Summary of Changes

This document summarizes the changes to the original 2015 version of the Certified Community Behavioral Health Clinic (CCBHC) criteria, which are reflected in the 2023 version.

Through a six-month process, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened listening sessions with interested parties to revise the CCBHC criteria. Input from individuals, organizations, states, and federal agencies shaped the 2023 version. The changes can be summarized into the following categories[1]:

- **Significant Updates to Advance the Field:** These are significant changes that correspond to updates to federal policies, national standards, evolving technologies, and/or infrastructure changes.
- **Needed Structural Changes to the Criteria:** These changes help align the delivery of service requirements with the statute or updated regulations.
- **Increased Flexibility:** These changes provide CCBHCs with additional flexibilities that were not available in the 2015 criteria.
- **Additions that Strengthen the Model:** These changes strengthen the CCBHC model.
- **Updated Language and Examples:** These changes reflect changing terminology in behavioral health. Examples are added to reflect emerging evidence-based services and to identify innovations in the field.
- **Clarifications:** These changes reflect clarification of the original criteria in areas where CCBHCs and states identified ambiguities.

Significant Updates to Advance the Field

Crisis Care

Since the initial criteria were published, SAMHSA has developed guidance around the components of a comprehensive crisis system in its *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*. In addition, the national 988 Suicide & Crisis Lifeline was established. States have also been working to develop their crisis response systems. Crisis care requirements in the criteria have been amended to align with the National Guidelines and the implementation of 988 while recognizing the difference in state definitions and the varying availability of crisis services. Trauma informed approaches must be applied to crisis care services.

2.c Incorporates education about 988.

3.a.5 Ensures that all persons receiving services have discussed a crisis plan, even if it simply to call 988.

[1] Some minor language changes may not be reflected in this table.

3.c.3 Requires that the CCBHC have a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.

4.c Integrates the *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* including minimum standards for the coordination of crisis services, mobile crisis response, and crisis stabilization. Describes expectations for emergency crisis intervention services that include coordination with state, regional, and systems to make referrals and coordinate and track care in real-time. Requires CCBHCs to establish protocols to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

4.c Describes expectations for mobile crisis care team availability and to respond within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Revisions permit the use of technologies when remote travel distances make response times unachievable. States that certify clinics that seek to use state sanctioned crisis systems that do not meet these requirements and individual CCBHCs that seek a DCO with a state-sanctioned crisis system that do not meet expectations may request approval HHS to do so.

4.c Describes crisis stabilization services and the minimum urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care.

4.c Incorporates the risk of drug and alcohol related overdose and intervention support following a non-fatal overdose and overdose prevention activities.

4.c Requires CCBHC training to focus on the application of trauma-informed approaches during crises.

Responding to the Opioid Epidemic

In the midst of the continuing national overdose crisis, the Criteria have been strengthened in several areas to increase the focus on substance use disorders and overdose:

1.b.2 Clarifies that the requirement that the CCBHC must have the capacity to prescribe FDA-approved medications used to treat opioid and alcohol use disorders makes an exception for Methadone. If the CCBHC does not have the ability to prescribe methadone directly, it should provide referral to an OTP with care coordination to ensure access to methadone and coordination with other services in the scope of their facility's legal ability to do so.

1.b.2 Adds requirement to consult with or have addiction medicine specialist or physician on staff unless the Medical Director has experience with substance use disorder.

1.b.2 Recognizes need for the availability of Methadone. If the CCBHC does not have the ability to prescribe methadone directly, it should provide referral to an OTP with care

coordination to ensure access to methadone and coordination with other services in the scope of their facility's legal ability to do so.

1.b.2 Other FDA-approved medications are added to Buprenorphine in 1.b.2.

1.c.1. Training on overdose prevention and response.

2.c.3 Includes focus on overdose prevention.

3.c.2 Updates partnerships to include an OTP if any exist within the CCBHC service area and included a focus on overdose prevention during transfers.

3.c.3 Adds SUD Recovery/Transitional housing to the list of examples of potential partnerships.

4.c.1 "Intoxication" including ambulatory and medical detoxification" replaced with "including risk of overdose and intervention following overdose reversal." Overdose prevention activities must include the provision of naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members.

4.d.3 Evaluation includes herbs and supplements and the indication for any newly started medications in the initial evaluation and replaced substances with "the use of any alcohol and/or other drugs."

4.d.4 Includes withdrawal and overdose risk concerns to the comprehensive assessment.

4.d.8 (Previously 4.d.9) Clarifies how CCBHCs act if unsafe substance use is identified during screening.

4.f.1 Adds a focus on harm-reduction and motivational techniques.

4.h.1 Adds supports for people deemed at high risk of suicide or overdose under targeted case management.

5.b.2 Adds events that require continuous quality improvement plans to address to include fatal and non-fatal overdoses, in response to the increase in overdose deaths resulting from opioid use and misuse.

Improving Health Equity

The Criteria have been updated to include a more intentional focus on disparities and social determinants of health.

1.c.1 Revises requirements to align training with National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to advance health equity, improve quality of services, and eliminate disparities.

2.a.6 Clarifies the meaning and intent of "outreach and engagement activities" to extend behavioral health services to unserved individuals and underserved communities.

4.b.2 Adds other cultural or ethnic groups in the recognition of particular cultural and other needs of clients and services that respond to the needs of sexual and gender minorities.

4.d.4 Adds a focus on social determinants of health and cultural, environmental, and linguistic factors that may affect the client's treatment plan as a part of the required comprehensive diagnostic and treatment planning evaluation.

5.b.1 Adds the requirements for CCBHCs to have an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and disaggregated data to track and improve outcomes for populations facing health disparities.

Full Summary of Changes

#	Location of Change	Category	Change
1	Throughout	Updated language	"Integration" is replaced with "coordination" for CCBHC services unless the word is used in specific context.
2	Throughout	Updated language	"Consumer" is replaced with "person [people] receiving services" whenever the term referred to person receiving services(s). In Section 6, Board Governance "consumer" was replaced "individuals with lived experience of mental and/or substance use disorders and families."
3	Throughout	Updated language	"Detoxification" is replaced with "medical withdrawal management."
4	Throughout	Updated language	"Catchment area" is replaced with "service area."
5	Throughout	Updated language	"State" is replaced with "certifying state."
6	Throughout	Updated language	"Mental health and substance use" is replaced with "behavioral health" unless the distinction is made for licensing or other purposes.
7	Throughout	Updated language	"Needs assessment" is replaced with "community needs assessment."
8	Throughout	Updated language	"Abstinence" is removed from the definition of health as a non sequitur.
9	Throughout	Updated language	Telehealth/telemedicine are expanded to include video conferencing, digital therapeutics, remote patient monitoring, asynchronous interventions, and other technologies to the extent possible in alignment with the preferences of the person receiving services.
10	Throughout	Updated language	"Medicaid Demonstration" is replaced with "Section 223 CCBHC Demonstration."

#	Location of Change	Category	Change
11	**Behavioral health** in Definitions	Updated language	The definition of behavioral health is updated to reflect promotion and prevention as well as treatment.
12	**Client** in Definitions	Updated language	"Client" is replaced with "Person or People Receiving Services" referring to people who receive one of the nine required CCBHC services. The new definition also points out that the person receiving services has a role in directing, expressing preferences, planning, and coordinating services. In these situations, when there is a legal guardian for the person receiving services, these roles shall also be filled by the legal guardian.
13	**Community Needs Assessment** in Definitions	Addition that strengthens the CCBHC model	CCBHC staffing plans, accessibility, and scope of service depend upon the completion of an accurate assessment of the behavioral health needs of the entire service area and all of the people who live there, including unserved and underserved communities. The requirements for the community needs assessments are assembled from the SAMHSA 223 web pages, criteria that cite the community needs assessment, the list of community partners identified in statute, requirements in SAMHSA's notice of funding availability for CCBHC Expansion grants, and the requirement that CCBHCs coordinate crisis care response with law enforcement agencies. The CCBHC is directly responsible for conducting the community needs assessment. Criteria that are impacted by the information gained from the community needs assessment are identified throughout the criteria.

#	Location of Change	Category	Change
14	**CCBHCs** in Definitions	Addition that strengthens the CCBHC model	The definition of CCBHCs makes the distinction between CCBHCs that are certified by states and those that are designated as CCBHCs after receiving SAMHSA CCBHC Expansion grants and indicates that CCBHCs must have the capacity to directly provide mental health and substance use services to people with serious mental illness and serious emotional disorders as well as developmentally appropriate mental health and substance use care for children and youth, unless substantially prohibited by their state because of their provider type. The definition describes how long certification and/or designation may last and under what circumstances they may end.
15	**Designated Collaborating Organizations** in Definitions	Clarification	The definition of a designated collaborating organizations clarifies the meaning of meeting CCBHC criteria by indicating that services that they provide under Criteria 4 must conform to the relevant applicable CCBHC criteria. Agreements with CCBHCs must include provisions that assure that the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria. DCOs are required to work towards inclusion of additional integrated care elements (e.g., including DCO providers on CCBHC treatment teams, collocating services). Language specific to Section 223 Demonstration payment mechanisms are removed from the definition.
16	**Measurement-Based Care** in Definitions	Addition that strengthens the CCBHC model	The definition of measurement-based care is included in Definitions and is referenced in 4.d.4 Comprehensive Evaluation.
17	**Peer/Family/Caregiver Support** in Definitions	Updated	“Peer/Family/Caregiver Support” replaces “Peer Support” and “Peer Support Specialist”
18	**Required Services** in Definitions	Clarification	The nine services that CCBHCs must provide are listed here.
19	**Satellite Facility** in Definitions	Updated	The definition of a satellite facility is updated because the services that CCBHCs must provide directly have changed.
20	**Targeted case management** was removed from Definitions	Updated	Targeted case management is defined in Criteria 4.h.

#	Location of Change	Category	Change
21	Appendix B	Updated	The quality measures used for the first Section 223 Demonstration program were updated for a variety of reasons including the recognition that CCBHCs are no longer restricted to participation in the 223 Demonstration program. The new measures are found in Appendix B.
22	1.a.1	Needed structural changes	Community needs assessments and staffing plans are prepared by the CCBHC. Its components are described in the terms and definitions of the criteria and must be updated regularly but no less frequently than every 3 years. Certifying states may add additional community needs assessment requirements.
23	1.a.2	Addition that strengthens the CCBHC model	Notes that staffing is based on the community needs assessment.
24	1.a.3	Increased flexibility	Removes the requirement that only CCBHCs operating within behavioral health professional shortage areas were permitted to hire a non-psychiatrist as the Medical Director, clarifies the role of the Medical Director and the need for consultation, recognizes positions that are equivalent to CEO, and clarifies the role of the Medical Director to provide guidance for clinical care. Adds that for CCBHCs unable to hire a psychiatrist and hire another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.

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25	1.b.2	Clarification	Clarifies that CCBHCs must include medically trained behavioral health care providers to prescribe FDA approved medications that can be used including methadone and specified treatment of tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. Defines experience in the assessment and treatment of substance use disorders, and that telehealth services delivered must be coordinated with other services delivered by the CCBHC. Certified/trained peer specialist(s)/recovery coaches and certified/staff family peer specialists are added to the examples of staff. Certifying states may specify which disciplines they require of staff.
26	1.c.1	Addition that strengthens the CCBHC model	Clarifies existing requirements and frequency of training specific to those staff in contact with clients and adds evidence-based practices; cultural competency; CCBHC policies and procedures for integration primary care; and care of co-occurring mental health, substance use, and health to required training. Clarifies that training must conform to CLAS standards.
27	1.c.2	Addition that strengthens the CCBHC model	Clarifies that staff competence is assessed regularly, and records of assessments are maintained for the duration of employment for staff with direct contact.
28	1.c.3	Addition that strengthens the CCBHC model	Encourages CCBHCs to provide initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.
29	1.d.1	Addition that strengthens the CCBHC model	Removes “if” from the expectation that CCBHCs take reasonable steps to provide meaningful access to individuals with limited English proficiency and language-based disabilities.
30	1.d.2	Clarification	Clarifies that translation/interpretation services are readily available in several formats.
31	1.d.3	Clarification	Clarifies that disabilities are not limited to hearing impairments.

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32	1.d.4	Addition that strengthens the CCBHC model	Updates the ways that clients can access information about CCBHC services by adding “online and paper format” and clarifies that resources should be available throughout the time the client is served. Adds that the community needs assessment informs the threshold for languages that require language assistance.
33	1.d.5	Increased Flexibility	Removes the interpretation of HIPAA Privacy Rule in their application to CCBHC policies.
34	2.a.1	Addition that strengthens the CCBHC model	Adds “sanitary” to the expectations of the CCBHC environment and encourages CCBHCs to establish tobacco free campuses.
35	2.a.2	Clarification	Notes that times and locations of CCBHC operations are informed by the community needs assessment.
36	2.a.3	Clarification	Provides examples of non-clinic settings that CCBHCs may provide services and that their selection is informed by the community needs assessment.
37	2.a.4	Clarification	Clarifies the intent behind transportation services.
38	2.a.5	Addition that strengthens the CCBHC model	Emphasizes alignment of service delivery technologies with preferences of people receiving services.
39	2.a.6	Clarification	Clarifies intent of outreach and engagement, adds “retention” and “inclusion” of underserved populations, and adds that it is informed by the community needs assessment. Assistance to access benefits and services are now described in 3.a.7
40	2.a.8	Clarification	Clarifies the meaning of a continuity of operations/disaster plan in reference to client services and access to medication as well as health IT systems including health records (both security/ransomware protection and backup) and access to these systems in case of disaster.

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41	2.b.1	Clarification	Clarifies that first contact with clients may include other remote forms of communication and changed terminology so that “preliminary screening” is referred to as “preliminary triage”. The “comprehensive person-centered and family-centered diagnostic and treatment planning evaluation” is reduced to “comprehensive evaluation". Notes that appropriate action may include plans to reduce or remove risk of harm and facilitation to outpatient services. Cross-references 4.c.1 regarding timelines and plans. Notes that recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers at the CCBHC’s discretion. Notes that independent screening and assessment processes for certain child and youth populations or other populations established by the state may be incorporated in the findings to avoid duplication of effort.
42	2.b.1 and 2.b.3	Clarification	Clarifies the difference between new person receiving services in 2.b.1 and existing person receiving services in 2.b.3 and that each must have timely access to services, including safety planning if appropriate.
43	2.b.2	Increased flexibility	The requirement for primary care consultation is removed. The frequency of treatment plan reviews and updates have been reduced from four times per year (every 90 days) to two times per year (every 6 months) and that changes are endorsed by the person receiving services.
44	2.b.3	Clarification	Clarifies language related to timely access to services for people who are already receiving services and accommodates their preferences. Same day and open access scheduling are encouraged.
45	2.c.1	Clarification	Clarifies that crisis management services must be available 7 days a week. The response time stated here is removed and referred to 4.c.
46	2.c.3	Updated language	Updates crisis planning by including 988 and overdose prevention. Cross-references to 3.a.4 and 1.d.
47	2.c.5	Clarification	Clarifies the purpose of establishing protocols with law enforcement.

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48	2.d.2	Addition that strengthens the CCBHC model	Recognizes literacy barriers as an issue for communicating sliding fees.
49	2.e.2	Addition that strengthens the CCBHC model	Encourages the CCBHC to consider technology or other practical service delivery mechanisms for people receiving services who live within the service area but distantly from CCBHC facilities. Clarifies that CCBHCs are not required to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. Protocols may address populations that may transition in and out of the service area including children in out-of-home placements and individuals who may be displaced by incarceration and housing instability.
50	3	Increased flexibility	Section 223 Demonstration states and participating clinics complained that time, energy, and legal resources were spent in futile attempts to obtaining legal documents from other non-DCO organizations to document care coordination agreements. As a result, CCBHCs have been unable to obtain care coordination agreements. The criteria have been revised to allow CCBHCs to achieve meaningful partnerships with community partners and expanded the means by which they can be documented. Criteria 3.c is renamed from "Care Coordination Agreements" to "Care Coordination Partnerships" and describes how partnerships, including attempts at partnerships, may be documented.
51	3.a.1	Clarification	Clarifies that CCBHCs also coordinate with other systems outside of the health system (criminal and juvenile justice and child welfare).
52	3.a.2	Clarification	Clarifies that to promote coordination of care, consent for release of information is obtained from CCBHC clients with providers outside of the CCBHC where information is not able to be shared under HIPAA and other federal and state laws and regulations. CCBHCs are encouraged to explore options for electronic documentation of consent when feasible and responsive to the person receiving services.

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53	3.a.3	Updated language	Replaces “confirming” that the appointment was kept with “tracking participation in service to ensure care coordination and receipt of supports”.
54	3.a.4	Clarification	Clarifies that the crisis plan that CCBHCs must develop with each consumer at minimum includes counseling the person receiving services on hot and warmlines, and mobile and crisis stabilization services should a crisis arise when providers are not in their office. Plans may support psychiatric advance directives as desired by the person receiving services and entered into the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where electronic health records are accessible.
55	3.a.5	Addition that strengthens the CCBHC model	Adds the requirement that the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications and during the comprehensive evaluation to the extent that state law allows.
56	3.a.6	Clarification	Recognizes that agreements for care coordination should not limit the person receiving services from choosing any provider.
57	3.a.7 (new)	Addition that strengthens the CCBHC model	The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them. These expectations had been included in 2.a.6 in and have been moved to create this new criterion.
58	3.b.1	Clarification	The description of health information technology systems is minimized in 3.b.1 and further expanded in subsequent sub-criteria.
59	3.b.2	Clarification	Adds that CCBHCs ensure that health IT systems have appropriate protections in place and adds quality measurement and reporting to the activities that these systems conduct. Provides guidance and examples when upgrading electronic systems such as utilizing nationally recognized, HHS-adopted standards, where available, to enable health information exchange and encourages CCBHCs to explore ways to support alignment with standards across data-driven activities.

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60	3.b.3	Needed Structural Change	Removes “if” and updates language to “current” technology. The revision clarifies the required core set of certified health IT capabilities that align with key clinical practice and care delivery requirements for CCBHCs. The note indicates that CCBHCs that do not meet these standards when certified should plan to adopt and use technology meeting these requirements over time. The note points out that CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities and that CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.
61	3.b.5	Clarification	The plan to focus on ways to improve care coordination between CCBHCs and all DCOs is to be produced within two years of certification or submission of attestation rather than within the “two-year demonstration program time frame”. The focus of this effort is elucidated to support integrated evaluation planning, treatment, and care coordination, integrating clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record.
62	3.C	Increased Flexibility	The criteria 3.C is retitled “Care Coordination Partnerships” from “Care Coordination Agreements.” Each of the sub-criteria under 3.c. Care Coordination Partnerships is now accompanied by a note that describes how partnerships may be documented.

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63	3.c.2	Addition that strengthens the CCBHC model	Adds OTP services, medical withdrawal management facilities, and tribally operated mental health and substance use services including crisis services, that are in the service area to the list of required partnerships. The criteria also clarify that CCBHCs establish protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth to a safe community setting.
64	3.c.3	Addition that strengthens the CCBHC model	Clarifies partnerships that are required, from those which are optional. In addition to partnerships required by statute, this criteria points out that the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located. A number of additional agencies are offered as examples important community entities with which CCBHCs may partner. These partnerships are documented slightly differently than the partnerships described in 3.c.1, 2, 4, and 5.
65	3.c.5	Clarification	Expectations for partnerships with medical withdrawal management facilities and ambulatory medical withdrawal management providers are moved to 3.c.2. Clarifies procedures and services, such as peer recovery specialist/coaches, to help individuals successfully and seamlessly transition from ED or hospital to CCBHC and community care. CCBHCs should request of relevant inpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge-Transfer (ADT) system.
66	3.d.1	Clarification	Clarifies that the members of the adult client's family whom the client "desires" (replacing "does not object to") may be included in the treatment team.

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67	3.d.1	Clarification	Adds legal guardian to family/caregiver members of the treatment team. Clarifies that the members of the adult client's family whom the client "desires" (replacing "does not object to") may be included in the treatment team and that HIPAA allows for clients to identify those persons who can receive information about their care. While the citation to the HIPAA Privacy Rule remains, its interpretation is deleted.
68	3.d.2	Addition that strengthens the CCBHC model	Adds family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, to the treatment team.
69	4.a.1	Needed structural change	The original criteria limited CCBHCs to organizations that directly provided four of the nine core services and may provide the other five services through formal agreement with designated collaborating organizations (DCOs). A recent determination by HHS concluded that CCBHCs are not required to directly provide 4 core services. This substantive change has required revisions throughout the document, including definitions of CCBHCs and DCOs, care coordination, and particularly to scope of services and expectations for CCBHCs competency in behavioral health. To avoid the type of service fragmentation that have been described in federal commissions over the past two decades, including the President's New Freedom Commission and in the Interdepartmental Serious Mental Illness Coordination Committee, the criteria bolster expectations that CCBHCs are fully licensed and credentialed behavioral health providers and that they will provide a substantial proportion (51% or more of encounters across the required services excluding Crisis Services) as this will enhance the ability of the CCBHC to provide a coordinated service package.
70	4.b.1	Addition that strengthens the CCBHC model	Adds that shared decision-making is the recommended approach for engagement.
71	4.b.2	Addition that strengthens the CCBHC model	Adds the expectation that care is responsive to the race, ethnicity, sexual orientation and gender identity of the person receiving services.

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72	4.c.1	Updated language	"Psychiatric" is replaced with "behavioral health" crisis. Please see Significant Changes to the Field; Crisis Services for an in-depth description of changes to 4.c.1.
73	4.d.1	Updated language	Adds neuropsychological testing as an example of specialized services that may be referred to an appropriate provider. Clarifies that screening, assessment, and diagnosis can be provided through telehealth/telemedicine.
74	4.d.2	Addition that strengthens the CCBHC model	Adds preferences of the person receiving services among considerations in screening, assessment, and diagnosis.
75	4.d.3	Addition that strengthens the CCBHC model	Several elements are added, and all are enumerated, commensurate with best clinical practice. These include asking about alcohol and drugs including current medications; herbs and supplements; cultural and environmental factors including linguistic services and supports; pregnancy and/or parenting status; a summary of treatment history and success of past treatments; intimate partner violence; and, for children and youth, whether they have system involvement (such as child welfare and juvenile justice).
76	4.d.4	Clarification	4.d.4 is eliminated because it repeated the requirement stated in 2.b.1 for a comprehensive person- and family-centered diagnostic and treatment planning evaluation. Subsequent items in section 4.d are renumbered.

#	Location of Change	Category	Change
77	4.d.4 (previously 4.d.5)	Addition that strengthens the CCBHC model	Clinicians are encouraged to use their best judgement with respect to the depth of the assessment, prioritizing people's preferences. Many of the existing considerations are updated and elucidated and some new considerations are added commensurate with best clinical practice. Additional considerations include social determinants of health and relevant social supports; cultural, environmental, and health-related social needs; pregnancy and parenting status; withdrawal and overdose risk; a more thorough assessment of substances, medications, and supplements, including information from the Prescription Drug Monitoring Program; risks including withdrawal; assessment of social service needs and involvement such as child welfare and juvenile justice and referral (for children and youth); and preference for receiving services including technologies.
78	4.d.5 (previously 4.d.6)	Greater flexibility	Notes that certifying states may elect to require other screenings.
79	4.d.6 (previously 4.d.7)	Clarification	Clarifies purpose of motivational interviewing and notes that screening and assessment tools are developmentally appropriate.
80	4.d.7 (previously 4.d.8)	Addition that strengthens the CCBHC model	Adds that screening tools also recognize differing literacy levels.
81	4.d.8 (previously 4.d.9)	Addition that strengthens the CCBHC model	Specific steps to address unsafe substance use are elucidated, including a full assessment and treatment by the CCBHC or referral to more appropriate care, and appropriate action as described in 2.b.1 if an immediate threat to safety is presented.
82	4.e.2	Addition that strengthens the CCBHC model	Adds that the treatment plan is developed with the person receiving services; is based on their goals and preferences; supports care in the least restrictive setting possible; addresses the person's prevention, medical, and behavioral health needs; clarifies that shared decision making is the preferred model of establishing goals; and mandates that all necessary releases of information are obtained and included in the health record.

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83	4.e.3	Addition that strengthens the CCBHC model	Adds the initial evaluation, comprehensive evaluation, and ongoing screening to consumer assessments to inform the treatment plan.
84	4.e.5	Addition that strengthens the CCBHC model	Adds recovery supports to the components of the treatment plan.
85	4.e.6	Addition that strengthens the CCBHC model	Adds examples of conditions for which consultation is sought during treatment planning such as traumatic brain injury, developmental and cognitive abilities of clients, interpersonal violence, and human trafficking.
86	4.e.7	Updated language	Clarifies that health record includes advanced directives unless the person receiving services does not want it included.
87	4.e.8 was eliminated and its contents moved to 4.e.7	Updated language	Instructions contained in 4.e.8 are moved to a note under 4.e.7, that certifying states should specify other aspects of person-centered and family-centered treatment planning they will require based upon the needs of the population served.
88	4.f.1	Addition that strengthens the CCBHC model	To ensure consistency of CCBHC outpatient services and to clarify expectations, a minimum set of outpatient services has been outlined in 4.f.1. Services must include the delivery of evidence based and best practices in individual, family and medication therapies as well as substance use treatment services that align with ASAM level 1 outpatient and ASAM level 2.1 intensive outpatient services and includes treatment of tobacco use disorders. Adds that services are delivered in alignment with state and federal laws and regulations and that when specialized services are not practically available, CCBHC professional staff may consult with specialty providers. CCBHCs are encouraged to engage persons who use potentially harmful substances using motivational techniques and harm reduction strategies to promote safety and reduce substance use.

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89	4.f.2 is eliminated, and its contents are incorporated under 4.f.1 as instructions to certifying states	Updated language	Updates examples of evidence-based and best practices including those for first episode psychosis; children, youth and their families; substance use disorders; effective but underutilized medications such as clozapine; and FDA-approved medications for substance use disorders including smoking cessation.
90	4.f.2 previously 4.f.3	Updated language	Encourages CCBHCs to use evidence-based strategies, such as measurement-based care (MBC), to improve service outcomes.
91	4.f.3 previously 4.f.4	Updated language	Reduces repetitive language.
92	4.g.1	Updated language	Because quality measures were revised and many CCBHCs and states found the requirements under Outpatient Clinic Primary Care Screening and Monitoring to be confusing, most of 4.g has been substantially revised. The CCBHC medical director establishes protocols for HIV and viral hepatitis; primary care quality measures from Appendix B; and other clinically indicated primary care key health indicators.
93	4.g.2	Addition that strengthens the CCBHC model	Directs the CCBHC Medical Director to develop organization protocols to screen people receiving services across the lifespan particularly those with chronic disease, ensuring that people receiving services are asked about their physical health symptoms, and establishing systems for the collection of laboratory samples. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. CCBHCs should have the ability to collect biologic samples and/or coordinate with the primary care provider of the people being served.
94	4.g.3	Addition that strengthens the CCBHC model	Adds that CCBHCs provide ongoing primary care monitoring of health conditions including ensuring access to primary care services; periodic lab testing and physical measurement of health status indicators and changes in the status of chronic health conditions; coordination with primary care; and promoting health lifestyle.

#	Location of Change	Category	Change
95	4.h.1	Clarification	The definition of targeted case management (TCM) is moved from Terms and Definitions to this criterion. Other revisions include when, where and for whom TCM may be most appropriate including critical periods, such as episodes of homelessness or transitions to the community from jails or prisons.
96	4.i.1	Addition that strengthens the CCBHC model	The purpose and scope of psychiatric rehabilitation services are more clearly described, and underscore needs supports to live and thrive in the community. CCBHCs must provide supported employment and supports for social inclusion; supported education; medication education, self-management and/or individual and family/caregiver psychoeducation; and finding and maintaining stable housing. Many psychiatric rehabilitation services are recommended for consideration. Notes that certifying states should specify which services, above the minimum required, they will require based on the needs of the population served.
97	4.j.1	Updated language	Updates the definition of peer support and description of peer services, as well as the variety of roles that peers can perform. Notes that certifying states should specify the scope of peer and family services they will require based on the population serviced.
98	5.a.1	Addition that strengthens the CCBHC model	Adds that data should be captured electronically when feasible.
99	5.a.2 (combined what had been 5.a.2 and 5.a.3)	Needed structural change	The quality measures used for the first Section 223 Demonstration program are updated for a variety of reasons, including the recognition that CCBHCs are no longer restricted to participation in the 223 Demonstration program. The new measures are found in Appendix B. Reporting requirements for CCBHCs funded through expansion grants are distinguished from those funded under the Demonstration. Notes that certifying states may require CCBHCs to collect and report optional clinic level measures. What was 5.a.3 regarding collection of data through DCOs is now in 5.a.2.

#	Location of Change	Category	Change
100	5.a.3 (previously 5.a.4)	Needed structural change	Instructions regarding data collection from DCO that had been in 5.a.3 have been incorporated into 5.a.2. 5.a.3 now addresses Medicaid claims data required of states participating in the Section 223 Demonstration program. Notes that CCBHCs participating in the Section 223 Demonstration program are responsible for providing data to the state and as may be required to HHS and the evaluator.
101	5.a.4 (previously 5.a.5)	clarification	Clarifies that cost reports refer only to CCBHCs participating in Section 223 Demonstration program.
102	5.b.1	Addition that strengthens the CCBHC model	Clarifies that CCBHCs are required to establish continuous quality improvement plans for services and a review process to review outcomes. Outcomes should address improvements in behavioral and physical health of people receiving services and reductions in rehospitalizations, emergency department use, and repeated crisis episodes. Adds that the Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.
103	5.b.2	Addition that strengthens the CCBHC model	Adds significant events that require continuous quality improvement plans that include fatal and non-fatal overdoses, deaths by suicide or suicide attempts, and all-cause mortality.
104	5.b.3 (new)	Addition that strengthens the CCBHC model	Adds a criterion that requires CQI plans to use quantitative and qualitative data and address the data resulting from the CCBHC-collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities and addresses how the CCBHC will use data to track and improve outcomes for populations facing health disparities.
105	6.a.2	Updated language	Replaces “AI/AN consumers” with “tribal members.”
106	6.a.3	Clarification	Clarifies that an independent financial audit is performed annually for all CCBHCs for the duration that they are designated CCBHCs.

#	Location of Change	Category	Change
107	6.b.1 (combines what had been 6.b.4)	Clarification	Replaces "the CCBHC's board members are representative of" with "CCBHC governance must be informed by" and "types of disorders" with health and behavioral health needs". Describes meaningful participation and identifies two options for CCBHCs to demonstrate meaningful participation in CCBHC governance (exceptions to this requirement are described in 6.b.3).
108	6.b.2	Clarification	Clarifies the processes for CCBHCs, certifying states, and federal grant funding agencies to ensure that meaningful participation as described in 6.b.1.
109	6.b.3	Clarification	Clarifies that CCBHCs comprising a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership must develop an advisory structure and other methods to provide meaningful participation as defined in 6.b.1.
110	6.b.4 (previously 6.b.5)	Clarification	Replaces "banking" with "accounting".
111	6.c.1	Needed structural change	Adds that the CCBHC must be enrolled as a Medicaid provider and licensed provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families unless there is a state administrative, statutory, or regulatory framework that prevents or substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. CCBHCs are also required to participate in the SAMHSA Behavioral Health Treatment Locator.
112	6.c.2	Needed structural change	Describes how CCBHCs are certified and notes that state certified CCBHCs may retain certification no longer than three years before certification lapses or they are recertified. Also notes that certifying states may use an independent accrediting body as part of the certification process.