

CCBHC-E Grantee Certification Criteria Overview

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SAMHSA
Substance Abuse and Mental Health
Services Administration

Agenda/Overview

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Purpose of this Call/Webinar Series

- Provide important information and clarification
- Answer questions and help support development of CCBHC model
- Create a learning collaborative environment

CCBHC Development Timeline

- 2014:** Initially authorized through Protecting Access to Medicare Act of 2014
- 2015:** Released original Certification Criteria, 24 State Planning Grants awarded
- 2016:** 8 States selected to participate in the Section 223 CCBHC Demonstration (MN, MO, NY, NJ, NV, OK, OR, & PA)
- 2018:** First 52 CCBHC-Expansion Grants awarded (Currently, there are more than 400 active grantees nationally)
- 2020-21:** 2 Additional States added to the Section 223 CCBHC Demonstration (KY & MI, authorized by Coronavirus Aid, Relief, and Economic Security Act)
- 2022:** Bipartisan Safer Communities Act authorizes addition of up to 10 states to the Demonstration every 2 years
- 2023:** 15 Planning Grants awarded, updated Certification Criteria released, guidance released for existing Demonstration states to add CCBHCs
- 2024:** Up to 10 additional states able to join the demonstration by July 1
- 2025:** Up to 15 additional planning grants to be awarded
- 2026:** Up to 10 additional demonstration states added
- 2027+:** Additional demonstration states added every two years

CCBHC Criteria Overview

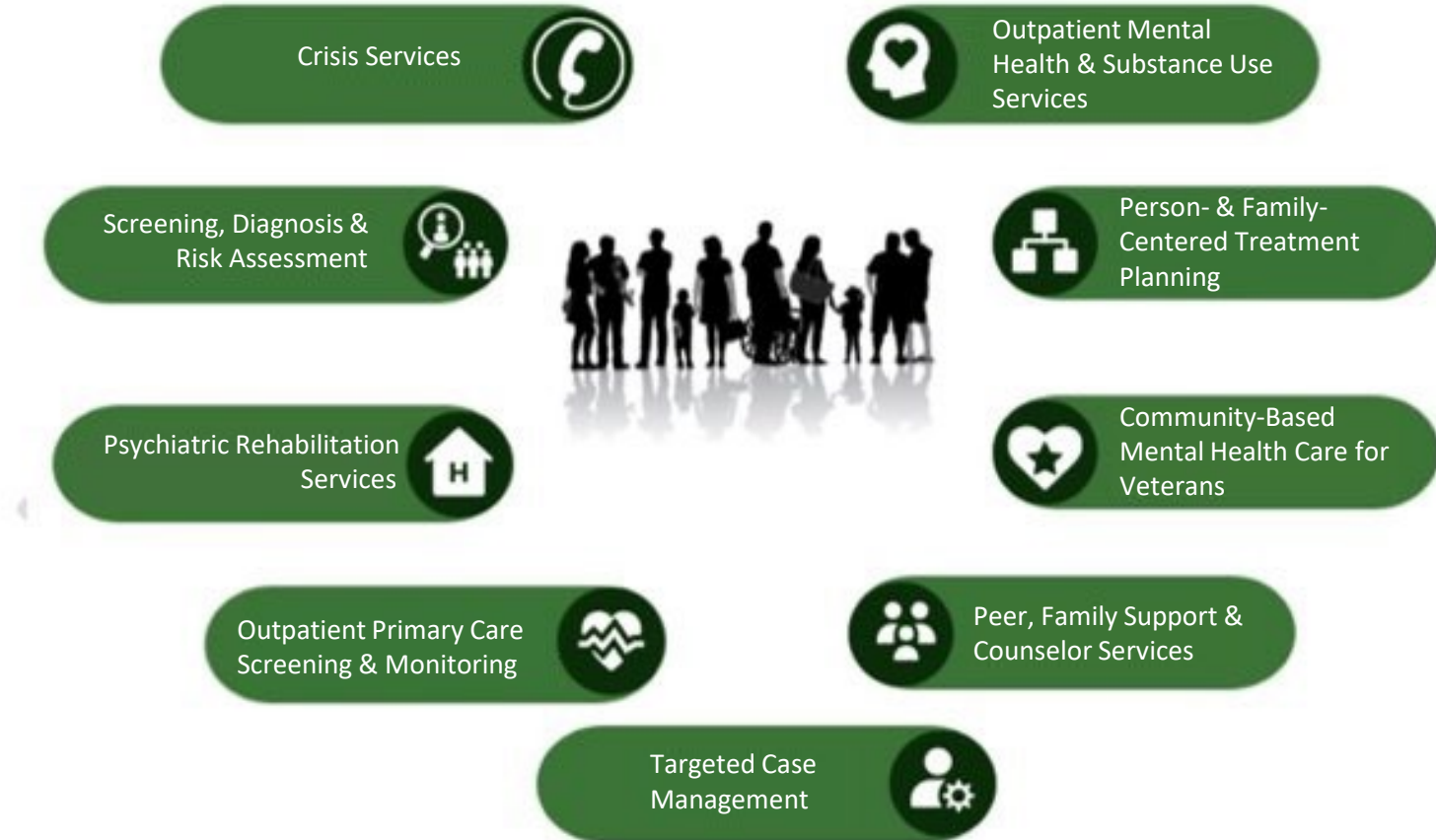
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CCBHC Criteria Structure (Set in Statute)

Six Program Requirements:

1. Staffing
2. Availability and Accessibility of Services
3. Care Coordination
4. Scope of Services
5. Quality and Other Reporting
6. Organizational Authority and Governance

CCBHCs Provide Nine Core Services Directly or Through Formal Partnerships



Criteria Set Basic Expectations / State Discretion

- Focusing on updated Certification Criteria
- Criteria create a floor of standards – CCBHCs may go beyond standards and there are areas of state discretion

Identifying State Roles and Concerns

A green dot identifies the few criteria, or parts of criteria, that are relevant to demonstration states that certify CCBHCs.



Program Requirement 1: Staffing

- Community Needs Assessment (1.A)
 - Before certification and every three years thereafter (1.a.1)
 - Informs staffing plan, languages used, chosen services/evidence-based practices, outreach and engagement, partnerships, hours of service delivery (important detail in Terms and Definitions) (1.a.1)
- General Staffing Requirements (1.A)
 - Develop staffing plan based on community needs assessment, including size and composition, that allows clinic to provide required services (1.a.2)
 - Requires Medical Director, and staff in following areas prescription of MOUD, addiction medicine (or consultation), licensed SUD treatment, children and youth with SED, and SMI (1.a.3)
- Licensure and Credentialing Providers (1.B)
 - Providers meet regulations to provide the required services (1.b.1)
 - Licensed/credentialed to provide behavioral health care including medication for OUD/AUD, children/adolescents with serious emotional disturbance, and adults with serious mental illness (1.b.2)

Program Requirement 1: Staffing (Continued)

- Cultural Competence and Other Training (1.C)
 - Develop training plans to include cultural competency, evidence-based practices, person-centered and family-centered, trauma-informed, co-occurring care, and military culture (1.c.1)
 - Ensures trainings align to standards to advance health equity, improve quality of services, and eliminate disparities (1.c.1)
- Linguistic Competence (1.D)
 - Ensure meaningful access to services such as language assistance, interpretation/translation services (1.d.1)
 - Documents and information are easily accessible for a person receiving services to assist in accessing care (1.d.4)

Program Requirement 2: Availability and Accessibility of Services

- General Requirements of Access and Availability (2.A)
 - Provides safe, clean, welcoming environment for people receiving services and for staff (2.a.1)
 - Community needs assessment informs standards around locations, hours of operations, addressing transportation needs, and use of telehealth/telemedicine options (2.a.2-2.a.6)
 - Continuity of operations/disaster plan (2.a.8)
- Requirements for Timely Access to Services and Assessment (2.B)
 - Preliminary triage is completed at first contact. Based on needs, provided services/evaluation within 3 hours for crisis, 1 business day for urgent need, and 10 business days for routine (2.b.1 & 2.b.3)
 - Person-centered and family-centered treatment plan is developed within 60 days and updated no less frequently than every 6 months (2.b.2)

Program Requirement 2: Availability and Accessibility of Services (Continued)

- Access to Crisis Management Services (2.C)
 - Crisis management is offered 24 hours a day, seven days a week (2.c.1)
 - Work with local hospital emergency departments to assist in process for individuals in psychiatric crisis who present to the ED (2.c.4)
 - Work with local law enforcement to improve safety of individuals in crisis and the community (2.c.5)
- Provision of Services Regardless of Ability to Pay and Residence (2.D & 2.E)
 - No individuals are denied services regardless of ability to pay (2.d.1)
 - Utilize sliding fee discount schedules (2.d.2)
 - No individuals are denied services due to place of residence, unhoused status, or lack of permanent address (2.e.1)

Program Requirement 3: Care Coordination

- General Requirements of Care Coordination(3.A)
 - Care coordination across a spectrum of health services (3.a.1-3.a.)
 - Physical health, Behavioral Health, Social Services such as Housing, Educational Systems, Employment, Child Welfare, and Criminal Justice
 - Active care coordination (e.g. help making appointments - supporting people to access care, assistance in accessing benefits/enrollment)
 - Development of a crisis plan
- Health Information Systems (3.B)
 - Maintain an electronic health record that meets ONC standards to allow for quality measurement and reporting, improvement, and reducing disparities, and allowing for care coordination with DCOs and other partners (3.b.1-3.b.4)

Program Requirement 3: Care Coordination (Continued)

- Agreements to Support Care Coordination (3.C)
 - Establish partnerships for care coordination with FQHCs, inpatient psychiatric treatment, OTP services, withdrawal management providers, and residential substance use disorder treatment programs, schools, Veteran Affairs, Indian Health Services, other human services, and a range of other systems based on the community needs assessment (3.c.1-3.c.5)
- Treatment Team, Planning, and Care Coordination Activities (3.D)
 - Interdisciplinary treatment team, which includes the person receiving services, work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery supports needed (3.d.2)

Designated Collaborating Organizations (DCOs)

- The DCO role is identified in statute
- DCOs are not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the required services
- From the perspective of the person receiving services and their family members, services received through a DCO should be part of a coordinated package with other CCBHC services and not simply accessing services through another provider organization
 - This should include coordinated intake process, coordinated treatment planning, information sharing, and direct communication between the CCBHC and DCO to prevent the person receiving services or their family from having to relay information between the CCBHC and DCO
- Regardless of DCO relationships, the CCBHC maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria
- The CCBHC retains responsibility for care coordination

Program Requirement 4: Scope of Services

- **General Service Provisions (4.A)**

- CCBHC is responsible for access to care to all nine required services, whether delivered directly through CCBHC or through DCO agreement (4.a.1)
- The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs (4.a.1)
- Any of the nine required services can be delivered through DCOs (4.a.2-4.a.4)

- **Requirement of Person-Centered and Family-Centered Care (4.B)**

- Involvement of the person receiving services and respectful of the needs, preferences, and values (4.b.1)
- Responsive to race, ethnicity, sexual orientation, and gender identity of person receiving services (4.b.2)

Program Requirement 4: Scope of Services (Continued)

- **Crisis Behavioral Health Services (4.C)**

- Crisis services delivered directly or through DCO agreement with existing state-sanctioned, certified, or licensed system (4.c.1)
- Must include:
 - Emergency crisis interventions
 - 24-hour mobile crisis teams
 - Crisis receiving/stabilization
 - Should include suicide and overdose prevention
- Ability to request approval of DCO for state-sanctioned crisis services that don't quite meet the CCBHC requirements

Program Requirement 4: Scope of Services (Continued)

- **Screening, Assessment, and Diagnosis (4.D)**
 - Conducts preliminary triage, initial evaluation, a comprehensive evaluation (4.d.1-4.d.4)
 - Uses standardized screening tools to ensure quality of care (4.d.5-4.d.8)
- **Person-Centered and Family Centered Treatment Planning (4.E)**
 - Involves treatment team, including person receiving services, to develop a strength-based, recovery-oriented treatment plan which is informed by screening, initial and comprehensive evaluation (4.e.1-4.e.7)
- **Outpatient Mental Health and Substance Use Services (4.F)**
 - Behavioral health care including psychopharmacological treatment, utilizing evidence-based practices for mental health and substance use disorders (4.f.1)
 - Developmentally appropriate care across the lifespan for adults, children, and families. (4.f.2)
 - Includes ASAM levels 1 and 2.1 – including tobacco (4.f.1)
 - Specialized needs are coordinated through referrals to appropriate providers (4.f.1)

Program Requirement 4: Scope of Services (Continued)

- **Outpatient Clinic Primary Care Screening and Monitoring (4.G)**
 - CCBHC is responsible for outpatient primary care screening and ongoing monitoring of key health indicators and health risk (4.g.1 & 4.g.3)
 - Must coordinate with primary care (4.g.3)
- **Targeted Case Management Services (4.H)**
 - Assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports (4.h.1)
 - Must focus on people at high risk of suicide or overdose, including people during high risk/critical periods (e.g., transition from hospital, reentry, homelessness) (4.h.1)
- **Psychiatric Rehabilitation Services (4.I)**
 - Includes evidence-based rehabilitation services for both mental health and substance use disorders (4.i.1)
 - Must include supported employment, social inclusion, supports to find and maintain housing (4.i.1)

Program Requirement 4: Scope of Services (Continued)

- **Peer Supports, Peer Counseling, and Family/Caregiver Supports (4.J)**
 - Must include peer specialist and recovery coaches and family/caregiver supports (4.j.1)
 - Could include peer-run wellness crisis respites, warmlines, peer-led crisis planning, peer navigators, peer support for older adults, peer education and leadership development, and peer recovery services (4.j.1)
- **Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans (4.K)**
 - Specific services for those members of the U.S. Armed Forces (4.k.1)
 - Care should be consistent with clinical guidelines contained in the Uniform Mental Health Services Handbook of Veterans Health Administration (4.k.2)

Program Requirement 5: Quality and Other Reporting

- **Data Collection, Reporting, and Tracking (5.A)**
 - Collect, report, and track encounter, outcome, and quality data on required standards, including clinic-collected and state-collected quality measures, if applicable (5.a.1-5.a.4)
- **Continuous Quality Improvement Planning (5.B)**
 - Establishes a critical review process to review CQI outcomes in order to implement changes to staffing, services, and availability that will improve behavioral and physical health outcomes (5.b.1)
 - Must address, suicides, overdose, all-cause mortality, hospitalization for MH or SUD, and disparities (5.b.2)

Program Requirement 6: Organizational Authority, Governance, and Accreditation

- **Organizational Authority and Financing (6.A)**
 - CCBHCs must meet at least one of the following: (6.a.1)
 - Non-profit organization
 - Part of a local government behavioral health authority
 - Operated under authority of the Indian Health Service or is an urban Indian organization
- **Governance (6.B)**
 - CCBHC governance must be informed by representatives of the individuals being served by the CCBHC, people with lived experience of MH or SUD and their families, with at least 51% of the governing board comprised of individuals with lived experience of mental and/or substance use disorders and families or another approved method for meaningful participation in board governance involving people with lived experience. (6.b.1)
- **Accreditation (6.C)**
 - CCBHCs should be enrolled as a Medicaid provider and licensed, certified, or accredited provider for mental health and substance use disorders including appropriate services for children, youth, and their family (6.c.1)
 - Must be certified by state or have had attestation accepted by SAMHSA (6.c.2)

2023 Criteria Update

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Reasons for the Criteria Update

- SAMHSA and the federal partners had been considering updates to the criteria, the passage of BSCA and the imminent addition of new states made this more urgent.
- We now have years of experience with the CCBHC model – it is a good model, but there are several areas of the criteria that needed to be updated:
 - 1) Respond to developments in the field (e.g., newer terminology, 988 and the crisis continuum, emerging best practices, workforce shortages, etc.),
 - 2) Update sections of the criteria that are no longer current (e.g., reference to outdated electronic health record standards), and
 - 3) Address areas suggested by CCBHCs, states, and other stakeholders (increased focus on SUD and social determinants of health).

Criteria Update Timeline

Nov 2022	Solicited public and partner input, including calls with 15 federal partners and stakeholders, listening sessions, a kick-off webinar (Nov 9), a general public listening session (Nov 17), and written feedback (Deadline Nov 21)
Dec 21	Posted draft criteria updates for public input
Jan 5, 17, and 19	Webinar to field on draft criteria updates and webinars with states
Jan 20	<p>Deadline for public comments</p> <p>We received comments from over 130 organizations and individuals including:</p> <ul style="list-style-type: none">– States (MN, KS, TX, OK, MO, KY, NY, PA, MI, IL, NV, CO, and OR)– Stakeholders (American Academy of Child and Adolescent Psychiatry, American Association of Nurse Practitioners, American Association of Psychiatric Pharmacists, American Society of Addiction Medicine, Depression and Bipolar Support Alliance, Eating Disorders Coalition, Mental Health America, Maternal Mental Health Leadership Alliance, National Alliance on Mental Illness, National Association of Community Health Centers, National Association of State Mental Health Program Directors, National Center for State Courts, National Council for Mental Wellbeing, National Partnership on Behavioral Health and Tobacco Use, National Rural Health Association, Vibrant Emotional Health, several state provider organizations)– CCBHCs and other providers– Other organizations (consulting groups, Mathematica [the Demonstration evaluator], Netsmart, NCQA, the Joint Commission)– Individual practitioners, experts, researchers, and advocates.
March 16	Updated criteria posted

Overview of Revisions to the CCBHC Criteria

1. Specific Areas of Focus

- Crisis care
- Responding to overdose epidemic
- Addressing health equity

2. Other Revisions:

- Necessary structural changes to the criteria
- Increased flexibility/reduced burden
- Additions that strengthen the model
- Updated language and examples
- Clarifications

3. Updated Quality Measures

Specific Areas of Focus (Highlights)

Crisis Care

- Required ***coordination with 988 crisis center*** serving the CCBHC service area (3.c.3)
- ***Updated crisis service requirements*** to align with SAMHSA's National Guidelines, including coordination with area air traffic control and urgent care/crisis walk-in capacity, aligned mobile crisis response with guidelines (4.c.1)

Responding to Overdose Epidemic

- Must have ***addiction medicine staffing or consultation*** (1.b.2)
- Placed ***stronger emphasis on the ability to prescribe buprenorphine and other MOUD including coordination with OTPs*** (if not an OTP) (1.b.2)
- Added provisions to ***strengthen ability to address overdose risk*** similarly to suicide risk and providing access to naloxone for opioid overdose reversal (throughout/4.c.1)
- Included requirement to provide ***intensive outpatient services for SUD*** (4.f.1)
- Requires ***quality improvement plans to address fatal and non-fatal overdoses*** (5.b)
- Required consultation with ***Prescription Drug Monitoring Programs*** as a part of evaluation and prescribing (3.a.5)
- Added focus on ***harm reduction*** (4.f.1)

Addressing Health Equity

- ***Updated training requirements*** to align with National Cultural and Linguistically Appropriate Services (CLAS) standards (1.c.1)
- Included ***stronger focus on outreach to underserved populations*** as required activity (2.a.6)
- Required that ***quality improvement plans have an explicit focus on health disparities*** (including racial and ethnic groups and sexual and gender minorities) and that CCBHCs disaggregate data to track and improve outcomes for populations facing health disparities (5.b)

Other Revisions to the Criteria (highlights)

Needed Structural Changes to the Criteria

- Provided ***updated guidance on EHR/HIT requirements*** (3.b)
- Changed ***requirements related to DCOs and provision of the nine core services*** – DCOs can provide any of the nine required services (throughout)
- Requires ***CCBHCs to directly deliver the majority (51% or more) of encounters*** across all of the nine services, excluding crisis services (4.a.1)
- Requires that CCBHCs be enrolled as ***Medicaid providers of mental health and substance use disorder*** services (6.c.1)
- Adapted Criteria to apply to ***CCBHC expansion grants*** in addition to the 223 Medicaid demonstration (throughout)

Increased Flexibility/Reduced Burden

- Increased ***flexibility for Medical Director position*** for CCBHCs unable to recruit a psychiatrist (1.a.3)
- Relaxed requirement for ***primary care involvement in treatment planning*** (2.b.2)
- Relaxed ***treatment plan update frequency*** requirements (2.b.2)
- Relaxed requirements for ***care coordination agreements*** (3.c)
- Provided ***flexibility on depth of assessment*** based on clinical judgement (4.d.4)
- Added language allowing CCBHC to use ***recent evaluations from other trusted providers*** as a part of their evaluations of people being served (2.b.1)
- Include a process for CCBHCs or states to request approval for use of ***state-sanctioned crisis services*** when they don't meet the standards for crisis services included in the CCBHC Certification Criteria (4.c.1)

Other Revisions to the Criteria (highlights)

Additions that Strengthen the Model

- Clearer guidance on **community needs assessment** (1.a.1 and Appendix A)
- Stronger **focus on shared decision making and client preferences** (Throughout)
- Added requirement around **assisting clients to access benefits and enroll in programs** such as Medicaid (3.a.7)
- Added additional **detail to outpatient service requirements** (4.f)
- Increased specificity in **primary care screening and monitoring including screening for HIV and viral hepatitis** (4.g)
- Required provision of **supports around employment/education, housing, and social inclusion in psychiatric rehabilitation** (4.i.1)
- Recommended use of **measurement-based care** (5.b.1)
- Added **additional focus on SMI, SED, and severe SUD** in Introduction
- Added requirement for **training on co-occurring mental health and substance use conditions** (1.c.1)
- Added language clarifying that **treatment of tobacco use disorders** is in the scope of outpatient service and **encouraging tobacco-free campuses** (4.f.1, 2.a.1)
- Added language encouraging **same day and open access scheduling** (2.b.3)
- Added language clarifying and encouraging that **services should be provided in community settings** (2.a.3)

Updated Language and Examples

- “Consumer” replaced with “**person or people receiving services**” (Throughout)
- “detoxification” replaced with “**withdrawal management**” (Throughout)
- Medication Assisted Treatment replaced with **Medications for Opioid Use Disorder, Alcohol Use Disorder, and Tobacco Use Disorder** (Throughout)
- Updated **language around peers** (Throughout)

Clarifications

- Provided clarification around what should be included in the **comprehensive screening and assessment** (4.d)
- Clarified definition of **targeted case management** and recommended implementing intensive supports similar to Assertive Community treatment and that TCM should be offered during critical periods (4.h.1)
- Clarified requirements related **to representation of people with lived experience and family members in governance** (6.b.1-2)
- **Removed explanatory language around HIPAA** (throughout)
- Minor changes reflect clarification of the original criteria in areas where stakeholders identified ambiguities (throughout)

Implementation Timeline for Updated Criteria

- New Section 223 CCBHC State Demonstration programs beginning on or after July 1, 2024 will be expected to comply with the Updated Certification Criteria.
- All SAMHSA CCBHC Expansion award recipients will be expected to meet the Updated Certification Criteria by July 1, 2024.
- Existing state Section 223 CCBHC Demonstration programs are expected to come into compliance with the Updated Certification Criteria by the start of the demonstration year beginning on or after July 1, 2024.
- Other state initiatives to support CCBHCs through mechanisms such as general funds, Medicaid state plan authorities, or Medicaid waivers are encouraged to adopt the Updated Certification Criteria by July 1, 2024.³

Updated Quality Measures (Appendix B)

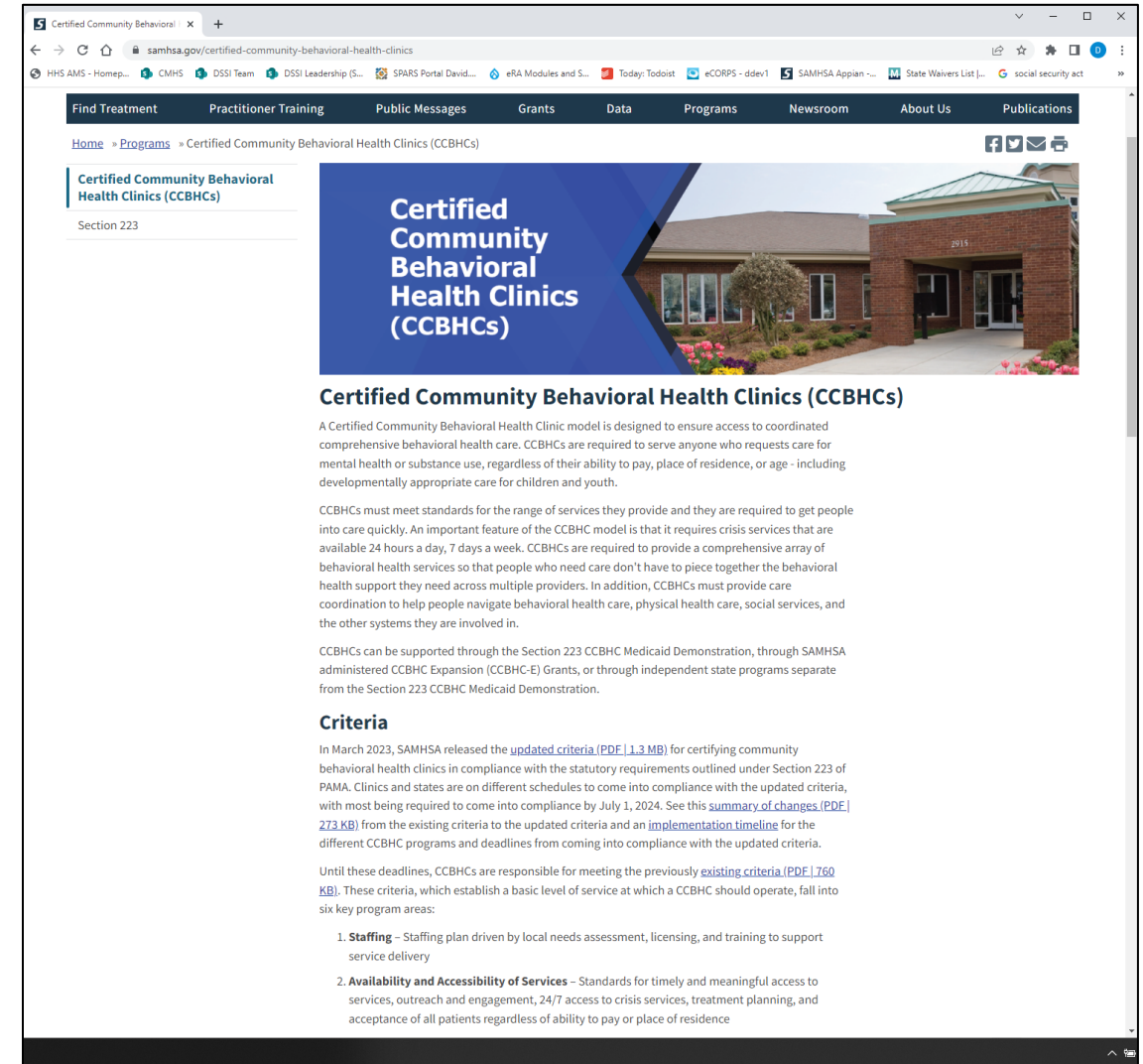
- Proposing 5 clinic collected measures and 13 state collected measures - a change from 9 clinic reported measures and 12 state reported measures.
- Strengthened the focus on time to services, crisis response, social determinants of health (SDOH), and Medications for Opioid Use Disorder (MOUD).
- Will be using updated technical specifications that are now out-of-date for existing CCBHC measures that are retained.
- Removing or making optional some of the existing quality measures that have been problematic. This will balance the burden created by new measures.

Clinic-Collected Measures (Required)
Time to Services (I-SERV)*
Depression Remission at Six Months (DEP-REM-6)
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)
Screening for Social Drivers of Health (SDOH)*
State-Collected Measures (Required)
Patient Experience of Care Survey
Youth/Family Experience of Care Survey
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)
Plan All-Cause Readmissions Rate (PCR-AD)
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
Antidepressant Medication Management (AMM-BH)
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)*
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)*

*new or significantly expanded measure

Links/Resources

- Updated Criteria:
<https://www.samhsa.gov/sites/default/files/cbhc-criteria-2023.pdf>
- Original Criteria:
https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
- Summary of Changes:
<https://www.samhsa.gov/sites/default/files/cbhc-certification-criteria-summary-of-changes.pdf>
- Redline from Original to Update:
<https://www.samhsa.gov/sites/default/files/cbhc-criteria-redline-edits-2023.docx>



Criteria Q & A

Criteria Q & A

- 1) Do grantees need to have the criteria fully implemented at the time of attestation, or would it be permissible for the attestation to describe implementation plans that are not fully actualized yet?
- 2) What supporting documentation should be submitted with the attestation?
- 3) Criteria 1c.2 initially uses the wording “individual furnishing services;” however, the Criteria later state “each employee who has direct contact with people receiving services.” We are interpreting the wording of the second to mean the same as the first wording- is that correct?
- 4) Are smoking cessation services required?

Criteria Q & A

- 5) Would client self-report meet the primary care screening requirements in 4.g.1. and 4.g.2?
- 6) Is there a standard lab requisition that CCBHC's can utilize when ordering labs for clients?
- 7) When we extend our hours to include night and weekend availability, do we need to ensure all CCBHC services are provided during those hours? We would like to limit the available services to those that are most sought-after, such as counseling and assessments.
- 8) Several times through the new/current criteria, a standard reference back to the needs assessment is made, for example, "informed by the needs assessment." Please advise how to meet a standard for which there is nothing in the needs assessment that addresses one of these specific areas?

Criteria Q & A

- 9) What does the CCBHC criteria require if an individual seeking services is a veteran who was dishonorably discharged?
- 10) Do grantees need to serve children, or can they use their DCOs to fulfill this requirement?
- 11) Criteria 3.b.4 (obtaining consents) and 3.b.5 (care coordination using a health IT system), pages 19-20, speak to CCBHCs working with DCOs. If the CCBHC is not working with a DCO to provide any of the required CCBHC services, how would we respond to those 2 criteria when preparing the attestation? Do we simply say that we are not currently partnering with a DCO? Or would we respond to those criteria in the event that we partner with a DCO in the future?

Criteria Q & A

- 12) Standard 1.b.2 states “Staffing shall be appropriate to address the needs of the people receiving services at the CCBHC as reflected in their treatment plans, and as required to meet program requirements of these criteria. Question: All things included in a treatment plan are not necessarily provided by the CCBHC. Was this an error and should have stated “as reflected in the staffing plan?”
- 13) Per Standard 4.c.1, what is the expectation of CCBHCs regarding this standard? If there is no call center that cannot coordinate with local crisis care, do we as the CCBHC need to take steps to implement one as part of the grant? We have been looking at a cloud-based platform that could do this between us law enforcement and 988.
- 14) Standard 4.c.1 (Crisis receiving/stabilization) states that CCBHCs have to provide this service and at a minimum include, urgent care/walk in mental health and substance uses disorder services for voluntary individuals. Further along in the standard it states that services provided must be capable of “addressing crises related to substance use, including support following a non-fatal overdose after the person is medically stable. **Question:** Per the standard, this support needs to be available as a walk-in service and to voluntary people. Does this standard extend to requiring CCBHCs to go to an emergency room and provide support there after an overdose? I think that this is important to do, but it would mean developing a specialized crisis response team module for non-fatal overdoses.

Additional Questions?

Thank You

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes

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www.samhsa.gov

www.samhsa.gov/certified-community-behavioral-health-clinics

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