STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Certified Community Behavioral Health Clinic (CCBHC) Stakeholder Committee

Meeting #4

August 24, 2023

Agenda

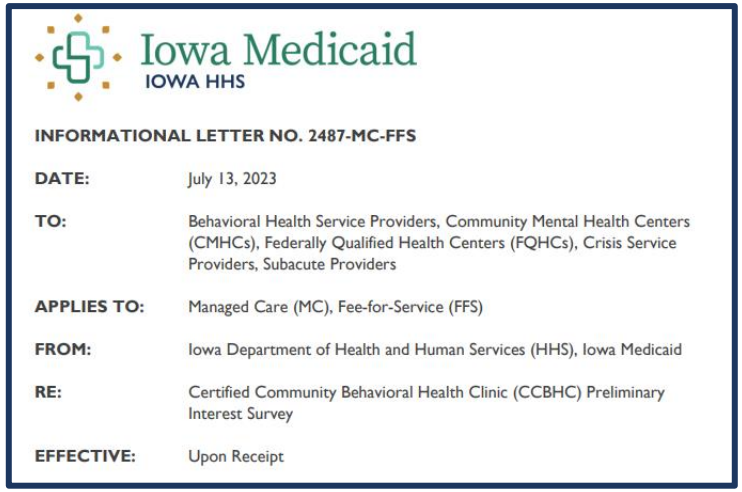
- Welcome and Introductions (5 minutes)
- CCBHC Readiness Survey Results (30 minutes)
- CCBHC Technical Assistance Planning (30 minutes)
- Introduction to CLAS Standards (30 minutes)
- Public Comment (20 minutes)

Welcome and Introductions

CCBHC Readiness Survey Results

CCBHC Preliminary Interest Survey

- On July 13, Iowa HHS issued **IL No. 2487 MC-FFS** announcing the CCBHC Preliminary Interest Survey
- All Medicaid-enrolled provider organizations and agencies interested in becoming certified as a CCBHC in 2024 as part of Iowa's CCBHC demonstration were asked to complete a survey to assess readiness against SAMHSA program requirements.
- The survey results will also serve as the baseline for Iowa's CCBHC Demonstration Evaluation.
- Completed surveys were due August 1
- **HHS received 22 complete responses by the due date**
- **Responses covered all proposed CCBHC catchment areas**



Iowa Medicaid
IOWA HHS

INFORMATIONAL LETTER NO. 2487-MC-FFS

DATE:	July 13, 2023
TO:	Behavioral Health Service Providers, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Crisis Service Providers, Subacute Providers
APPLIES TO:	Managed Care (MC), Fee-for-Service (FFS)
FROM:	Iowa Department of Health and Human Services (HHS), Iowa Medicaid
RE:	Certified Community Behavioral Health Clinic (CCBHC) Preliminary Interest Survey
EFFECTIVE:	Upon Receipt

Level of Readiness Across Survey Responses

Domain	Level of Readiness
Care Management, Wraparound, Outreach	92%
Training, EBPs	91%
Quality, Compliance	89%
Treatment, Service Planning	89%
Community Needs	87%
HIT, HIE	85%
Equity	84%
Staffing	81%
Designated Collaborative Organizations	81%
Consumer and Family Voice (Board Composition)	80%
Required Services and Timeframes	79%
Primary Care Screening	77%
Veteran Service	77%

Survey Results – Key Take-Aways

- **Strengths:**
  - All providers are over 80% Ready in the Treatment, Service Planning category
  - Almost all providers are over 80% Ready in the Training, EBPs category
  - Almost all providers are over 80% Ready in the Care Management, Wraparound, Outreach category
- **Potential Risks – the following categories have the highest number of providers under 50% Ready:**
  - Designated Collaborative Orgs
  - Primary Care Screening
  - Consumer and Family Voice (Board Composition)
- **Overall Average Score:**
  - Despite the risks above, all respondents are over 60% Ready
  - About half of the providers are over 80% Ready

Survey Results – Key Take-Aways

- **Additional Information:**

Are you currently using an HIT system that includes an EHR?

	Count	Percent
Yes	22	100%
No	0	0%
Total	22	100%

Do you have experience using or submitting data to IBHRs?

	Count	Percent
Yes	20	94%
No	2	6%
Total	22	100%

Specific Criteria With Lower Rates of Readiness

Community & Cultural Needs:

- Training plan for staff that addresses culturally competent services
- Staffing plan is responsive to community needs assessment
- The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer
- Key documents and information are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats.

Specific Criteria With Lower Rates of Readiness

Crisis Services:

- We have an established protocol specifying the role of law enforcement during the provision of crisis services
- A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public

Specific Criteria With Lower Rates of Readiness

Designated Collaborative Organizations:

- For services that will be coordinated with a DCO to provide, we have necessary oversight in place to ensure DCOs are compliant with all CCBHC requirements
- The CCBHC retains ultimate clinical responsibility for services provided at the DCO, and the CCBHC has formal agreements with its DCOs to make this accountability clear
- The CCBHC has formal arrangements and shared systems/processes with the DCO to obtain access to needed data on consumers served (including those related to all required reporting requirements) and to obtain appropriate consents necessary to satisfy HIPAA, 42 CFR Part 2, and other requirements
- We have established communication with DCOs for the purposes of care coordination which utilizes HIT

Specific Criteria With Lower Rates of Readiness

Primary Care Screening:

- Primary care screening and monitoring is age appropriate and includes key health risks and responsible for ensuring indicated services are received in a timely fashion
- Primary care screening includes weight assessment and counseling for nutrition and physical activity for children and adolescents
- Primary care screening includes diabetes care for people with serious mental illness
- Primary care screening includes cardiovascular health screening for people who are prescribed antipsychotic medications
- Primary care screening includes cardiovascular health monitoring for people with cardiovascular disease and schizophrenia

Specific Criteria With Lower Rates of Readiness

Services for Veterans:

- Directly provide or coordinate to provide services for veterans (including those who are dishonorably discharged but have a history of service) and military families

Consumer Input:

- A substantial portion of the governing Board members are families, consumers, or people in recovery, and other methods for meaningful consumer/family input into policies, processes, and services are established

HIT/HIE:

- Data collection, reporting, tracking and sharing systems are in place for all data and quality metrics, including for DCOs

Specific Criteria With Lower Rates of Readiness

Quality & Compliance:

- CQI plans address consumer suicide attempts and deaths, fatal and non-fatal overdoses, 30-day hospital readmissions, and quality of care issues including monitoring for metabolic syndrome, movement disorders, and other medical side effects of psychotropic medications
- Quality improvement plans have an explicit focus on health disparities (including racial and ethnic groups and sexual and gender minorities)
- MOUs/MOAs are in place (or at least letters of support) with FQHCs/RHCs, other primary care providers, inpatient psychiatry, inpatient SUD treatment, residential programs, other regional support providers (criminal justice, child welfare, etc.), the nearest VA facility, hospitals, and other BH providers
- Outreach has been made to tribal or urban Indian organizations within the service area and agreements are in place to assist with the provision of services to AI/AN consumers

CCBHC Technical Assistance Planning

Survey Feedback Regarding TA Topics

Cost Reporting	Data Collection & Quality Reporting	Crisis Services	DCOs and Partnerships	Other
» General requests for cost reporting/ PPS assistance	» IBHRS Reporting » Data Collection » HEDIS Measures » QI » Help to establish data management consistency throughout the State » Outcome measures and methodology » Data coordination between partnering organizations » Using data from MCO's and other sources for best practice care coordination	» No TA requested	» Contracting / responsibilities for oversight of DCOs » DCO Contracting best practices » DCO rate development and oversight » Victims of Crime (VOCA) - confidentiality restrictions with sharing victim information with DCOs	» Anything that would reduce or dispel the fear of such a significant system change. » On-site and virtual » Provide various outreach opportunities to meet the needs of the providers

Survey Feedback Re: TA Topics

CCBHC Required Services

- Adding primary care services
- Bridging gaps in care with Veterans
- Clarification on the 51% requirement and what is considered an encounter
- CLAS Standards
- Completing the needs assessment
- Delivery of person-centered treatment planning for all clients
- Evidence Based Practice
- Data sharing from ED's when clients have been seen or have been inpatient, psychiatric, rehabilitative services
- Implementation timelines
- Incorporating Co-Occurring Treatment Modalities
- IPR expansion
- IPS (supportive employment)
- Peer Support including supervision of peer support
- Primary care integration
- Strategies to address health disparities
- Strategies to successfully serve rural areas
- Training related to military culture
- Walk in MH services

Proposed Training Modules and Concepts

Training Module	Training Concepts
Module 1 **Cost Reporting**	• PPS 101 • Allowable Costs • Projecting Total Number of Visits • Metrics for Quality Bonus Payment • Components of Cost Report
Module 2 **Data Collection & Quality Reporting**	• Required Measures • Collection methods - IBHRS • Reporting Requirements • Data Sharing between partners
Module 3 **CLAS Standards & Culturally Responsive Care**	• Introduction to National Culturally and Linguistically Appropriate Services (CLAS) Standards • Advancing Behavioral Health Equity • Culturally Responsive Care in Mental Health
Module 4 **DCOs and Partnerships**	• Introduction to DCO and Care Coordination Partnerships • Deep Dive: CCBHC & DCO Contracting and Oversight • Understanding Data Sharing and Care Coordination Workflows
Module 5 **CCBHC Required Services**	• Primary Care Screening: Best Practices • Crisis Services Continuum: Best Practices • Integrated MH& SUD Care: Best Practices
Module 6 **Specialty Populations: Veterans Health & Tribal Health in Iowa**	• Partnering and Providing Behavioral Health Services for Veterans • Partnering and Providing Tribal Behavioral Health Services

Introduction to CLAS Standards

Adapted from: *"Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care," U.S. Department of Health and Human Services Office of Minority Health*

What are CLAS Standards?

- In 2000, the federal government developed national standards on culturally and linguistically appropriate services (CLAS) in health care.
- CLAS are respectful and responsive to each person's culture and communication needs.
- CLAS helps providers take into account:
  - Cultural health beliefs
  - Preferred languages
  - Health literacy levels
  - Communication needs

What are CLAS Standards?

- The National CLAS standards gives health organizations action steps for providing CLAS.
- They offer guidance in the areas of:

CLAS Standard #1

Provide effective, equitable, understandable, and respectful quality care and services

- Purpose:
  - To create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care
  - To ensure that all individuals who receive health care and services have culturally and linguistically appropriate encounters
  - To meet communication needs so that individuals can understand the health care and services they are receiving, participate effectively in their own care, and make informed decisions
  - To eliminate discrimination and disparities
- Standard 1 is the **Principal Standard**
- Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of CLAS that are necessary to achieve the Principal Standard.

CLAS Standard #2

Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources

- Purpose:
  - To ensure the provision of the appropriate resources and accountability needed to support and sustain initiatives
  - To model appreciation and respect for diversity, inclusiveness, and all beliefs and practices
  - To support a model of transparency and communication between the service setting and the populations it serves
- Implementation Strategies:
  - Engage community members in the designing and furnishing of physical spaces to promote a welcoming and culturally respectful environment.
  - Develop strategies to collect authentic, sustained representative public input that includes the immigrant community.
  - Develop multiple communication channels with community members.
  - Place a priority focus on outreach to and engagement with immigrant families by establishing relationships with community leaders in these groups.

CLAS Standard #2

Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources

- Implementation Strategies (cont.):
  - Engage state- and local-level leadership to promote and support the National CLAS Standards at an institutional and community level.
  - Develop and implement a sustainability plan that includes annual evaluation of CLAS competencies and related policies and practices.
  - Establish regularly scheduled CLC trainings, and identify and leverage funding opportunities for CLC professional development.
  - Post the National CLAS Standards in public areas to inform clients of their rights and the center's intent to provide culturally and linguistically competent services.

CLAS Standard #3

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce responsive to the population in the service area

- Purpose:
  - To create an environment in which culturally diverse individuals feel welcome and valued
  - To promote trust and engagement with the communities and populations served
  - To infuse multicultural perspectives into the planning, design, and implementation of CLAS
  - To ensure that diverse viewpoints are represented in governance decisions
  - To increase staff knowledge and experience related to culture and language

CLAS Standard #3

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce responsive to the population in the service area

- Implementation Strategies:
  - Allocate resources to assist the administration in identifying pools of qualified leadership and staff members who are proportionately representative of the community served.
  - Provide hiring opportunities for education and mental health professionals, through multiple strategies including job fairs, advertisements in listservs and newsletters of national ethnic associations or organizations placing a priority on individuals that are more representative of the community served.
  - Build community trust and engagement by hiring highly qualified education and mental health professionals who are more reflective of local residents.

CLAS Standard #3

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce responsive to the population in the service area

- Implementation Strategies (cont.):
  - Establish a National CLAS Standards taskforce inclusive of representatives from immigrant families and community advocacy groups to establish goals, objectives, tasks, timelines, quality indicators, and responsible parties to:
    - develop a comprehensive strategic plan for ensuring a diverse, sustainable and inclusive leadership and staff; and,
    - ensure that diverse inclusive opinions are represented in governance decisions.
  - Develop a set of key activities and strategies focused on improving CLAS-driven equity, access, and quality service.

CLAS Standard #4

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis

- Purpose:
  - To prepare, support and sustain a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations
  - To increase the capacity of staff to provide culturally and linguistically appropriate services
  - To assess the progress of staff in developing skills in cultural, linguistic, and health literacy competency
  - To foster an individual's right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and health care

CLAS Standard #4

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis

- Implementation Strategies:
  - Allocate resources to provide CLAS training, professional development, and tools to service providers, staff, and administration.
  - Allocate resources for new and existing mental health service providers and community stakeholder groups that focus on building collective CLAS competencies and making related policy, procedural, and practice improvements.
  - Consult with professional staff to learn how to respect and integrate cultural beliefs and practices with western practices to improve access, use, and health outcomes; and implement training protocols.
  - Monitor the development in staff, administration, and mental health service provider's competency in delivering culturally and linguistically appropriate practices.

CLAS Standard #4

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis

- Implementation Strategies (cont.):
  - Establish policies and procedures to support the rights of patients, their families and community to receive respectful and nondiscriminatory services by developing and implementing education and training programs that address the impact of culture on health and health care.
  - Encourage and support all other service providers to take the same steps internally and hold themselves accountable to do these actions through strategic planning in an effort to improve access, use, and outcome for all community members

CLAS Standard #5

Offer language assistance to individuals who have limited English proficiency and/or other communication needs at no cost to them to facilitate timely access to all health services

- Purpose:
  - To ensure that individuals with LEP and/or other communication needs have equitable access to health services
  - To help individuals understand their care and service options and participate in decisions regarding their health and health care
  - To increase individuals satisfaction and adherence to care and services
  - To improve patient safety and reduce medical error related to miscommunication
  - To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements

CLAS Standard #5

Offer language assistance to individuals who have limited English proficiency and/or other communication needs at no cost to them to facilitate timely access to all health services

- Implementation Strategies:
  - Conduct community needs assessments and Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses to assess the language needs of their patients and family members.
  - Ensure that staff are fully aware of, and trained in, the use of language assistance services, policies and procedures.
  - Develop strategies for identifying the language(s) an individual speaks and add this information to that person's health record.
  - Conduct an internal assessment of organizational capabilities, including the capacity to provide free language interpretation.
  - Use qualified and trained interpreters to facilitate communication, including ensuring the quality of the language skills of self-reported bilingual staff who use their non-English language skills during patient encounters.

CLAS Standard #5

Offer language assistance to individuals who have limited English proficiency and/or other communication needs at no cost to them to facilitate timely access to all health services

- Implementation Strategies (cont.):
  - Recruit and hire qualified bilingual providers/practitioners.
  - Ensure communication with community members is appropriate to diverse linguistic characteristics, including, but not limited to, primary language, literacy skills, and disability status.
  - Assist with community members' access to federally required interpreter services.
  - Plan and implement language access services that are low-cost or, if possible, free of cost. 10. Post signs that inform patients that language assistance services are available.
  - Establish contracts with interpreter services for in-person, over-the-phone, and video remote interpreting.
  - Partner with organizations and community members to ensure training incorporates aspects of cultural humility needed for social flourishing, community resilience and empowerment.

CLAS Standard #6

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing

- Purpose:
  - To inform individuals with LEP, in their preferred language, that language services are readily available at no cost to them
  - To facilitate access to language services
  - To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements

CLAS Standard #6

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing

- Implementation Strategies:
  - Develop verbal and written language service notification protocol and training for personnel that describes the type of communication and language assistance available, including telephonic language services, to whom they are available, and the process for identifying patients with LEP and how to connect them to appropriate language services.
  - Place written language service notifications, which are easy to understand at low literacy levels, on the registration desks, in the waiting rooms, and in financial screening rooms.
  - Standardize procedures for personnel who serve as initial point of contact to provide staff with a script to ensure that they inform clients and family members in both verbal and written form of the availability of language assistance and to inquire whether they will need to utilize any of the services available.

CLAS Standard #6

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing

- Implementation Strategies (cont.):
  - Develop organization policies for cross-communication exchange and interpreter services such as using "I speak" cards written in native languages for patients to indicate their preferred language to personnel upon arrival.
  - Develop and utilize a patient survey tool that identifies and documents the patient's language preference and type of language services needed (verbal or written), and include it in the patient's medical files.
  - Ensure all written intake forms clearly state that communication and language assistance is provided by the organization, and whether it is free of charge to individuals.
  - Publicize availability of language assistance services in local foreign language media, such as television channels and newspapers.

CLAS Standard #7

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

- Purpose:
  - To provide accurate and effective communication between individuals and providers
  - To reduce misunderstanding, dissatisfaction, the omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues caused by reliance on staff or individuals lacking interpreter training
  - To empower individuals to negotiate and advocate, on their own behalf, important services through effective and accurate communication with health and health care staff
  - To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements.

CLAS Standard #7

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

- Implementation Strategies:
  - Establish policies that recognize interpreting in a mental health situation is a specialized skill, even for experienced healthcare interpreters. Interpretation requires knowledge of culture, including an understanding of the idioms used to express emotions. The National Council on Interpreting in Health Care offers resources on mental health care in translation.
  - Develop a process for ensuring the availability of qualified individuals who can provide language assistance services based on the language, hearing and visual needs of the district. These individuals should meet the standards established by interpreting professional organizations such as the American Translators Association, National Council on Interpreting in Health Care or in the Registry of Interpreters for the Deaf for American Sign Language.

CLAS Standard #7

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

- Implementation Strategies (cont.):
  - Partner with certifying agencies for healthcare interpreters, or language companies for training individuals in providing language assistance. Interpreter services can also be found in registries maintained by national/international organizations such as:
    - American Translators Association
    - National Board of Certified Medical Interpreters
    - Certification Commission for Healthcare Interpreters
    - Registry of Interpreters for the Deaf
  - Develop and administer a survey to assess personnel's rating of the interpreter services offered and if they can recognize when a patient is using an untrained interpreter (e.g., minor, family member).

CLAS Standard #7

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

- Implementation Strategies (cont.):
  - Develop and administer a survey to assess personnel's rating of the interpreter services offered and if they can recognize when a patient is using an untrained interpreter (e.g., minor, family member).
  - Employ a "multifaceted model" of language assistance. Provide language assistance in a variety of models, including bilingual staff, dedicated language assistance (e.g., a contract interpreter), telephone or digital technology.
  - Partner with the foreign language, public health education, and communication departments of local colleges and universities to identify and utilize faculty members and/or advanced/graduate students who can be/are trained to serve as interpreters and translators. Independent study credits for health education and health promotion can be offered to reduce the costs to the clinic

CLAS Standard #7

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

- Implementation Strategies (cont.):
  - Develop a strategy to ensure the staff who wish to communicate in a language other than English are trained and tested.
  - Hire qualified mental health translators to translate all materials into the languages used in the area.
  - Engage community members to do the translation, including dialects used among the community to create and sustain community partnerships to address behavioral health issues.
  - Track how often interpretation is done by untrained interpreters (e.g., staff members, patient's family or friends, etc.) as part of quality improvement monitoring

CLAS Standard #8

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by populations in the service area

- Purpose:
  - To ensure that readers of other languages and individuals of various health literacy levels are able to access care and services
  - To provide access to health-related information and facilitate comprehension of and adherence to instructions and health plan requirements
  - To enable all individuals to make informed decisions regarding their health, health care, and service options
  - To offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members
  - To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirement

CLAS Standard #8

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by populations in the service area

- Implementation Strategies:
  - Conduct ongoing needs assessments of the cultural and linguistic appropriateness of the communication and language assistance.
  - Develop and administer patient and staff surveys to assess the literacy levels of educational materials and the variety/quality of translated languages used in educational materials. Assessment tools like CDC's Clear Communication Index and AHRQ's Patient Education Materials Assessment Tool can also be used for English-only materials.
  - Develop protocols to evaluate the print and multimedia materials and signage used that are responsive to the populations served by using easy-to-understand language.
  - Develop protocols to establish a standard for the availability of copies of important documents in languages other than English. Protocols should also include provisions for sight translation where an interpreter explains an English form on the spot to a patient. The National Council on Interpreting in Health Care offers guidelines for sight and written translation for healthcare interpreters.

CLAS Standard #8

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by populations in the service area

- Implementation Strategies (cont.):
  - Conduct ongoing assessments of staff and personnel of the understanding and availability of patient's educational materials and the cultural and linguistic appropriateness of signs and maps.
  - Promote translated print and multimedia materials and language assistance signage to all patients and families, and supplement written information with oral translation by trained staff members when needed.

CLAS Standard #9

Infuse CLAS goals, policies, and management accountability throughout an organization's planning and operations

- Purpose:
  - To make CLAS central to the organization's service, administrative, and supportive functions
  - To integrate CLAS throughout the organization (including the mission) and highlight its importance through specific goals
  - To link CLAS to other organizational activities, including policy, procedures, and decision making related to outcomes accountability

CLAS Standard #9

Infuse CLAS goals, policies, and management accountability throughout an organization's planning and operations

- Implementation Strategies:
  - Develop a patient assessment form that considers the patient's holistic health needs related, but not limited to cultural and religious beliefs, socio-emotional needs and considerations, desire and motivation to learn, physical or cognitive limitations, or barriers to communication.
  - Develop a protocol to use the assessment form to inform the comprehensive Cultural and Linguistic Competence (CLC) plan.
  - Identify a CLC Lead Coordinator.
  - Convene and support a CLC Committee to develop CLC policies and procedures, as part of the governance structure, that includes representatives from the communities to be served (e.g., youth, family, and providers), and key partners.

CLAS Standard #9

Infuse CLAS goals, policies, and management accountability throughout an organization's planning and operations

- Implementation Strategies (cont.):
  - Develop a CLC/CLAS strategy through a series of actions regarding the infusion and implementation of CLC as an iterative, developmental process reflecting the importance of a team approach and shared responsibilities. Its purpose is to facilitate the development and integration of CLAS and CLC. See A Treatment Improvement Protocol Improving Cultural Competence (TIP 59) for additional details.
  - Coordinate the implementation of the community team's CLC organizational self-assessment. Provide information and consultation about the community's CLC strengths, challenges, and opportunities; and include information about the community's linguistic diversity.
  - Convene a comprehensive continuous quality improvement process team where the evaluator and other team members address and assess local disparities and disproportionalities identified in the community needs assessment—where the population of focus resides.

CLAS Standard #9
Infuse CLAS goals, policies, and management accountability throughout an organization's planning and operations

- Implementation Strategies (cont.):
  - Ensure CLC Committee participates in the:
    - hiring process by developing interview questions and participating in interviews, to ensure proportionate representation that reflects the population to be served both culturally and linguistically.
    - writing/editing of contracts/subcontracts/memoranda of understanding to ensure that CLC is addressed, especially in expectations and performance indicators/measures.
    - process for designing performance appraisals and the performance appraisal for staff by incorporating CLC-related performance indicators/measures, which can later be used to achieve standard
    - activities for developing a culturally and linguistically competent workplace, including processes, policies, procedures, practices, and evaluation.

CLAS Standard #9

Infuse CLAS goals, policies, and management accountability throughout an organization's planning and operations

- Implementation Strategies (cont.):
  - Engage the administrative team in the CLC self-assessment process as a professional development tool to assess strengths, areas of improvement and needs. Address any needs through coaching, training, information and resource sharing, and TA.
  - Develop a plan to follow up on the results of the CLC self- and organizational assessment and community needs assessment.
  - Develop CLC professional development goals and performance measures for staff.

CLAS Standard #10

Conduct ongoing assessments of an organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities

- Purpose:
  - To assess performance and monitor progress in implementing the National CLAS Standards
  - To obtain information about the organization and the people it serves to tailor and improve services
  - To assess the value of CLAS-related activities relative to the fulfillment of governance, leadership, and workforce responsibilities

CLAS Standard #10

Conduct ongoing assessments of an organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities

- Implementation Strategies:
  - Conduct an organizational needs assessment using existing cultural and linguistic competency (CLC) assessment tools to inventory structural policies, procedures, and practices. These tools can provide guidance to determine whether the core structures and processes, such as management, governance, delivery systems, and customer relation functions necessary for providing CLAS are in place.
  - Use results from CLC assessments to identify assets (e.g., existing relationships with community-based ethnic organizations and leaders), risks (e.g., no translated signage or CLC training), and opportunities to improve the organization's structural framework and capacity to address CLC in care (e.g., revise mission statement)

CLAS Standard #10

Conduct ongoing assessments of an organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities

- Implementation Strategies (cont.):
  - Develop CLAS policies/management procedures following the CLC assessment. Ensure protocols are in place for subsequent ongoing CLC assessment to help organizations monitor their progress in refining their strategic plans.
  - Conduct assessment of client/patient feedback through a survey of services (e.g. interpreter, provider CLC, physical space, attention to care etc.). The client/patient feedback can provide a measure of patient experiences integral to improving and ensuring the care provided is high quality and tailored for individuals a center serves.

CLAS Standard #11

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

- Purpose:
  - To accurately identify population groups within a service area
  - To monitor individual needs, access, utilization, quality of care, and outcome patterns
  - To ensure equitable allocation of organizational resources
  - To improve service planning to enhance access and coordination of care
  - To assess and improve to what extent health care services are provided equitably
- Implementation Strategies:
  - Develop protocols to streamline data collection processes across agencies to ensure that data are not fragmented or poorly integrated, modify and streamline data collection instruments, and create standardized demographic data collection instruments, taking into account the HHS Data Collection Standards.

CLAS Standard #11

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

- Implementation Strategies (cont.):
  - Identify how individual data collection methods and instruments can be modified to align more closely with the National CLAS standards (see pages 109 and 110 in the Blueprint for Advancing and Sustaining CLAS Policy and Practice).
  - Work with the community members to identify the racial, ethnic, gender, language, sexual orientation, gender identity and disability status categories most relevant to the community.
  - Identify and train data collection personnel in CLC.
  - Identify and develop data-sharing mechanisms that adhere to confidentiality requirements, including the utilization of health information technology, quality assurance and accountability measures.

CLAS Standard #11

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

- Implementation Strategies (cont.):
  - Develop a process that can facilitate client self-identification versus staff observation and visual determinations.
  - Develop Memoranda of Agreements related to data collection and sharing.
  - Develop a plan to use demographic data in concert with service and quality care data for evaluation and continuous quality improvement activities.
  - Use a validated and reliable CLC behavioral health organization self-assessment tool to inform continuous quality improvement. Refer to the Evaluation of the National CLAS Standards toolkit (https://minorityhealth.hhs.gov/assets/PDF/Evaluation_of_the_Natn_CLAS_Standards_ Toolkit_PR3599_final.508Compliant.pdf) for a guide to evaluating the implementation of the National CLAS Standards.

CLAS Standard #12

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

- Purpose:
  - To determine the service assets and needs of the populations in service areas (needs assessment)
  - To identify all services available and unavailable to populations in the service areas (resource inventory and gap analysis)
  - To determine which services to provide and how to implement them, based on the results of the community assessment
  - To ensure that health and health care organizations obtain demographic, cultural, linguistic, and epidemiological baseline data (quantitative and qualitative), and update the data regularly to better understand the populations in their service areas

CLAS Standard #12

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

- Implementation Strategies:
  - Establish a coalition that includes representatives of the community to develop and conduct a comprehensive community service assessment to assess the behavioral health needs, prevention/early identification/intervention resources, and gaps.
  - Analyze quantitative data from the assessment and the qualitative data from the consultations with cultural leaders to inform culturally appropriate services that meet the unique needs of its diverse youth population.
  - Partner with the different systems to negotiate data-sharing agreements to provide as many data points as possible to inform the process.

CLAS Standard #12

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

- Implementation Strategies (cont.):
  - Collaborate with a local university to analyze assessment data, disaggregated by race, ethnicity, gender, language, sexual orientation, gender identity, and disability status.
  - Identify disparities or disproportionalities from the disaggregated data through a community participatory effort.
  - Invite cultural leaders and healers from the communities-at-large to inform the coalition about the historical and current cultural underpinnings that contribute to this behavior, and to inform the community's efforts to develop culturally and linguistically appropriate interventions, in order to be inclusive, representative and critical of the intersectionality present in the diverse community.

CLAS Standard #13

Partner with a community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

- Purpose:
  - To provide responsive and appropriate service delivery to a community
  - To ensure that services are informed and guided by community interests, expertise, and needs
  - To increase the use of services by engaging individuals and groups in the community in the design and improvement of services to meet their needs and desires
  - To create an organizational culture that leads to more responsive, efficient, and effective services and accountability to the community
  - To empower members of the community to become active participants in the health and health care process.

CLAS Standard #13

Partner with a community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

- Implementation Strategies:
  - Engage all sectors of the community from the beginning and throughout the process in identifying the issues, planning the process, designing the approach and interventions, implementing the recommendations, and evaluating the policies and practices to ensure a culturally and linguistically good fit.
  - Listen to the community, especially those who have never been included in discussions or decisions about solutions to community challenges—particularly those involving behavioral health issues.
  - Value the general community's experience and expertise in resolving complex issues because all sectors of the community—not only those in possession of authority, power, or academic knowledge—are equally valuable for developing solutions.

CLAS Standard #13

Partner with a community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

- Implementation Strategies:
  - Evaluate existing behavioral health policies that affect funding, research, practice, or evaluation to determine whether they are producing the intended outcome; if they are not, work to change them so they do.
  - Assess areas that lack policies and, with partners, develop new policies and work to enact them if the existing ones are ineffective.
  - Identify "cultural brokers" that are known and trusted members of the community, to serve as a bridge between the community where they are trusted and the agencies, organizations, and systems that provide services. For example, in Spanish-speaking communities, *promotores de salud* or community health workers are indispensable members of a behavioral health team because they are also trusted members of the community who share the language, culture, customs, and values of the people they work with and can share valuable and potentially lifesaving behavioral health information.

CLAS Standard #14

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

- Purpose:
  - To facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations
  - To anticipate, identify, and respond to cross-cultural needs
  - To meet federal and/or state-level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and procedures
- Implementation Strategies:
  - Establish an advisory board with representatives from partner organizations, and key community based offices with representatives from underserved populations, including local African American, Latinx, and sexual and gender minority organizations.

CLAS Standard #14

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

- Implementation Strategies (cont.):
  - Convene advisory board to discuss issues affecting the diverse communities and address identified disparities in services experienced by the African Americans, Latinx, and sexual and gender minority youth and adults.
  - Prepare data fact-sheets containing current community data, disaggregated by underserved demographic groups and distribute to all advisory board members for review, prior to each meeting. During meetings, encourage all members to brainstorm and produce recommendations to improve practice in areas of need and craft messages for the community's social marketing strategies, tailored to the focus population.

CLAS Standard #14

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

- Implementation Strategies (cont.):
  - Develop and distribute short memos, on a quarterly basis, that summarize agency-level efforts to provide CLAS in the community. Design memos in appropriate languages that are easy to understand and are aligned with Standard 8 strategies. Include demographic data on subpopulations, summaries of related staff competency trainings, results from the community assessment (Standard 10), and a synthesis of issues and complaints from consumers (Standard 14). And, distribute memos throughout agency and community-based organization listservs, to be shared at management meetings. Additionally, post memos on agency websites for public access.

CLAS Standard #14

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

- Implementation Strategies (cont.):
  - Host a biannual community forum that is open to the general public to review progress and needs, and arrange to have the forum broadcast online, on local public access television or a similar venue to reach community members that are unable to attend. Each forum could provide written materials for service providers as well as youth and families that come from diverse backgrounds to address issues related to public health and primary care.

CLAS Standard #15

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

- Purpose:
  - To convey information to intended audiences about efforts and accomplishments in meeting the National CLAS Standards
  - To learn from other organizations about new ideas and successful approaches to implementing the National CLAS Standards
  - To build and sustain communication on CLAS priorities and foster trust between the community and the service setting
  - To meet community benefit and other reporting requirements, including accountability for meeting health care objectives for addressing the needs of diverse individuals or groups

CLAS Standard #15

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

- Implementation Strategies:
  - What steps can a community health center take to communicate progress in implementing and sustaining CLAS?
  - Establish an advisory board with representatives from partner organizations, and key community based offices with representatives from underserved populations, including local African American, Latinx, and sexual and gender minority organizations.
  - Convene advisory board to discuss issues affecting the diverse communities and address identified disparities in services experienced by the African Americans, Latinx, and sexual and gender minority youth and adults.

CLAS Standard #15

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

- Implementation Strategies (cont.):
  - Prepare data fact-sheets containing current community data, disaggregated by underserved demographic groups and distribute to all advisory board members for review, prior to each meeting. During meetings, encourage all members to brainstorm and produce recommendations to improve practice in areas of need and craft messages for the community's social marketing strategies, tailored to the focus population.
  - Develop and distribute short memos, on a quarterly basis, that summarize agency-level efforts to provide culturally and linguistically appropriate services in the community. Design memos in appropriate languages that are easy to understand and are aligned with Standard 8 strategies. Include demographic data on subpopulations, summaries of related staff competency trainings, results from the community assessment (Standard 10), and a synthesis of issues and complaints from consumers (Standard 14). And, distribute memos throughout agency and community-based organization listservs, to be shared at management meetings. Additionally, post memos on agency websites for public access.

CLAS Standard #15

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

- Implementation Strategies (cont.):
  - Host a biannual community forum that is open to the general public to review progress and needs, and arrange to have the forum broadcast online, on local public access television or a similar venue to reach community members that are unable to attend. Each forum could provide written materials for service providers as well as youth and families that come from diverse backgrounds to address issues related to public health and primary care

Public Comment

Thank You!

Questions?

We would greatly appreciate all participants in today's meeting completing this brief survey that will help us know more about Iowa CCBHC stakeholders and also provide you an opportunity to share your thoughts about the behavioral health system. Please click on this link to complete this voluntary survey.

https://idph.qualtrics.com/jfe/form/SV_8wfkjr2yXtj62Sa

Appendix

Survey Results

Survey Results – Community Needs

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
1A - We can complete a needs assessment for our target geographic catchment area that addresses cultural, linguistic, treatment and staffing needs and resources of the area to be served by the CCBHC and addresses transportation, income, culture, and other barriers, and includes consumer/family and community partner input.	36%	0%	0%	14%	11%	39%
1A - We are prepared to update the needs assessment every three years (at least).	36%	3%	0%	3%	14%	44%
1A - Our service package design is driven by the CCBHC needs assessment.	36%	6%	6%	11%	17%	25%
4H - Our case management services are targeted at specific population(s) identified by the CCBHC's needs assessment	36%	0%	6%	8%	25%	25%
1C - We have a training plan for staff that addresses the need for culturally competent services (including for veterans and active duty military) given the needs identified in the needs assessment	36%	0%	6%	14%	22%	22%
1A - We have a staffing plan and it is responsive to the findings in our community needs assessment	36%	0%	0%	14%	28%	22%
1A - Needs assessment informs which populations require language assistance.	36%	6%	6%	6%	19%	28%

Survey Results – Treatment Service Planning

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4A - Consumers have choice of provider within the program	39%	0%	0%	8%	6%	47%
4A - Consumers have access to a grievance process	39%	0%	0%	0%	3%	58%
4D - We collect a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking and the indication for any medication	39%	0%	0%	0%	14%	47%
4D - We obtain consents to share information	39%	0%	0%	0%	0%	61%
4B - Care is person/family-centered, recovery oriented, self-directed, culturally competent, and for children/adolescents, developmentally appropriate	39%	0%	0%	0%	14%	47%

Screening & Assessments Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
2B - Assessments are updated at least every 12 months or when a consumer's status changes	36%	0%	0%	6%	19%	39%
4D - Screening, assessment, and diagnosis services are provided by licensed professionals, timely (within 60 days) and responsive, utilizing culturally/linguistically appropriate standardized and validated tools that accommodate disabilities	36%	0%	0%	3%	17%	44%
4D - Provide screening and offer cessation intervention for tobacco use	36%	0%	6%	8%	14%	36%
4D - Provide screening and brief counseling for unhealthy alcohol use	36%	0%	3%	3%	14%	44%
4D - Provide suicide risk assessment for child and adolescent major depressive disorder	36%	0%	0%	3%	8%	53%
4D - Provide suicide risk assessment for adult major depressive disorder	36%	0%	0%	3%	6%	56%
4D - Provide screening and follow-up plan for clinical depression	36%	0%	0%	3%	11%	50%
4D - Screening/assessment/diagnosis services consider preliminary diagnosis (if applicable)	36%	0%	0%	3%	3%	58%
4D - Screening/assessment/diagnosis services consider source of referral	36%	0%	0%	0%	11%	53%
4D - Screening/assessment/diagnosis services consider reason for seeking care, as stated by the consumer or other individuals who are significantly involved	36%	0%	0%	0%	3%	61%
4D - Screening/assessment/diagnosis services consider the consumer's immediate clinical care needs related to the diagnoses for mental and substance use disorders	36%	0%	0%	0%	0%	64%
4D - Conduct an assessment of whether the consumer is a risk to self or to others, including suicide risk factors	36%	0%	0%	0%	0%	64%
4D - Conduct an assessment of whether the consumer has other concerns for their safety	36%	0%	0%	3%	11%	50%
4D - Conduct an assessment of need for medical care (with referral and follow-up as required)	36%	0%	0%	6%	19%	39%
4D - Determine whether a person presently is or ever has been a member of the U.S. Armed Services	36%	0%	0%	3%	14%	47%
4D - Conduct other assessment as the state may require as part of the initial evaluation	36%	0%	3%	6%	6%	50%

Survey Results – Treatment Service Planning

continued

Treatment & Service Planning Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
2B - Treatment plans are updated at least every six months of when a consumer's status changes	36%	0%	3%	8%	11%	42%
4D - Make a determination regarding the need for every service the CCBHC offers	39%	0%	3%	11%	17%	31%
4E - Person and family-centered treatment planning includes consumer (and family if appropriate) endorsement	36%	0%	0%	6%	8%	50%
4E - Use individualized treatment planning that includes shared decision-making	36%	0%	0%	0%	11%	53%
4E - Treatment planning addresses all services required	36%	0%	0%	11%	17%	36%
4E - Treatment planning is coordinated with the staff or programs needed to carry out the plan	36%	0%	0%	8%	8%	47%
4E - Treatment planning includes provision for monitoring progress toward goals	36%	0%	0%	0%	3%	61%
4E - Treatment planning is informed by consumer assessments	36%	0%	0%	0%	11%	53%
4E - Treatment planning considers consumers' needs, strengths, abilities, preferences, and goals, expressed in a manner capturing consumers' words or ideas and, when appropriate, those of consumers' families/caregivers	36%	0%	0%	3%	6%	56%
4E - Treatment planning seeks consultation for special emphasis problems and the results of such consultation are included in the treatment plan	36%	0%	0%	22%	11%	31%
4E - Treatment planning documents consumers' advance directives related to treatment and crisis management or consumers' decisions not to discuss those preferences	36%	0%	6%	8%	19%	31%
3D - Treatment planning is consumer/family centered, HIPAA compliant, culturally appropriate, and conducted by a culturally competent multi-disciplinary team	36%	0%	0%	8%	19%	36%
2C - Crisis plans are in place for all clients, including education on 988 resources	36%	3%	0%	3%	19%	39%

Survey Results – Required Services and Timeframe

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4A - Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all 9 required services	36%	0%	3%	6%	17%	39%
4A - The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.	36%	3%	3%	11%	17%	31%

Timely Provision of Care Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
2B - Existing consumers are seen within 10 business days for routine needs and within one business day for urgent needs	36%	0%	0%	17%	14%	33%
2B - Procedures are in place for immediate response to emergency/crisis needs	36%	0%	0%	0%	17%	47%
2B - Initial telephonic evaluations are followed up in person expeditiously with a completed evaluation within 10 business days	39%	0%	6%	6%	14%	36%

Outpatient MH & SUD Services Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4A - Directly provide or coordinate comprehensive outpatient MH and SUD services	36%	0%	0%	3%	8%	53%
4F - Outpatient MH and SUD services prioritize people with SMI (including those participating in AOT (also known as involuntary civil commitment) if current)	36%	0%	0%	3%	11%	50%
Directly provide or coordinate access to Medication Assisted Therapy (MAT) (except Methadone)	36%	0%	3%	14%	11%	36%
1B - If CCBHC is an Opioid Treatment Program (OTP), provide access to Methadone	53%	31%	3%	0%	3%	11%
1B - If CCBHC is not an OTP, we have a referral relationship with the local OTP and provide care coordination to ensure access to Methadone	36%	6%	0%	14%	11%	33%
4F - Intensive outpatient services for SUD	36%	8%	8%	3%	8%	36%
4F - Outpatient MH and SUD services utilize evidence-based practice	36%	0%	0%	8%	3%	53%
4F - Outpatient MH and SUD services include telehealth	36%	0%	0%	0%	6%	58%
4F - Outpatient MH and SUD services make specialized care available when needed	36%	0%	0%	6%	14%	44%
4F - Outpatient MH and SUD services are developmentally and functionally appropriate	36%	0%	0%	3%	8%	53%
4F - Outpatient MH and SUD services address comprehensive needs	36%	0%	0%	6%	11%	47%
4F - Outpatient MH and SUD services are delivered by specifically trained staff	36%	0%	0%	3%	3%	58%

Survey Results – Required Services and Timeframe continued

Crisis MH Services Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
2C - Directly provide or coordinate 24-hour crisis mental health services through an existing state-sanctioned, certified or licensed system or network. If the crisis partner is a state-sanctioned system that operates under less stringent standards, the CCBHC has requested HHS approval.	36%	3%	0%	3%	6%	53%
4A - Directly provide or coordinate treatment planning including crisis plan development	36%	0%	0%	0%	3%	61%
4C - Crisis services include 24x7 mobile crisis teams, emergency crisis intervention services, crisis stabilization services, suicide crisis response, and services for substance abuse crisis and intoxication (including ambulatory and medical detoxification services)	36%	6%	3%	8%	3%	44%
4C - Crisis response within one hour (two hours in rural and frontier settings) is available 24x7x365, advertised to the public, and coordinated with local EDs and law enforcement	36%	8%	0%	3%	14%	39%
4C - We have an established protocol specifying the role of law enforcement during the provision of crisis services	36%	3%	3%	19%	14%	25%
4C - A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public	36%	6%	3%	11%	22%	22%

Survey Results – Required Services and Timeframe continued

Additional Required Services Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4A - Directly provide or coordinate to provide primary care screening and monitoring	36%	8%	0%	6%	17%	33%
4G - Directly provide or coordinate screening for HIV and hepatitis A, B, and C	36%	0%	3%	14%	11%	36%
4A - Directly provide or coordinate to provide case management	39%	0%	3%	0%	8%	50%
4A - Directly provide or coordinate to provide psychiatric rehabilitation services and include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment	36%	3%	3%	17%	3%	39%
4I - Directly provide or coordinate to provide social support services such as clubhouse	36%	3%	6%	8%	8%	39%
4A - Directly provide or coordinate to provide recovery supports including peer support and family support	36%	0%	0%	11%	6%	47%
4A - Directly provide or coordinate to provide services for veterans (including those who are dishonorably discharged but have a history of service) and military families	36%	6%	6%	6%	22%	25%
3A - Care coordination (for both adults and children/adolescents) addresses medical, BH, and social services needs and complies with HIPAA and 42 CFR Part 2	36%	0%	3%	11%	14%	36%
4A - Directly provide or coordinate to provide screening, assessment, risk assessment, and diagnosis	36%	0%	0%	0%	8%	56%

Survey Results – Designated Collaborative Orgs

Criteria Percent

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
NA - For services we do not directly provide, we have identified appropriate DCO partners to coordinate in the provision of identified services to our clients	36%	0%	3%	3%	22%	36%
NA - For services that will be coordinated with a DCO to provide, we have executed contracts and/or Memorandum of Understandings (MOUs) with DCOs for the provision of services	39%	3%	6%	8%	19%	25%
NA - For services that will be coordinated with a DCO to provide, we have necessary oversight in place to ensure DCOs are compliant with all CCBHC requirements	39%	6%	11%	28%	11%	6%
1B - CCBHC and all participating DCOs comply with all local and state requirements for licensing, accreditation, and certification	39%	0%	3%	6%	8%	44%
4A - DCO services are held to the same quality standards and consumers served by a DCO have the same rights	39%	0%	0%	11%	14%	36%
4A - The CCBHC retains ultimate clinical responsibility for services provided at the DCO, and the CCBHC has formal agreements with its DCOs to make this accountability clear	39%	8%	6%	17%	19%	11%
1B - Practitioners (including in any DCOs) practice within the scope of their license	39%	0%	0%	0%	8%	53%
5A - The CCBHC has formal arrangements and shared systems/processes with the DCO to obtain access to needed data on consumers served (including those related to all required reporting requirements) and to obtain appropriate consents necessary to satisfy HIPAA, 42 CFR Part 2, and other requirements	39%	8%	14%	22%	6%	11%
3C - We have established communication with DCOs for the purposes of care coordination which utilizes HIT	39%	17%	11%	17%	6%	11%
3D - DCOs are involved in the treatment planning as appropriate	39%	8%	6%	17%	11%	19%

Survey Results – Staffing

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
1A - The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer	36%	3%	0%	8%	28%	25%
The management team includes, at a minimum, a CEO or equivalent/Project Director	36%	0%	0%	0%	6%	58%
1A - CCBCH management team includes a psychiatrist as Medical Director (does not need to be a full time employee)	36%	3%	0%	3%	14%	44%
If Medical Director is not experienced in treatment of SUD, the CCBHC employs or has an arrangement with an addiction medicine physician or specialist	42%	8%	0%	11%	3%	36%
1A - The staffing plan is consistent with state licensure requirements and any other needed accreditation standards	39%	0%	3%	0%	6%	53%
1A - The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan	36%	0%	0%	3%	14%	47%
1B - CCBHC employs prescribers who can prescribe and manage medications independently under state law, including buprenorphine, naltrexone and other medications used to treat opioid and/or alcohol use disorders	36%	3%	3%	8%	3%	47%
1B - CCBHC employs substance abuse specialists and people with expertise addressing trauma and promoting recovery for people with SMI and children with SED	39%	3%	0%	6%	8%	44%
1B - The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state	36%	0%	0%	0%	8%	56%
1B - Staff includes 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 (excludes Methadone unless CCBHC is also an Opioid Treatment Program [OTP])	36%	3%	3%	6%	8%	44%
1B - The CCBHC supplements its core staff as necessary in order to adhere to program requirements and individual treatment plans, through arrangements with and referrals to other providers	36%	0%	0%	0%	14%	50%
1C - Our organization has a CCBHC training plan that meets requirements and provider skills and competencies are tracked	36%	0%	6%	6%	17%	36%

Survey Results – Primary Care Screening

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4G - Primary care screening and monitoring is age appropriate and includes key health risks and responsible for ensuring indicated services are received in a timely fashion	36%	6%	6%	11%	17%	25%
4G - Primary care screening includes adult body mass index (BMI) screening and follow-up	36%	6%	6%	6%	19%	28%
4G - Primary care screening includes weight assessment and counseling for nutrition and physical activity for children and adolescents	36%	8%	6%	8%	22%	19%
4G - Primary care screening includes care for controlling high blood pressure	36%	8%	6%	6%	17%	28%
4G - Primary care screening includes diabetes screening for people who are using antipsychotic medications	36%	8%	3%	8%	11%	33%
4G - Primary care screening includes diabetes care for people with serious mental illness	36%	8%	3%	11%	17%	25%
4G - Primary care screening includes metabolic monitoring for children and adolescents who are prescribed antipsychotic medications	36%	11%	3%	11%	11%	28%
4G - Primary care screening includes cardiovascular health screening for people who are prescribed antipsychotic medications	36%	8%	3%	19%	8%	25%
4G - Primary care screening includes cardiovascular health monitoring for people with cardiovascular disease and schizophrenia	39%	8%	3%	17%	8%	25%
4G - Organizational protocols include screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan	36%	8%	3%	14%	11%	28%
4G - Able to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization	39%	3%	3%	11%	8%	36%

Survey Results – Veteran Services

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4K - Provide and coordinate to provide intensive, community-based behavioral health care for members of the U.S. Armed Forces and veterans is recovery-oriented, provided by a Principal Behavioral Health Provider, addresses co-occurring disorders in an integrated way, and is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA)	36%	3%	8%	6%	19%	28%
4K - Military service is documented and assistance with enrollment in VHA benefits is offered to clients who are eligible	36%	3%	6%	17%	11%	28%
4K - All staff are trained in military cultural competence	36%	8%	11%	11%	6%	28%
4K - We obtain veteran's verbal consent to the treatment plan in addition to other consent requirements	36%	0%	6%	0%	6%	53%

Survey Results – Veteran Services

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
6B - The Board is representative of the individuals being served in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, and sexual orientation, and in terms of types of disorders. Meaningful consumer participation in governance is provided in one of the following ways:	36%	6%	11%	6%	8%	33%
6B - 51% of the Board are families, consumers, or people in recovery	42%	8%	6%	14%	3%	28%
6B - A substantial portion of the governing Board members are families, consumers, or people in recovery, and other methods for meaningful consumer/family input into policies, processes, and services are established	42%	6%	8%	14%	11%	19%
6B - Consumer/family member representation on the Board is impossible, so an advisory structure that reports to the board, and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies processes, and services have been developed	44%	0%	6%	11%	11%	28%
3A - Family member participation is encouraged subject to privacy and confidentiality requirements and consumer consent	36%	0%	3%	6%	17%	39%
6B - 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	36%	6%	3%	3%	6%	47%

Survey Results – Equity

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
1D - Your organization takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities	36%	0%	0%	8%	6%	50%
1D - Interpretation (oral)/translation (written) service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population. To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting	36%	3%	3%	3%	6%	50%
1D - Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities	36%	3%	6%	0%	22%	33%
1D - Key documents and information are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC	36%	6%	6%	14%	17%	22%
1D - Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of the people receiving services	36%	3%	0%	8%	17%	36%
2A - Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations	36%	0%	0%	3%	31%	31%

Survey Results – HIT, HIE

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
5A - Data collection, reporting, tracking and sharing systems are in place for all data and quality metrics, including for DCOs	39%	6%	6%	19%	17%	14%
3B - EHR can capture demographics, diagnoses, and medications, provides decision support, has e-prescription capabilities, and allows reporting on CCBHC quality measures	36%	0%	3%	0%	11%	50%
3B - Policies and procedures for using data to improve quality are in place	36%	0%	3%	6%	22%	33%
5B - CCBHCs can disaggregate data to track and improve outcomes for populations facing health disparities	36%	0%	0%	11%	19%	33%
5B - If our CCBHC budget uses federal funding to acquire, upgrade, or implement technology to support these activities, the systems utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange	39%	3%	0%	3%	14%	42%
5B - Technology is certified to current criteria under the ONC Health IT Certification Program for relevant health IT capabilities	39%	3%	0%	8%	3%	47%
5B - We ensure DCOs have taken all steps, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements	36%	6%	11%	14%	3%	31%
5B - By the second year of operation, we will implement a plan to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system	39%	3%	0%	11%	11%	36%

Survey Results – Quality Compliance

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
NA - We are prepared to complete the CMS Cost Report (CMS 10398-43)	36%	0%	8%	14%	14%	28%
5B - CQI plans address consumer suicide attempts and deaths, fatal and non-fatal overdoses, 30-day hospital readmissions, and quality of care issues including monitoring for metabolic syndrome, movement disorders, and other medical side effects of psychotropic medications	36%	0%	8%	22%	17%	17%
5B - Quality improvement plans have an explicit focus on health disparities (including racial and ethnic groups and sexual and gender minorities)	39%	3%	8%	19%	19%	11%
3C - MOUs/MOAs are in place (or at least letters of support) with FQHCs/RHCs, other primary care providers, inpatient psychiatry, inpatient SUD treatment, residential programs, other regional support providers (criminal justice, child welfare, etc.), the nearest VA facility, hospitals, and other BH providers	36%	0%	3%	19%	28%	14%
3C - CCBHC has a care coordination partnership with the 988 crisis center in its service area	36%	0%	0%	14%	17%	33%
3C - Protocols are in place for tracking consumers, transitioning consumers from emergency settings on an expedited basis and establishing suicide prevention plans within 24 hours of discharge	36%	3%	3%	22%	8%	28%
1A - We maintain adequate liability/malpractice insurance adequate for the staffing and scope of services provided	36%	0%	0%	0%	3%	61%
1B - The clinic maintains all necessary state-required licenses, certifications, or other credentialing	36%	0%	0%	3%	6%	56%
1B - Practitioners (including in any DCOs) practice within the scope of their license according to federal, state, and local laws	36%	0%	0%	0%	6%	58%
6A - An annual financial audit is done and corrective actions are taken as indicated	36%	0%	0%	0%	3%	61%
3A - Policies and procedures for medication reconciliation with other providers are in place	36%	3%	0%	8%	17%	36%
2A - We comply with court-ordered services	36%	0%	0%	0%	0%	64%
2A - Continuity of operations/disaster plans are in place	36%	0%	0%	3%	6%	56%
2D - No client is refused services for financial reasons, and information about the sliding fee scale is available both online and in the facility	36%	0%	3%	0%	11%	50%
2E - No client is refused services due to the location of their residence, even if it is out of state	36%	3%	3%	6%	3%	50%
6A - Outreach has been made to tribal or urban Indian organizations within the service area and agreements are in place to assist with the provision of services to AI/AN consumers	39%	14%	17%	11%	3%	17%
1D - Services are accessible to people with limited English proficiency, non-English speakers, and people with disabilities (including intellectual and sensory)	36%	3%	8%	0%	8%	44%
1D - Consumer confidentiality is maintained, and consent processes are in place	36%	0%	0%	0%	3%	61%
2A - The location is clean, welcoming, safe, functional, compliant with state and federal regulations, easily accessible to the public, open at least some nights and weekends, and aligned with the needs identified in the needs assessment	36%	0%	0%	8%	6%	50%
1B - CCBHC and all participating DCOs comply with all local and state requirements for licensing, accreditation, and certification	36%	0%	0%	0%	6%	58%
1B - When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws	36%	0%	0%	0%	8%	56%
1D - Policies are explicit in ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider	36%	0%	0%	0%	11%	53%

Survey Results – Training, EBPs

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
1B - The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families	36%	0%	0%	11%	3%	50%
1B - The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state	36%	0%	0%	8%	6%	50%
1C - The training plan includes all CCBHC-required topics including: Evidence-based practices; Cultural competency; Person-centered and family-centered, recovery-oriented planning and services; Trauma-informed care; The clinic's policy and procedures for continuity of operations/disasters; The clinic's policy and procedures for integration and coordination with primary care; Care for co-occurring mental health and substance use disorders	36%	0%	0%	11%	17%	36%
1C - Required trainings are given at orientation and periodically thereafter	36%	0%	0%	3%	14%	47%
1C - Policies and procedures are in place to implement the training and track it	36%	0%	0%	3%	6%	56%
1C - In-service training and education programs are provided by qualified staff and documented	36%	0%	3%	0%	6%	56%
4F - Outpatient MH and SUD services utilize evidence-based practice	36%	0%	0%	0%	11%	53%
4I - Psychiatric rehabilitation services are evidence-based	36%	3%	6%	6%	6%	44%
1C - At orientation and annually thereafter, you provide trainings on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff	36%	0%	3%	11%	19%	31%
1C - Training are aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)	36%	0%	8%	11%	11%	33%
1C - Staff are regularly assessed on skills and competence in furnishing services and, as necessary, the CCBHC provides in-service training and education programs	36%	0%	0%	17%	14%	33%
1C - Policies and procedures describe the method(s) of assessing competency and the CCBHC maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services	36%	0%	0%	11%	25%	28%
1C - The staff personnel record documents whether trainings demonstration of competency are successfully completed (13)	36%	0%	0%	8%	8%	47%

Survey Results – Care MGMT, Wraparound, Outreach

	(blank)	1 = Not Ready	2 Readiness	3 Readiness	4 Readiness	5 = Fully Ready
4J - Peer specialist and recovery coaches, peer counseling, and family/caregiver supports are available	36%	0%	6%	3%	3%	53%
4H - Case management services assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports	36%	0%	3%	3%	0%	58%
2A - Transportation vouchers and telehealth options are available for clients who need them	36%	0%	3%	0%	3%	58%
2A - Outreach and engagement strategies are in use	36%	0%	0%	11%	14%	39%
2A - Outreach/engagement includes extending BH services to unserved individuals and underserved communities	36%	0%	3%	14%	6%	42%