linking the child and family team and intensive outpatient services and supports provider, services provided by LTPC service Provider and transition and discharge planning. This should include collaborative relationships with all system partners to achieve continuity of care. d. Ensures that utilization of LTPC is reserved for the most acute and complex cases and only for the period of time necessary and medically appropriate to remediate symptoms that led to admission. e. Works to assure timely discharge and transition from a psychiatric residential treatment facility to the most appropriate, independent and integrated community-based setting possible	
Comments:		
Acute Inpatient Hospital Psychiatric Care	**The CCO has written policies and procedures related to acute inpatient hospital psychiatric care that address:**	
Exhibit M(17) *OAR 309-033-0640* *OAR 309-032-0850 through* *OAR 309-032-0870*	79. Providing Acute Inpatient Hospital Psychiatric Care for members who do not meet the criteria for LTPC and for whom it is medically appropriate.	Y ☐ N ☐
	80. Submitting required data through the acute care reporting database as instructed by OHA.	Y ☐ N ☐
	81. If the CCO performs a Medication Override Procedure only after the member has been committed, there is good cause as described in OAR 309-033-0640, and the requirements of OAR 309-033-0640 have been met.	Y ☐ N ☐
	82. Developing and implementing an individualized management plan for contacting and offering services to each member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period.	Y ☐ N ☐
	83. Ensuring all members discharged from Acute Care Psychiatric Hospitals are provided a warm handoff to a community case manager, peer, or other community provider prior to discharge, and that all such warm handoffs are documented.	Y ☐ N ☐
	84. Ensuring all members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral health and primary health care in the community prior to discharge and that all such linkages are documented, in accordance with OAR 309-032-0850 through 309-032-0870.	Y ☐ N ☐
	85. Ensuring all adult members receive a follow-up visit with a community behavioral health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital, or three (3) days if member is involved in Intensive care coordination services.	Y ☐ N ☐
	86. Coordination with system community partners to ensure members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or behavioral health agency to ensure these members are linked to housing in an integrated setting, consistent with the member's treatment goals, clinical needs and informed choice.	Y ☐ N ☐

	87. Working with OHA and the CMHPs to ensure that members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and shall work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the member's treatment goals, clinical needs, and informed choice. The CCO shall notify or require the Acute Care Psychiatric Hospital to notify the community provider to facilitate the implementation of the plan for housing.	Y ☐ N ☐
Comments:		
Women's Health	**The CCO has written policies and procedures related to women's health that address:**	
Exhibit M(18) *OAR 410-141- 3515*	88. Ensuring members receiving prenatal and post-partum care are screened using validated tools for behavioral health needs at least once during pregnancy and post-partum and ensure medically appropriate follow-up and Referral as indicated by screening.	Y ☐ N ☐
	89. Ensuring pregnant women receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3515.	Y ☐ N ☐
Comments:		
Children and Youth Behavioral Health Services	**The CCO has written policies and procedures related to children and youth behavioral health services that address:**	
Exhibit M(19) *OAR 410-141- 3860* *OAR 410-141- 3870* *OAR 410-141- 3515* *OAR 410-172-0690* *OAR 309-022-0155*	90. Ensuring women with children, unpaid caregivers, families and children ages birth through five (5) years, receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3515.	Y ☐ N ☐
	91. Maintaining an intensive and flexible service continuum for children and youth who are at risk of placement disruption, school failure, criminal involvement, becoming Homeless or other undesirable outcomes due a behavioral health disorder.	Y ☐ N ☐
	92. Utilization of evidence-based behavioral health interventions for the behavioral health needs of members who are children and youth.	Y ☐ N ☐
	93. Ensuring members have access to evidence-based dyadic treatment and treatment that allows children to remain living with their primary parent or guardian. Dyadic treatment is specifically designed for children eight (8) years and younger.	Y ☐ N ☐
	94. Ensuring children in the highest levels of care (subacute, residential or day treatment) received Family treatment with their caregivers provided that no social determinants of health or other conditions will preclude such caregivers from actively and meaningfully participating in Family treatment	Y ☐ N ☐
	95. Ensuring children in the highest levels of care (subacute, residential or day treatment) have a psychological evaluation current within the past twelve months and receive a child psychiatric evaluation and ongoing psychiatric care in accordance with OAR 309-022-0155	Y ☐ N ☐

	96. For child under age six (6) in day treatment, subacute, or residential care settings, a developmental evaluation shall be done in addition to a psychological evaluation, if clinically indicated.	Y ☐ N ☐
	97. Ensuring ICC is available, at a minimum, for members seventeen (17) and younger for any of the following situations, in accordance with OAR 410-141-3860 and 410-141-3870: a. Children and youth placed in a correctional facility solely for the purpose of stabilizing a behavioral health condition. b. Children and youth placed out of CCO's service area in behavior rehabilitation service programs under the jurisdiction of Child Welfare. c. Children and youth, known to be receiving or to have received care in an emergency department, or admission to acute Inpatient Psychiatric Care and/or sub-Acute care or upon discharge from such care.	Y ☐ N ☐
	98. Coordination of admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for members seventeen (17) and under, including members in the care and custody of DHS Child Welfare or Oregon Youth Authority (OYA). For a member seventeen (17) and under, placed by DHS Child Welfare through a voluntary placement agreement (CF 0499), how the CCO also coordinates with such member's parent or legal guardian.	Y ☐ N ☐
	99. Development and maintenance written policies and procedures relating to the use of psychotropic drugs for children, especially those in the custody of DHS, in accordance with Para. d, Sec. 7, Ex. B, Part 2 of the OHA Health Care Services CCO 2.0 Contract.	Y ☐ N ☐
	100. Admission to PRTS in accordance with Certificate of Need process described in OAR 410-172-0690 and conducted through an OHA-approved independent reviewer.	Y ☐ N ☐
	101. Level of care criteria for behavioral health outpatient services and intensive outpatient services and supports to include children birth through five (5) years in accordance with OAR Chapter 309, Division 22. (Requirement for providers to provide a minimum level of intensive outpatient level of care for children birth through five (5) years with indications of adverse childhood events and high complexity).	Y ☐ N ☐
	102. Periodic social-emotional screening for all children birth through five (5) years is conducted in the primary care setting and ensure any concerns revealed by the screening are addressed in a timely manner.	Y ☐ N ☐
	103. Ensuring only providers who have been certified by the Praed Foundation for administering the Child and Adolescent Needs and Strengths Comprehensive Screening (CANS) – Oregon (as found at https://www.schoox.com/login.php) administer CANS Oregon to the CCO's members.	Y ☐ N ☐
	104. Ensuring a CANS Oregon is administered to each member enrolled in Fidelity Wraparound and complete a CANS Oregon within thirty (30) days of initial program enrollment, after a significant event, and upon exit from the Fidelity Wraparound program. a. Ensure a CANS Oregon is administered each member age seventeen (17) or younger in Child Welfare, regardless of enrollment in Fidelity Wraparound, and entry of the CANA data into OR Kids, the online data system for youth in Child Welfare, within sixty (60) days of notification that the member is entering foster care or from date of Referral from DHS caseworker.	Y ☐ N ☐

Comments:	
Intensive In-Home Behavioral Health Treatment	**The CCO has written policies and procedures related to intensive in-home behavioral health treatment**
	105. Provide access to intensive in-home behavioral health treatment (IIBHT) services for all eligible member age twenty (20) and younger in accordance with OARs 309-019-0167, 410-172-0650, and 410-172-0695
	106. IIBHT services are community-based services that are delivered in the member's home (e.g., biological home, foster home, group home), school, or other community location demined by member.
	107. Member is eligible for IIBHT if they have a primary mental health diagnosis funded on the Prioritized List of health services and require intensive services to provide for community stabilization, to prevent the need for facility-based car, or as step -down to the community for facility-cased care. a. Member shall not be required to participate in any other programs or treatments as a condition of eligibility for IIBHT. b. Wraparound or Intensive Care Coordination to a member who receives IIBHT but shall not make member ineligible for IIBHT if wraparound or intensive care coordination is not indicated.
	108. Ensure all members receiving IIBHT services have an assessment, crisis and safety plan, and service plan completed in accordance with OAT 309-019-0167. Contractor shall also ensure that all contracted IIBHT providers are able to offer members: a. Child psychiatric services provided by a board eligible or certified child and adolescent psychiatrist, or a psychiatric nurse practitioner under the supervision of a board eligible or certified child and adolescent psychiatrist. b. Individual therapy c. Family therapy d. Skills training e. Case manager, f. Peer delivered services g. In home proactive support and crisis response available 24 hours each day.
	109. No fewer than four (4) hours of in-person planned program services must be offered to the member each week, as identified within the assessment and service plan.
	110. Members must be considered for IIBHT services orientation, religion, creed, national origin, age, intellectual and/or developmental disability, IQ score, or physical disability
	111. If contractor lack provider capacity to provide IIBHT services, contactor shall notify OHA and develop a plan to increase provider capacity. a. Lack of capacity may not be a basis to allow members who are eligible for IIBHT to be placed on a waitlist b. No member eligible for IIBHT services may be without services for more than fourteen (14) days.
	112. Contractor shall ensure contracted IIBHT providers are trained in the RedCap system to enter participant and outcome data. Trainings will be provided by an OHA approved contractor.

	113. Contractor shall ensure contracted IIBHT providers enter participant and outcome data into the RedCap system for members in IIBHT within (7) days prior to discharge as required by OAR 309-019-0167.	
	114. Contractor shall authorize IIBHT services in accordance with OAR 410-172-0695.	
	115. Contractor shall maintain sufficient funding and resources to implement the IIBHT program for members seventeen (17) years and younger for any member meeting entry criteria.	
Comments:		
Providers	**The CCO has written policies and procedures related to providers that address:**	
Exhibit M(21)	116. Ensuring the CCO's employees, Subcontractors, and providers are trained in integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/) and provide regular, periodic oversight and technical assistance on these topics to providers.	Y ☐ N ☐
	117. Ensuring the CCO's employees, subcontractors, and providers of behavioral health services are trained in recovery principles, motivational interviewing.	Y ☐ N ☐
	118. Requiring providers, in developing Individual Service and Support Plans for members, to assess for Adverse Childhood Experiences (ACE), trauma and resiliency in a culturally and linguistically appropriate manner, using a trauma informed framework.	Y ☐ N ☐
	119. Ensuring that providers who have a waiver under the Drug Addiction Treatment Act of 2000 and 42 CFR Part 8, are permitted to treat and prescribe buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be medically appropriate.	Y ☐ N ☐
	120. Ensuring that employees or providers who evaluate members for access to, and length of stay in, SUD programs and services use the most current American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, for level of care placement decisions, and that they have the training and background necessary to evaluate medical necessity for SUD Services using the ASAM.	Y ☐ N ☐
	121. Recognition of OHA's licensing standards for mental health and SUD programs as the minimum necessary requirements to enter the provider network.	Y ☐ N ☐
	122. Require behavioral health residential treatment participating providers including those providing sub-acute psychiatric services to: a. Enroll in OHA's centralized behavioral health provider directory, b. Be part of the necessary and ongoing technical assistance provided by OA or designee, c. Enter data required from the directory in a timely and accurate manner in order to provide up-to-date capacity information to users of the directory.	
Comments:		

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	