Clinical Criteria and Certification Subcommittee

Meeting Minutes

Friday, 10/30 from 9-10am ET. This was a public, hybrid meeting. Slides from the meeting are available on Vermont's CCBHC webpage.

I. Attendees, Introductions

Attendees

- Eva Dayon (Certification Process State Lead)
- Lori Vadakin (Clinical Criteria State Lead)
- Tony Folland (Clinical Criteria State Lead)
- Patricia Breneman (Clinical Criteria State Lead)
- Over 20 representatives from Vermont state partners, Designated Agencies, Vermont Care Partners, peers, individuals and family members with lived experience, consultants, and community partners participated in the 10/30 Subcommittee meeting.

II. Review Vermont Discretionary Items for Requirement Areas 1-3[1]

Vermont Discretionary Items, Requirement Areas 1-6 (Inform)

- Vermont presented DMH/VDH decisions on Criteria 1.a.1, 1.c.1, 3.c.2, 4.c.1, 4.d.4, 4.d.5, 4.e.1-7, 4.f.1, 4.g.3, 5.a.2, 6.b.1-4, and 6.c.2
  - Details on Vermont's approach to each criterion are available in the meeting slides on Vermont's CCBHC webpage.
- A Subgroup member raised a question on Criteria 4.f.1: Are CCBHCs required to have the capacity to offer every EBP on Vermont's list, or can CCBHCs offer a subset of the EBPs on the list?
  - Vermont confirmed that CCBHCs must have the capacity to offer every required EBP.
- A Subgroup member raised a question on Criteria 1.c.1: Are the CCBHC trainings required to be delivered to all staff at the CCBHC? For example, would a CCBHC need to train all staff members on risk assessments and EBPs, or just the staff members who would be delivering risk assessments and EBPs?
  - Vermont noted the State can follow up with more specific guidance on the required CCBHC trainings. In-depth trainings on clinical practices such as risk assessments and EBPs would only need to be delivered to the appropriate staff members administering those services at the CCBHC.
- A Subgroup member raised a question on Criteria 4.d.5: Is the PHQ-2/9 required by SAMHSA in addition to the CANS and ANSA?
  - Vermont clarified that the State will require three baseline screenings, which align with SAMHSA's quality measure reporting requirements outlined in

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[1] *For details on CCBHC certification requirements areas and specific criteria, see the SAMHSA CCBHC Certification Criteria.*

Appendix B of the SAMHSA criteria: Depression (PHQ-2/9, PHQ-9M), Substance use (AUDIT or specific question), Social Drivers of Health (18+) (there is no specific SDOH tool required; CCBHCs should align with federal recommendations). In addition, Vermont will require CCBHCs to use the CANS and ANSA assessments. The State will not require additional screenings nor assessments to meet SAMHSA's requirements in Criteria 4.d.5.

Vermont Discretionary Items, Requirement Areas 1-6 (Discuss)

- **Criteria 3.c.3:** The following partnerships are required for CCBHCs: Schools, child welfare agencies, juvenile and criminal justice agencies and facilities, child-placing agencies for therapeutic foster care, Veterans Administration, and other social and human service agencies.
- **Question:** Vermont will explicitly require CCBHCs to have partnerships with Specialized Service Agencies (NFI and Pathways Vermont), Preferred Providers, and Federally Qualified Health Centers. Should Vermont require any additional partnerships?
    - The Subgroup recommended that in statewide CCBHC guidance, Vermont should clarify what "partnerships" means in the context of CCBHCs. CCBHCs can have different levels of partnerships, ranging from MOUs to formalized contracts to a DCO relationship. It is also important to clarify if there are minimum numbers of partnerships CCBHCs will be required to have. For example, if a CCBHC's catchment area includes multiple child welfare agencies and multiple schools, is the CCBHC required to partner with all of the child welfare agencies and schools in their area?
        - The Subgroup suggested that rather than the State setting a minimum required number of partners, the volume of partnerships should be informed by the CCBHC's community needs assessment.
        - Vermont noted that the CCBHC certification criteria 3.c.3 has details on the SAMHSA requirements for formal, signed agreements with CCBHC partners.
    - The Subgroup did not recommend requiring additional partners beyond those proposed by Vermont.
- **Criteria 4.d.5:** Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix B of the SAMHSA criteria.
    - The targeted case management model includes the following populations: Supports for people deemed at high risk of suicide or overdose, particularly during times of transitions from higher levels of care; individuals experiencing an episode of homelessness; individuals transitioning to the community from jails or prisons; individuals with complex or serious mental health or substance use conditions, youth with serious emotional disturbance; individuals who have a short-term need for support in a critical period, such as an acute episode or care transition

- **Question:** Will the State require any targeted case management services for specific populations- beyond those in the model?
  - One Subgroup member recommended that Vermont include guidance on the eligibility criteria for the different populations in the model, such as specific screening scores that constitute high risk of suicide or overdose.
    - Vermont noted that its ongoing re-envisioning of the CRT program could provide parameters for eligibility criteria. Although the populations in the model could include almost all individuals in the CRT program, not all individuals in the CRT program need targeted case management.
  - Another Subgroup member noted that often, results on assessments such as CANS and ANSA may not directly correlate with an individual's level of care. It is important to allow flexibility for DAs to determine if individuals in higher intensity levels of care need to receive targeted case management services, even if their CANS or ANSA assessments do not qualify them for the populations in the model.
    - The State agreed that determining if an individual needs targeted case management requires more nuanced clinical judgement beyond the CANS or ANSA assessments. Ideally, DAs would continue to make determinations of whether or not an individual needs targeted case management services under the CCBHC criteria.
- **Criteria 4.h.1**
  - The following aspects of psychiatric rehabilitation are required:
    - Supported employment programs with on-going support to obtain and maintain competitive, integrated employment
    - Participation in supported education or educational services
    - Achieve social inclusion and community connectedness
    - Participate in medication education, self-management, and/or family/caregiver psycho-education
    - Find and maintain safe and stable housing
  - SAMHSA recommendations to consider (these services may be provided or enhanced by peers):
    - Training in personal care skills
    - Community integration services
    - Cognitive remediation
    - Facilitated engagement in substance use disorder mutual help groups and community supports
    - Assistance for navigating healthcare systems
    - Illness Management & Recovery
    - Financial management
    - Dietary and wellness education
- **Question:** Will the state require these or other psychiatric rehabilitation services?

    - The Subgroup agreed that Vermont should align with SAMHSA's baseline requirements for this criteria, and allow CCBHCs flexibility to offer the additional recommended services.
- **Criteria 4.j.1**: The following aspects of peer services are required: Peer specialists; recovery coaches; peer counseling; family and caregiver supports
- **Question:** Will the state require other peer services?
    - One Subgroup member noted that Pathways Vermont peer centers already fulfill most or all of the SAMHSA-required aspects of peer services.
    - Another Subgroup member noted that their DA would fulfill the recovery coach requirement through their partnership with Turning Point centers. Using the existing recovery coach system available through Turning Point centers would be preferable to building a separate recovery coach system within a CCBHC.
        - Vermont confirmed that this approach would be allowable, and that many DAs have expressed interest in fulfilling parts of the peer services requirements through DCOs with organizations that are already doing peer supports work well, instead of re-creating a separate peer services system in CCBHCs.
    - A Subgroup member asked if there is a possibility to include funding for peer-run crisis respite services in CCBHC cost reports?
        - Vermont noted they would follow up on this question. Given that peer crisis respite is not an outpatient service it would not be reimbursable under the CCBHC PPS rate.
        - Vermont noted that mutual support and self-help peer groups within recovery support organizations are other areas of partnerships that CCBHCs could explore.

III. Public Comment & Questions

- The Subgroup suggested that Vermont maintain as much flexibility as possible when making decisions about baseline CCBHC requirements. For example, SAMHSA's requirement for CCBHCs to update treatment plans at least every six months allows for a longer timeframe than Vermont's current Preferred Provider standards. Vermont could align with the less stringent SAMHSA requirement, which would allow CCBHCs more flexibility and increase their likelihood of successfully meeting the criteria.
    - Vermont noted that CCBHCs are not inclusive of all Preferred Providers, such as Hubs, in the state. The State recognizes the importance of maintaining as much flexibility as possible without creating a dual system of requirements for CCBHCs.

IV. Next Steps and Upcoming Meetings

Next Steps

- The Subcommittee is encouraged to complete the CCBHC question gathering survey.

Upcoming Clinical Criteria and Certification Subcommittee Meetings*

- 12/4 from 9-10am
- 12/18 from 9-10am

*May cancel if not needed