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| CCBHC Application for Certification Instructions: 1. Please read through all the certification requirements necessary for CCBHCs.
2. Provide the documentation type that confirms your organization meets the specified requirement. If you do not meet a requirement but have documented plans to implement the requirement within 4 months, please attach along with an effective date.
3. Submit the completed certification narrative form with all attachments to MN\_DHS\_CCBHC@state.mn.us. Use the following subject line: <Clinic Name> CCBHC Certification Narrative Form.
 |
| For additional assistance with CCBHC certification, please contact MN\_DHS\_CCBHC@state.mn.us or visit [MN CCBHC webpage](https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/ccbhc/). |

**Criteria Certification Requirements**

Please attach one or multiple documents that includes all of the following responses labeled according to the numbering in the checklists below.

**Program Requirement 1: STAFFING**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **#** | **Type** | **Request** |
|[x]  1.1 | Document | Provide your needs assessment or statement of need for your clinic |
|[ ]  1.2 | Narrative | What cultural, linguistic and treatment needs of populations in your service area were identified in your needs assessment or statement of need? What staffing needs of populations served by your clinic were identified? |
|[ ]  1.3 | Plan | Clinic Staffing Plan:Size, composition, licenses/experience levels, appropriateness for populations served, capability to serve all ages, linguistic capability, ability to prescribe buprenorphine, utilization of peer staff and expertise in trauma. |
|[ ]  1.4 | Narrative | Does your clinic have a psychiatrist as a Medical Director? If not, describe how your clinic is in compliance with federal criteria (1.b.2) and Rule 29 or have a variance in place to satisfy this requirement. Also, verify that your clinic has (or has access to) a medically trained behavioral health care provider who can prescribe medication including buprenorphine and other medications used to treat opioid and alcohol use disorders. |
|[ ]  1.5 | Narrative | Describe how peer staff are integrated into your clinic's programming. Describe the current status and future plan. Ensure that Certified Peer Specialists, Certified Family Peer Specialists and Certified Recovery Specialist are included in the Clinic Staffing Plan. |
|[ ]  1.6 | Procedure | Procedure for Staff Skills and Competencies:Assessments used to determine training needs of staff, documentation of each staff person's training received, and documentation that each staff person’s licensure and credentials are in good standing. Including how DCOs will follow these policies. |
|[ ]  1.7 | Plan | Clinic Training Plan: Demonstrating that all clinic personnel, including those providers who are contracted with or work at a DCO, receive training at orientation, and annually thereafter, that addresses risk assessment, suicide prevention, and suicide response; the roles of families and peers; cultural competency; person-centered, family-centered, recovery-oriented, evidence-based, and trauma- informed care; primary care/behavioral health integration; military culture, and the clinic’s continuity plan.Including organization's training needs based on certification/licensing requirements and state needs assessment, how a list of trainings for the next 12 months is maintained, and qualifications of trainers. |
|[ ]  1.8 | Narrative | Describe how your clinic addresses the needs of people with Limited English Proficiency and/or language-based disabilities, including the use of interpreters that are verified in the state registry system and accessibility of written information. |
|[ ]  1.9 | Procedure | Procedure for provision of services to uninsured and underinsured:Sliding scale fee determination process and verification that DCOs follow the same policy. |
|[ ]  1.10 | Procedure | Sliding fee discount schedule: Definitions of income and family size, Eligibility for sliding fee discounts based only on income and family size for all consumers, Methods for making consumers aware of the availability of sliding fee discounts that are effective and appropriate for the language and literacy levels of the patient population, Documentation and verification requirements used to determine eligibility for sliding fee discounts and frequency of re-evaluation of eligibility, Specific structure of all sliding fee discount schedule(s), including consideration of locally prevailing rates or charges. |
|[ ]  1.11 | Procedure | Confidentiality and Data Privacy Policy to satisfy HIPAA and 42 CFR Part 2 including, but not limited to,: (1) Care of minors, (2) documentation of consumer preferences for sharing their information with families and others, and (3) Releases of Information for care coordination. |
|[ ]  1.12 | Documents | Provide 5 personnel files (one each of medical director, MH professional, MH practitioner, LADC, peer). The state will review for evidence of:(1) Training records with evidence of training in CBT, MI, Stages of Change, and trauma treatment, (2) License verification at time of hire and throughout employment. |

**Program Requirement 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES**

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|  | **#** | **Type** | **Request** |
|[ ]  2.1 | Procedure | Procedure for ensuring the clinic environments are safe, functional, accessible, clean and welcoming for consumers and staff. |
|[ ]  2.2 | Narrative | Do any of your locations/programs offer night and weekend hours? Describe how you determined these evening and weekend hours meet the needs of the populations served (e.g., satisfaction or needs surveys) and any plans to expand these hours. Also, describe your after-hours availability for services other than Crisis Response Services |
|[ ]  2.3 | Narrative | Describe the geographic accessibility of your clinic locations to the populations served and any evidence of consumer satisfaction with those locations. |
|[ ]  2.4 | Narrative | Describe how your clinic(s) uses mobile in-home and telehealth/telemedicine treatment services. |
|[ ]  2.5 | Narrative | Describe how your clinic(s) engage(s) in outreach and engagement activities to assist consumers and families to access benefits and services including any changes made at the clinic in response to unmet needs discovered during outreach. |
|[ ]  2.6 | Plan | Continuity of operations/disaster plan |
|[ ]  2.7 | Plan | Plan for Integrated Evaluation, Referral and Integrated Treatment Plan:Including Preliminary Screening and risk assessment tool, initial evaluation data elements or form and screening tools, releases of information and consents, comprehensive evaluation data elements or form, plan for updating the comprehensive evaluation, and qualifications of staff involved in assessment process. Individualized Treatment Plan form that is person centered or family centered, conforms to HIPAA and 42 CFR Part 2, designates an interdisciplinary treatment team, incorporates culturally traditional practices, and includes external, care coordination and DCO-provided services.  |
|[ ]  2.8 | Procedure | Procedure for response to outcome of preliminary risk assessment tool including process flow for consumers if crisis, urgent or routine need. |
|[ ]  2.9 | Procedure | Procedure for completion of Initial Evaluation within 24 hours if urgent or 10 days if routine. Including review process for telephonic evaluations and process flow for response to recommendations and next steps identified. |
|[ ]  2.10 | Procedure | Procedure for completion of Comprehensive Evaluation within 60 days of first contact.  |
|[ ]  2.11 | Procedure | Procedure for completion of Integrated Treatment Plan within 60 days of first contact and updates no less than every 180 days. |
|[ ]  2.12 | Procedure | Procedure for completion of Crisis Plan including form (Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan). |
|[ ]  2.13 | Procedure | Procedure for completion of all of the following (derived from the Appendix A quality measures): (1) tobacco use: screening and cessation intervention; (2) unhealthy alcohol use: screening and brief counseling; (3) child and adolescent major depressive disorder suicide risk assessment; (4) adult major depressive disorder suicide risk assessment; and (5) screening for clinical depression and follow‐up plan. |
|[ ]  2.14 | Procedure | Procedure that ensures (1) provision of services regardless of ability to pay; (2) waiver or reduction of fees for those unable to pay; (3) equitable use of a sliding fee discount schedule that conforms to the requirements in the criteria; and (4) provision of information to consumers related to the sliding fee discount schedule, available on the website, posted in the waiting room, and provided in a format that ensures meaningful access for the consumer and/or family and to the information. |
|[ ]  2.15 | Procedure | Procedure that ensures: (1) provision of services regardless of place of residence (or homeless status), including provision of crisis services, provision of other services, and coordination and follow‐up with providers in the individual’s catchment area; and (2) services will be available for consumers living in the CCBHC catchment area but who are distant from the CCBHC. |

**Program Requirement 3: CARE COORDINATION**

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| --- | --- | --- | --- |
|  | **#** | **Type** | **Request** |
|[ ]  3.1 | Plan | Care Coordination Plan: Plan for coordinating care with (1) FQHCs or RHCs; (2) other primary care providers; (3) inpatient psychiatric treatment, inpatient treatment with ambulatory and medical detoxification, post-detoxification step-down services, and residential programming (including system for tracking intakes and discharges); (4) community services such as schools, child welfare, juvenile and criminal justice, specialty courts, Indian Health Service youth RTCs, and therapeutic foster care placement agencies; (5) based on population served, providers of medications for opioid or alcohol dependence, suicide/crisis hotlines, Indian Health Service, homeless shelters, housing agencies, coordinated entry, employment services, aging and disability services, domestic violence, grief counseling, Affordable Care Act navigators, food and transportation programs; (6) Veteran Health services.Include a care coordination agreement template that includes: (1) referral process, (2) obtaining and confirming appointments with external providers are kept, (3) aligned with consumer preferences, (4) maintaining complete and up-to-date list of all medications prescribed.  |
|[ ]  3.2 | Procedure | Procedure for securing Care Coordination agreements with the organizations listed above. Including: (1) Transitioning individuals from emergency department, inpatient psychiatric, detoxification, and residential settings to a safe community setting; (2) transfer of records (e.g. prescriptions), (3) follow up after discharge from the hospital within 24 hours and 30 days, (4) suicide and safety planning, and (5) peer assistance.  |
|[ ]  3.3 | Procedure | Procedure for securing agreements with nearby jurisdictions governing care for consumers who present to the clinic but are not in the state-established catchment area, allowing the clinic to track and refer care and ensuring that the responsible area (seamlessly) assumes responsibility for the consumer’s care. |
|[ ]  3.4 | Narrative | Report on progress securing care coordination agreements including your clinic's justification for lack of agreements, contingency plan for completion, and/or any work that has been completed so far. Include a description of any other written materials collected such as Letters of Support. |
|[ ]  3.5 | Procedure | Health Information Technology (HIT) procedure: (1) that includes EHRs; (2) can capture demographic information, diagnoses, and medication lists; (3) provide clinical decision support; and (4) can electronically transmit prescriptions to the pharmacy, allow reporting on data and quality measures, conduct activities such as population health management, quality improvement, disparity reduction, outreach and research, certified to accomplish the activities above; to send and receive the full common data set for all summary of care records; to support capabilities including transitions of care, privacy, and security; and to meet the Patient List Creation criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC’s Health IT Certification Program. |
|[ ]  3.6 | Plan | HIT plan for the future focusing on ways to improve care coordination between the CCBHCs and DCOs using HIT. The plan should include how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system they have or are developing related to transitions of care. |
|[ ]  3.7 | Procedure | Procedure defining the treatment team as interdisciplinary and that planning is person-centered or family-centered, comply with confidentiality standards and includes the consumer, the family/caregiver of child consumers, and the adult consumer’s family, to the extent that the consumer does not object, and any other person the consumer chooses. |

**Program Requirement 4: SCOPE OF SERVICES**

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|  | **#** | **Type** | **Request** |
|[ ]  4.1 | Narrative | Describe how all clinic services, including those supplied by its DCOs, are provided in a manner (1) reflecting person- and family-centered, recovery-oriented care; (2) respectful of the individual consumer’s needs, preferences, and values; and (3) ensuring consumer choice, consumer involvement and self-direction of services received. |
|[ ]  4.2 | Narrative | Describe how all services for children and youth are family-centered, youth-guided and developmentally appropriate. |
|[ ]  4.3 | Narrative | Describe how the clinic provides person-centered and family- centered care that recognizes particular cultural and other needs as reflected in the results of the needs assessment. |
|[ ]  4.4 | Procedure | Procedure for TCM eligibility criteria that includes process for including consumers identified at high risk for suicide by a CCBHC licensed mental health professional. |
|[ ]  4.5 | Procedure | Procedure for consumer grievances including consumer grievance form and consumer access to grievance process |
|[ ]  4.6 | Narrative | Describe your readiness to implement the required Evidence Based practices: Cognitive Behavioral Treatment, Motivational Interviewing, Stages of Change, and a trauma treatment appropriate for the populations you serve. Also describe any other Evidence Based Practices your clinic provides. |
|[ ]  4.7 | Procedure | Procedure for how your clinic is collecting and reporting the following (derived from the Appendix A quality measures): (1) adult body mass index (BMI) screening and follow‐up; (2) weight assessment and counseling for nutrition and physical activity for children and adolescents; (3) care for controlling high blood pressure; (4) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications; (5) diabetes care for people with serious mental illness: Hemoglobin A1c (HbA1c); (6) metabolic monitoring for children and adolescents on antipsychotics; (7) cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications; and (8) cardiovascular health monitoring for people with cardiovascular disease and schizophrenia. |
|[ ]  4.8 | Attach | Completed DCO Agreements including, but not limited to:DCO must accommodate outcome of grievance procedures and process for ensuring DCO meets CCBHC quality standards. |

**Services Grid**

**Please answer “yes” to affirm your clinic’s capacity to meet these requirements (either through CCBHC or DCO) or “no” if your clinic does not have the capacity.**

| **SERVICE** | **REQUIREMENTS** |
| --- | --- |
|  | Enrollment as a crisis provider | 24 hour access/service within 3 hours | stabilization services | Marketing plan | Role of and coordination with law enforcement | ambulatory and medical detoxification |
| **Adult Crisis mental health services** | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. |
| **Child Crisis mental health services** | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. |
|  | preliminary risk assessment | initial evaluation | comprehensive assessment | Screening and assessment tools | consumer process flow |  |
| **Screening, assessment, and diagnosis** | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. |  |
|  | multidisciplinary staff | consumer and family involvement |  |  |  |  |
| **Person-centered treatment planning** | Choose an item. | Choose an item. |  |  |  |  |
|  | Rule 29 Certification | Rule 31 Licensure |  |  |  |  |
| **Outpatient mental health and substance use services** | Choose an item. | Choose an item. |  |  |  |  |
|  | Coordination with PC providers |  |  |  |  |  |
| **Primary care screening and monitoring of key health indicators and health risk.** |  Choose an item. |  |  |  |  |  |
|  | Rule 79 Certification for children | Rule 79 Certification for adults |  |  |  |  |
| **Targeted case management** | Choose an item. | Choose an item. |  |  |  |  |
|  | ARMHS Certification | CTSS Certification |  |  |  |  |
| **Psychiatric rehabilitation services** | Choose an item. | Choose an item. |  |  |  |  |
|  | Have at least one peer staff  |  |  |  |  |  |
| **Peer support and counselor services and family supports** |  Choose an item. |   |  |  |  |  |
|  | Consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA) | Ask and document asking all individuals who inquire about services whether they have ever served in the U.S. military | Offer assistance to enroll in the VHA for the delivery of medical and behavioral health services to persons affirming former military service | Assign a Principal Behavioral Health Provider to every veteran seen, unless the VHA has already assigned one |  Adhere to the guiding principles of recovery, VHA recovery, and other VHA guidelines | Clinic staff members trained in cultural competency and specifically in military and veterans’ culture |
| **Intensive, community-based mental health care for members of the armed forces and veterans** | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. |

**Program Requirement 5: QUALITY AND OTHER REPORTING**

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|  | **#** | **Type** | **Request** |
|[ ]  5.1 | Plan | Data collection and reporting plan:With the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; (9) consumer outcomes; (10) reports reflect data for all clinic consumers; (11) or, at minimum, all Medicaid enrollees; and, if necessary, (12) relationship with DCO that allows for collection of data. |
|[ ]  5.2 | Plan | Clinic-wide, data driven CQI plan including:(1) identifying CQI projects that are based on the needs of the clinic population and reflect the scope, complexity, and past performance of the clinic’s services and operations; (2) address priorities for improved quality of care and client safety; (3) CQI projects evaluated annually and for effectiveness; (4) focus on indicators related to improved behavioral and physical outcomes and call for actions designed to improve clinic performance in those areas; (5) document each CQI project implemented, the reasons for the projects, and measurable progress achieved by the projects; (6) Identifying person responsible for operating the CQI program; (7) CCBHC consumer suicide deaths or suicide attempts, CCBHC consumer 30 day hospital readmissions for psychiatric or substance use reasons, alcohol or drug-related deaths or injuries, vulnerable adult reports, serious injuries of any kind. |
|[ ]  5.3 | Procedure | Procedure for submitting an annual cost report with supporting data to the state within 6 months after the end of each fiscal year. |

**Program Requirement 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION**

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|  | **#** | **Type** | **Request** |
|[ ]  6.1 | Narrative | If the clinic does not operate under the authority of the Indian Health Service, an Indian tribe, or a tribal or urban Indian organization, but does serve a population that includes American Indian and Alaska Native (AI/AN) consumers, describe how the clinic has reached out to the Indian Health Service, Indian tribes, or tribal or urban Indian organizations in the area to assist in the provision of services to AI/AN consumers and to inform the provision of services to those consumers. |
|[ ]  6.2 | Procedure | Procedure for an independent financial audit, performed in accordance with federal audit requirements (45 CFR Part 75) conducted annually including submission of a corrective action plan that addresses all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. |
|[ ]  6.3 | Narrative | Describe how your clinic incorporates meaningful input to the board about the CCBHC’s policies, processes, and services by adult consumers with mental illness, adults recovering from substance use disorders, and family members of clinic consumers. (Refer to SAMHSA CCBHC Criteria 6.b.1 through 6.b.4 for requirements). If your clinic has not yet met this requirement, provide your transition plan with timelines to meet criteria. |
|[ ]  6.4 | Narrative | Describe how your clinic satisfies the following criteria: Members of the governing or advisory boards will be representative of the communities in which the CCBHC’s service area is located and will be selected for their expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry. |
|[ ]  6.5 | Narrative | Is your clinic accredited by a nationally recognized organization and, if so, which one(s)? |

**Site Visit Checklist**

**Please be prepared for the following items at the site visit.**

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| --- |
|[ ]  Demonstrate how a copy of your clinic needs assessment are available to review on site |
|[ ]  Demonstrate that your clinic has a safe, functional, clean, and welcoming environment for consumers and staff |
|[ ]  Demonstrate your knowledge of the screening and assessment process, integrated treatment plans and comprehensive evaluations. |
|[ ]  Describe how a telehealth/telemedicine treatment service is completed. [State provides rating of Advanced, Moderate or Little/None] |
|[ ]  Demonstrate that the sliding fee discount schedule(s) is/are included on the clinic website, posted in the clinic waiting room, readily accessible to consumers and families, and communicated in languages/formats appropriate for individuals seeking services who have Limited English Proficiency (LEP) or communication disabilities |
|[ ]  Demonstrate how the health IT system: (1) captures consumer demographic information, (2) diagnoses, (3) medication lists, (4) provide clinical decision support, (5) electronically transmit prescriptions to pharmacies, (6) report data and quality measures, (7) Population Health Management, (8) Quality improvement activities, (9) reduce health disparities, (10) conduct research and outreach, (11) all DCOs follow same rules, (12) care coordination improvement plan. |
|[ ]  Demonstrate consumer access to grievance policy/form |

By signing below, the CEO/ED agrees that the CCBHC provider agency understands and will comply with the above application requirements, the content of this application is accurate, and indicates the agency's intent. It also acknowledges that, once certified, this document will serve as a contract for services and a failure to meet these requirements may be cause for decertification or denial of certification as a CCBHC provider.

|  |  |
| --- | --- |
| Signature | Date |
| Printed Name |  |
| Title |  |