Behavioral Health Home Certification Rule

Agency and Performing Providers

Department of Human Services
Division of Behavioral Health Services
October 6, 2014

The purpose of the DBHS Behavioral Health Home Certification Rule is to establish requirements, standards, and procedures for certification of Behavioral Health Homes (BHH) and related performing providers.

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I. PURPOSE

The purpose of the DBHS Behavioral Health Home Certification Rule is to establish requirements, standards, and procedures for certification of Behavioral Health Homes (BHH) and related performing providers.

The purpose of these standards is to require BHHs to:

1. Address the comprehensive needs of clients by utilizing a "whole-person" and "person-centered" approach while ensuring personal choice throughout service planning and service delivery;
2. Provide services that address issues of access to care, accountability, and active participation on behalf of both providers and clients/families receiving services, continuity of care across all medical, behavioral, and social supports, and comprehensive coordination/integration of all needed services
3. Align a fragmented system of needs assessment, service planning, care coordination, transitional care, and direct care service delivery, and
4. Utilize health information technology as a means to improve service delivery and health outcomes of the clients served.

The rules herein are subject to change. If a conflict should arise between the provisions of this policy manual and the *Arkansas Outpatient Behavioral Health Services Medicaid Manual* or the *DBHS Certification Rules for Providers of Outpatient Behavioral Health Services*, the *Arkansas Outpatient Behavioral Health Services Medicaid Manual* and the *DBHS Certification Rules for Providers of Outpatient Behavioral Health Service*s will control.

II. DEFINITIONS

Within this policy, certain words that appear have the following special meaning:

1. **Accreditation:** An organization's satisfaction and demonstration of full conformance to the treatment standards of the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), or Council on Accreditation (COA). This does not include provisional or probationary accreditation.
2. **Adverse License Action:** Any unfavorable action or decision by a licensing authority that imposes restrictions on the licensee's practice privileges or relates to client care.
3. **Applicant:** Organization making formal application to provide BHH services.
4. **Behavioral Health:** Overall emotional and psychological condition including the use of a client's cognitive and emotional capabilities, ability to function in society, and other skills needed to meet the ordinary demands of everyday life.
5. **Behavioral Health Agency (BHA):** An organization meeting DBHS defined requirements to provide reimbursable outpatient behavioral health services.
6. **Behavioral Health Home (BHH):** An organization meeting DBHS defined requirements to provide comprehensive care management and care coordination for individuals identified by a functional assessment as being in need of Tier 2 or Tier 3 Behavioral Health services.
7. **Certification:** A written designation issued by DBHS to a Behavior Health Agency, Behavioral Health Home, or Certified Performing Provider satisfying the defined requirements to provide reimbursable behavioral health services.

8. **Certified Performing Provider (CPP):** A behavioral health professional trained, certified, and authorized by DBHS to provide outpatient behavioral health services with direct supervision: Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partner, Qualified Behavioral Health Providers (Non-degreed and Degreed), Care Coordinator, and Care Manager/Director.
9. **Compliance:** Adherence to accreditation standards, DBHS certification requirements, and applicable state and federal, laws, rules, and regulations.
10. **Compliance Review:** Record review and (or) on-site visit conducted by DBHS personnel or designee, to examine sites, case files, records, and other documentation for adherence to DBHS' *Behavioral Health Home Certification Rule*, and applicable state and federal laws, rules and professionally recognized standards of care.
11. **Comprehensive Care Management:** A person centered, goal oriented, and culturally relevant process to assure a client receives needed services in a supportive, effective, efficient, timely, and cost effective manner. Comprehensive care management emphasizes prevention, continuity of care, and coordination of care which advocates for and links clients to services as necessary across providers and settings.
12. **Corrective Action Plan:** A provider prepared plan of remediation purposed to correct any and all deficiency noted in a Compliance Review report.
13. **Deficiency or Non Compliance:** Non-conformance with accreditation standards, DBHS certification requirements, or applicable state and federal, laws, rules and regulations as amended from time to time.
14. **Home and Community Based:** A DHS recognized option for client to receive reimbursable outpatient behavioral health services in his or her own home or community.
15. **Independent Assessment Report:** A written designation prepared by an independent assessor, approved by DHS, designed to determine client eligibility and Tier of services available.
16. **Individualized Treatment Plan:** A written description of the treatment objectives for the client that is prepared and maintained by a Licensed Performing Provider, and included in the client's records. Plans describe: the treatment regimen, projected schedule for service delivery, personnel delivering services, and a projected schedule for completing client reevaluations and updates.
17. **Integrated Care Plan:** A master plan focusing on the whole person that incorporates client choice and actively engages the client and all appropriate members of the health care team to compile all care and treatment plans associated with the client. The integrated care plan is actively managed and maintained by the BHH.
18. **Integrated Care Team:** A group of professionals and informal supports working together to plan, deliver services and supports to a client in a coordinated, comprehensive manner. The Integrate Care Team members will be designated according to client choice. At a minimum, the Integrated Care Team should include the BHH Care Coordinator, the client's behavioral health clinician, and physical health providers.
19. **Outcome:** A measurement of improvement, maintenance, or decline as it relates to client health, client experience, or measures of cost-effectiveness.
20. **Outpatient Behavioral Health Services:** An array of services that may be provided to eligible Medicaid client by enrolled providers or certified provider sites.
21. **Performing Provider:** A DBHS recognized behavioral health professional authorized to deliver direct services to a client. Performing providers are either certified or enrolled by DBHS.

22. **Patient Centered Medical Home:** A team-based care delivery model led by Primary Care Physicians who comprehensively manage clients' health needs with an emphasis on health care value.
23. **Person-Centered:** Planning, delivering, and evaluating health care through client driven decision making that is based on participation, cooperation, trust, and respect of client perspectives and choices. It also incorporates the client's knowledge, values, beliefs, and cultural background into care planning and delivery. Client and family centered care applies to clients of all ages.
24. **Population:** The specified group of clients (children, youth, or adults) a Behavior Health Agency, Behavior Health Home, or Licensed Performing Provider renders service.
25. **Quality Assurance:** An examination of clinical records for completeness, adequacy and appropriateness of care, quality of care, and efficient use of provider resources.
26. **Recovery:** The journey of healing and learning to improve individual life skills so that a person can reach his/her highest potential as a productive member of our community by gaining a sense of meaning, a positive identity, the capacity to cope with adversity, and with recognition of the gifts and lessons learned through the transitional process. Recovery is individual to each person and requires a partnership of support, community, and resources.
27. **Referral:** Any oral, written, faxed, or electronic request for outpatient behavioral health services made by any person, or client's legal guardian, family member, health plan, primary care physician, hospital, jail, court, probation and parole officer, school, governmental or community agency.
28. **Reporting:** A written or spoken account submitted by the provider related to the services provided. Information, manner, and timeframe are prescribed by DBHS.
29. **Resiliency:** The personal and community qualities that enable a client to rebound from adversity, trauma, tragedy, threats, and other stresses and continue with a sense of mastery, competence, and hope.
30. **Sanction:** Any unfavorable action, penalty, or decision by an accreditation, state, or federal authority that imposes restrictions on the provider's practice privileges, business operations, impacts financial records, and (or) relates to client care.
31. **Serious and Persistent Mental Illness**: A Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) designation and a Tier 2 or Tier 3 determination
32. **Supervision:** Directing, inspecting, observing, and evaluating the delivery of services and performance.
33. **Supervision Documentation:** A written record, maintained by the BHA or BHH, the date, time, subject matter, and duration of direct supervision.
34. **Tier:** The range of medically necessary behavioral healthcare services available to clients eligible for the Arkansas Medical Assistance Program (Medicaid). Service array is Tier specific (i.e. 1, 2, or 3) and may vary.
35. **Whole-Person:** A process of caring not just for a client's physical/behavioral conditions, but providing linkage to long term community care services and supports, social services and family services. The process looks at all the needs of the person across a life span and does not compartmentalize aspects of the person, his or her health, or his or her wellbeing.

III. SCOPE OF SERVICE

A. Overview

The BHH is an integrated care management model that addresses comprehensive care coordination needs including physical health, acute care, behavioral health, developmental disabilities, and long term services and supports. The BHH is an integrated care model with expected outcomes of:

1. Emphasizing wellness and prevention for better population-based care management;
2. Paying for effective, coordinated care rather than for client services;
3. Helping people live as independently as possible, and
4. Aligning financial incentives to achieve a transformed system.

B. Services

The BHH will provide a range of services to ensure the comprehensive needs of the clients are met. Services provided to a client must adhere to client's Integrated Care Plan. BHH services include the following:

a) Comprehensive Care Management

1. Works with high-risk clients utilizing client and population-based data to manage care;
2. Assessing and ongoing re-assessing of needs of clients to develop and update the client's Integrated Care Plan to incorporate client needs and person-centered goals;
3. Facilitating Integrated Care Team engagement to ensure the comprehensive needs of the client are addressed;
4. Monitoring client and client panel status to inform care plan updates and progress towards stated goals;
5. Monitoring client and client panel status to inform treatment guidelines and evidence-based/evidenced-informed practice patterns, and
6. Coordinating and disseminating information and reports that guide progress of service delivery and outcomes.

b) Care Coordination

1. Integrating care plans across systems (including behavioral health, medical, developmental disabilities, and long-term supports) and providing input for plan updates;
2. Maintaining documentation from all providers involved with client;
3. Supporting and enabling care plan adherence by providing assistance with referrals, scheduling, and arrangement for transportation to appointments;
4. Providing regular check-ins with client to understand barriers to plan adherence;
5. Monitoring chronic disease indicators and performance metrics;
6. Developing and maintaining communication between all stakeholders involved with the client;
7. Providing referrals to quality-based services and high performing providers;
8. Coordinating care across all medical, behavioral health, and other treatment plans, and
9. Participating in hospital discharge planning and coordinating transitional and aftercare services.

c) Health Promotion

1. Arranging for or providing client and family specific health education services;

2. Educating and supporting client on self-management plans and routine clinical care, and
3. Coordinating and supporting access to behavioral health care.

d) Comprehensive Transitional Care

1. Establishing processes to ensure prompt notification of planned and unplanned care (i.e. developing crisis management plans and processes for hospital admissions and emergency department visit notifications)
2. Coordinating and sharing transition planning with relevant persons/entities
3. Providing regular education on client access to services and transitional care needs.

e) Client and Family Support Services

1. Matching clients (and families) to support services and advocating on their behalf for participation, and
2. Facilitating awareness of and interacting with service providers to ensure they are meeting client needs.

C. Population Served

1. Individuals eligible for a Behavioral Health Home must have a behavioral health diagnosis and a functional impairment due to their behavioral health diagnosis.
2. The functional impairment will be assessed by an Independent Assessment.
3. Clients must receive an Independent Assessment to be eligible to receive BHH services.
4. The Independent Assessment will generate an Independent Assessment Report.
5. The Independent Assessment Report will define if the client is eligible for BHH services and designate tier of services.

IV. BHH CERTIFICATION PROCESS

1. For an agency to be certified as a BHH prior to January 1, 2017, the agency must meet all BHH Level I Standards detailed in Section V.
2. Upon being granted a BHH Certification prior to January 1, 2017, a BHH must be recertified one calendar year later. To be recertified, the BHH must meet BHH Level I Standards outlined in Section V and BHH Level II Standards outlined in Section VI.
3. Effective January 1, 2017, agencies applying to become a BHH must meet BHH Level I Standards outlined in Section V and BHH Level II Standards outlined in Section VI in this policy to be certified as a BHH.
4. After BHH is certified or recertified based on Level I and Level II Standards, BHH Certification cycle will sync with BHA Certification and National Accreditation cycle.

V. BHH LEVEL I STANDARDS

To meet Level I Standards, agencies must meet the following infrastructure, staffing, care, and access standards:

A. DBHS Behavioral Health Agency Certification

1. An agency must possess a Behavioral Health Agency (BHA) certification as granted by DBHS to be eligible to apply for BHH Certification.
2. The DBHS BHA Certification must be in good standing to maintain the BHH Certification.

B. Personnel

The BHH must be staffed to establish and implement integrated care plans for each client served. BHHs must maintain the following roles:

a) Care Coordinator

1. **Overview:** Care Coordinators are responsible for interacting with clients, the client's family, and his/her other treatment providers and ensuring the client's needs are being addressed. The Care Coordinator is accountable for coordinating the provision and continuity of the integrated care, treatment, or services and facilitating the client's access to all needed care, treatment, or services, whether behavioral or physical. This includes crisis planning and transitional/discharge planning from inpatient or residential levels of care. The Care Coordinators are responsible for implementing the Integrated Care Plan and for coordinating the Integrated Care Team, while the broader Integrated Care Team will assist with the provision of necessary services.
2. **Certification:** Care Coordinators must be certified by DBHS to provide BHH services. For certification requirements and processes, see Section XV.
3. **Client Ratio:** The maximum client to Care Coordinator ratio is 40:1 for Tier 2 clients and 20:1 for Tier 3 clients.
4. **Supervision:** Care Coordinators must be supervised by a DBHS Certified Care Director or Care Manager.

b) Care Director

1. **Overview:** The Care Director is responsible for supervising the BHH Care Coordinators, facilitating problem-solving with the Care Coordinators, operating the BHH, and reviewing the Integrated Care Plan. The Care Director is charged with establishing relationships with providers, support service providers, Patient Centered Medical Homes (PCMHs), and other related service providers. The Care Director is responsible for managing budgetary, operational oversight, and other administrative duties of the BHH.
2. **Care Manager Role:** Based on established ratios, if a BHH exceeds ten Care Coordinators, the BHH must employ a Care Manager to assist in supervision of Care Coordinators and administrative duties.
3. **Certification:** Care Directors and Care Managers must be certified by DBHS. For additional certification requirements and processes, see Section XV.
4. **Ratio:** The maximum Care Director/Manager to Care Coordinator ratio is 1:10.
5. **Supervision:** The Care Director must be supervised by the agency's Clinical Director.
6. **Requirements:** The BHH must have a Care Director who is a full time staff member.

C. Enhanced Client Access

BHHs must provide enhanced client access, which includes heightened service and staff availability:

a) Service Availability

1. The BHH must provide all applicable and appropriate services as listed in Section III;
2. The BHH must offer flexible scheduling to accommodate the client's care, treatment, or service, and
3. The BHH must have a process to respond to a client's urgent care needs 24 hours a day, 7 days a week.

b) Staff Availability

1. The BHH must establish protocols for client access to BHH staff 24 hours a day, 7 days a week, and
2. The organization must provide clients served with the ability to contact the BHH for an appointment and request clinical advice for urgent health needs 24 hours a day, 7 days a week.

D. Emergency and Crisis Services Coordination and Follow Up

1. The BHH must ensure access to emergency services, critical care, and the full continuum of Tier 1, Tier 2, and Tier 3 services by delivery, referral, or both;
2. The BHH must work with clients to develop and implement crisis plans;
3. The BHH must work with clients, client's family if applicable, the identified Integrated Care Team, and other providers of clinical, support, and crisis services to coordinate client's care, and implement the client's developed crisis plans, and
4. The BHH is responsible for following up with clients within 24 hours of crisis and emergency events to update the client's Integrated Care Plan and crisis plan, to provide follow up and transitional care if needed, and to coordinate any needed clinical and support services.

E. Person-Centered Approach

To meet the unique needs of clients, BHH must ensure services and activities are person centered. Therefore, BHHs must meet the following guidelines:

1. The BHH must utilize a person centered approach to care management and coordination that takes into consideration that the client's desired future is the framework for all planning and that the preferences of the client must be included in all plans of services, and
2. The BHH must include input from the client and the people most important to the client in the planning process as evidenced by, including but not limited to, the client's active role on the Integrated Care, in Integrated Care Plan development, and in crisis planning.

F. Health Information Technology

The BHH must utilize health information technology to:

1. Review progress notes;
2. Develop and update treatment plans;
3. Review current and past medications;
4. Create problem lists, and
5. Send secure messages in accordance with HIPPA and HITECH.

G. Prevention, Early Intervention, and Screening

1. The BHH must provide access to a primary care physician or PCMH for consultation purposes at all times;
2. The BHH must provide access to a behavioral health care clinician for consultation purposes at all times, and
3. The BHH must implement prevention and early intervention strategies to address and promote health and well-being.

H. Culturally and Linguistically Appropriate Care

To meet the unique needs of clients, the BHH is expected to provide care in a culturally appropriate manner. Therefore, BHHs must meet the following guidelines:

1. Establish procedures for English as a Second Language (ESL) clients;
2. Establish procedures for hearing impaired clients;
3. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs;
4. Offer language assistance to individuals who have limited English proficiency and other communication needs to facilitate timely access to all health care and services;
5. Clearly inform all individuals of the availability of language assistance, and
6. Provide easy-to-understand print and multimedia materials and signage in the language commonly used by the populations in the service area.

I. Integrated Care Plan

1. The BHH must develop and implement Integrated Care Plans for each client;
2. Integrated Care Plans must be person centered and coordinate and integrate all of the client's clinical and non-clinical health-care related needs and services, and
3. The Integrated Care Plan must be updated on an annual basis.

J. Integrated Care Team

1. The BHH is responsible for facilitating an integrated approach to providing care for BHH clients.
2. The BHH will work with the client, and if applicable the family, and specific individuals and organizations to comprise and facilitate an Integrated Care Team

VI. BHH LEVEL II STANDARDS

BHHs must provide whole person, quality driven, cost effective, and culturally appropriate care based on the needs of the client and family of the client.

A. Community Partnerships and Access

1. The BHH is required to either provide or establish collaborative agreements or Memorandums of Understanding to guarantee access to the full service array within each Tier based on applicability to population served;
2. To ensure a formalized and structured transitional care planning, a mutual awareness and communication regarding shared clients, and collaboration to identify and serve clients in need of BHH services, the BHH must establish a formalized relationship through collaborative agreements or Memorandums of Understanding with the following entities in its community:
   - Hospitals/Emergency Departments
   - PCMHs
   - Residential Care Facilities
   - Psychiatric Residential Treatment Facilities
   - Substance Abuse provider
3. To ensure access to all needed services, including support services, BHHs must establish partnerships with the following entities in their community:
   - Regional Prevention Provider

- Courts
- Jails
- Police Departments
- County Office
- Schools

B. Electronic Health Record

BHH must have an operational Electronic Health Record.

C. Health Information Exchange

BHH must join the State Health Alliance for Records Exchange (SHARE), the statewide interoperable health information exchange[1].

D. Health Information Technology

The BHH must utilize health information technology to:

1. Facilitate communication among Integrated Care Team members and provide feedback to practices, as feasible and appropriate;
2. Integrate with other health system platforms;
3. Implement and monitor quality improvement activities;
4. Report on data that permits an evaluation of increased coordination of care on client-level clinical outcomes, experience of care outcomes, and quality of care outcomes;
5. Collect, analyze, and report on performance management data;
6. Provide appointment reminders to clients;
7. Facilitate the client's online access to their personal health information after the information is available to the Integrated Care Team, and
8. Capture treatment activities and outcomes.

E. Prevention, Early Intervention, and Screening

1. The BHH must provide access to prevention, early intervention, and needed screenings for their clients including, but not limited to, obesity, substance abuse, high blood pressure, and tobacco use and ensure the needed monitoring and appropriate follow up by coordinating with physical health providers, and
2. The BHH must promote behavioral health protective factors, including but not limited to connectedness to community, access to support services, sense of belonging at school, school achievement, and good physical health.

F. Culturally and Linguistically Appropriate Care

To meet the unique needs of clients, the BHH is expected to provide care in a culturally appropriate manner. Therefore, BHHs must meet the following guidelines:

1. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices, and
2. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's current and ongoing planning and operations.

[1] Requirement will be based on the availability and readiness of SHARE

G. Integrated Care Plan

The BHH must develop and implement Integrated Care Plans for each client. Integrated Care Plans must be developed and implemented in the following manner:

1. Integrated Care Plans must coordinate and integrate all of the client's clinical and non-clinical health-care related needs and services;
2. The client and members of the Integrated Care Team must be actively engaged in the development of the Integrated Care Plan;
3. Joint understanding with the client and Integrated Care Team of the Integrated Care Plan must be met;
4. Pertinent elements of the Independent Assessment Report regarding the client's health risks and chronic condition must be incorporated into the Integrated Care Plan;
5. The Integrated Care Plan must be evaluated, updated, and jointly modified on an ongoing basis to reflect the goals of recovery and resiliency for the client;
6. The client and Integrated Care Team members must be provided a copy of the Integrated Care Plan each time the plan is changed or modified, and
7. The Integrated Care Plan must include, if applicable, goals and action plans for:
   - Preventive care;
   - Care for chronic conditions;
   - Housing;
   - Employment status;
   - Custody;
   - Financial services;
   - Juvenile or criminal justice;
   - Education;
   - Medication Management;
   - Transportation;
   - Crises, and
   - Other elements as determined by client and Integrated Care Team.

H. Integrated Care Team

1. The BHH is responsible for facilitating an integrated approach to providing care for BHH clients;
2. The BHH is responsible for:
   - Establishing an Integrated Care Team for each BHH client;
   - Working with the client to identify the members of the client's Integrated Care Team;
   - Working with the Integrated Care Team to actively engage the client and verify joint understanding of the Integrated Care Plan;
   - Facilitating the development of the Integrate Care Plan with the client and Integrated Care Team, and
   - Working with the client and Integrated Care Team to review, evaluate, and if appropriate, amend the Integrated Care Plan on an ongoing basis.
3. The Integrated Care Team is responsible for:
   - Assisting the client identify, utilize, and access community supports and services;
   - Supporting the client to make informed choices, and
   - Assisting the client in reaching his or her personal goals.

4. When applicable to the client, he BHH will be required to include the following roles as part of the BHH Integrated Care Team:
    - Individual, families, caregivers
    - Care Coordinator
    - Certified Family Support Partner
    - Certified Peer Support Specialist
    - Qualified Behavioral Health Provider (Paraprofessional)
    - Physician, Advanced Practice Nurse, or Registered Nurse (will be required to be contracted/hired by the BHH based on the medical acuity of the population served)
    - Licensed Clinician
    - Licensed Substance Abuse Clinician
    - Division of Child and Family Services (DCFS) personnel (i.e. child welfare worker)
    - School-based Mental Health Providers and other school personnel as needed
    - Judicial or other court system personnel (i.e. probation officer, ad litem representative, etc.)
    - Supported employment providers, etc.

VII. METRICS

1. Process and Outcome Metrics, as established in the Outpatient Behavioral Health Medicaid Manual, will be tracked for the initial two years of BHH implementation, and
2. In Year 3, as defined in the Outpatient Behavioral Health Medicaid Manual, the BHH must meet the targets established in the Outpatient Behavioral Health Medicaid Manual to maintain BHH Certification in good standing.

VIII. MINIMUM PATIENT PANEL

BHH must maintain a 250 minimum patient panel of BHH clients.

IX. REQUIRED REPORTING

The BHH must adhere to the following reporting requirements:

1. BHH must notify DBHS of any business operations changes specific to the operation of the BHH within thirty (30) calendar days, including staffing changes which affect the delivery of BHH services;
2. BHH must notify DBHS within thirty (30) calendar days of any change affecting the accuracy of the BHH's certification records;
3. Upon deciding to cease providing BHH services permanently or temporarily, BHH must immediately provide written notice to clients, DBHS, and the Division of Medical Services (DMS). Notice must state the last planned day of service.
    - If the closure is permanent, the certification expires at 12:00 a.m. on the day following the date referenced in the notice.
    - If the BHH closure is temporary and for reasons unrelated to an adverse governmental action, DBHS may deem the site certification "Inactive" for up to one (1) year. If the BHH is not operating and in compliance within the time allotted, the certification expires at 12:00 a.m. the day after the "Inactive"

designation. BHHs that are unable, despite reasonable diligence and a showing of good cause, to come into compliance within the time permitted may be extended additional time. Any extensions of time are at the sole discretion of DBHS.

4. If a BHH involuntarily closes site due to reasons including but not limited to, fire, natural disaster, or adverse governmental action, BHH must immediately notify clients, DBHS, and DMS of the closure and the reason(s) for the closure. Certification expires in accordance with any pending regulatory action. If there is no pending regulatory action, certification expires at 12:00 a.m. on the day following permanent closure.
5. If the BHH ceases to provide services, the BHH must assure and document continuity of care for all clients receiving BHH services. BHH must:
   - Submit a transition plan consistent with DBHS standards and requirements.
   - Assure and document client's receipt of notice of the closure, closure date, and any information or instructions necessary for the client to obtain transition services.

X. BHH APPLICATION PROCESS

A. Application Materials

1. All BHH Certification applications must include:
   - Completed application form, see Appendix A, Form 1: Application for BHH Certification;
   - Proof of BHA Certification;
   - A list of BHH service delivery sites, including each site's address, telephone number, and fax number must be submitted;
   - Organizational chart, and
   - Qualifications of Care Coordinator(s) and Care Director(s)/Manager(s).
2. Applicants must submit the completed application to:

   DHS Division of Behavioral Health Services
   Attn: Division Director
   305 S. Palm Street
   Little Rock, Arkansas 72205

3. BHH Certification is not transferable or assignable.
4. The privileges of the BHH certification are limited to the certified entity.
5. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

B. Application Process Timeline

1. DBHS or designee will review BHH applications within 90 calendar days after DBHS receives a completed application. DBHS or designee will return incomplete applications to applicant without review.
2. Site surveys will be scheduled within twenty (20) business days of the approval date of an application.
3. Applicant will receive a site survey report within ten (10) business days of the site visit.

4. Applicants with noted deficiencies on a site survey report must submit a Site Review Plan to DBHS or its designated representative within thirty (30) calendar days of receipt of the site survey report.
5. DBHS or its designated representative will accept or reject a Site Review Plan in writing within ten (10) business days of receipt of a plan.
6. Within thirty (30) calendar days of an approved Site Review Plan, the applicant must document implementation of the approved plan and correction of any deficiencies listed in the site survey report. Applicants that are unable, despite demonstrating reasonable diligence and a showing of good cause, to correct deficiencies within the time permitted may be extended an additional ten (10) days. Any extensions of time are at the sole discretion of DBHS.
7. For approved applications, a certification will be sent via postal or electronic mail to the applicant within 10 calendar days of approval.
8. BHH certifications are not transferrable or assignable. Privileges are limited to the certified entity.

XI. BHH RECERTIFICATION PROCEDURE

1. DBHS must receive the BHH's Recertification form fifteen business days before the BHH Certification expiration date. See Appendix B for Application for BHH Recertification.
2. Applicants must submit the completed application to:

DHS Division of Behavioral Health Services
Attn: Division Director
305 S. Palm Street
Little Rock, Arkansas 72205

XII. DBHS ACCESS TO APPLICANTS/PROVIDERS

1. DBHS may contact applicants and providers at any time.
2. DBHS may make unannounced visits to applicants/providers.
3. Applicants/providers shall provide DBHS prompt and direct access to applicant/provider documents and to applicant/provider staff and contractors, including, without limitation, clinicians, paraprofessionals, physicians, administrative, and support staff.
4. DBHS reserves the right to ask any questions or request any additional information related to certification.

XIII. COMPLIANCE REVIEW AND APPEALS

Please reference the "Certification Rules for Providers of Outpatient Behavioral Health Services" for information regarding and procedures for Compliance Reviews and Appeals.

XIV. BHH CERTIFIED PERFORMING PROVIDERS

BHH Certified Performing Providers (CPP) are behavioral health professionals trained, certified, and authorized by DBHS to provide behavioral health home services as part of a certified BHH. CPP's must provide services consistent with the following standards and supervision requirements:

A. Care Coordinator

Care Coordinators are responsible for interacting with clients, the client's family, and his/her other treatment providers and ensuring the client's needs are being addressed. The Care Coordinator is accountable for coordinating the provision and continuity of the integrated care, treatment, or services and facilitating the client's access to all needed care, treatment, or services, whether behavioral or physical.

a) Description

1. Work with client and family to develop and implement integrated care plan by providing assistance with referrals, scheduling and getting to appointments, etc.;
2. Coordinate Integrated Care Team meetings and assign responsibilities to appropriate team members;
3. Match clients and families to services that support compliance of the integrated care plan and advocate on their behalf for participation;
4. Regularly check-in with client to identify and understand potential risks to plan adherence and create preventative measures;
5. Develops crisis intervention plan with client/family including creating options for increased access
6. Arrange for or provide early intervention, prevention, and promotion health education (e.g. tobacco cessation activities);
7. Educate and support client on self-management plans and routine clinical care;
8. Monitor chronic disease indicators and performance metrics;
9. Coordinate and share transition planning with relevant coordinators;
10. Maintain client documentation, and
11. Updates Care Director or Care Manager on client status and compliance.

b) Education and Experience

1. Minimum of Bachelor's degree in Psychology, Social Work, Addiction Studies, Nursing, or related field, OR be a Registered Nurse in good standing in the state of Arkansas, and
2. Minimum of three years of experience in behavioral health.

c) Training

1. Minimum of forty hours of initial training;
2. An additional twenty hours of training must be completed within one year of certification, and
3. All training must be facilitated or approved by DBHS or designee and align with outlined required competencies.

d) Required Competencies

1. Knowledge of mental illnesses, substance abuse, suicidality, and treatment modalities;
2. Knowledge of recovery and resiliency treatment in mental illness and substance abuse;
3. Knowledge of developmental tasks involved in social and emotional development associated with specific ages;
4. Recognize barriers to treatment and development;
5. Understanding of the importance of collaboration in service planning to support whole person recovery/resiliency focused treatment;
6. Knowledge of community resources.
7. Knowledge of how to provide effective, equitable, understandable and respectful quality care that is responsive to diverse cultural health beliefs, and practices, preferred languages, health literacy and other communication needs;

8. Knowledge of crisis prevention techniques;
9. Knowledge of appropriate relationships and professional boundaries with clients, and
10. Knowledge of trauma-informed care.

e) Continuing Education

1. Must complete 20 hours of Continuing Education annually;
2. All continuing Education hours must be facilitated or approved by DBHS or designee and align with outlined required competencies.

f) Supervision

1. Care Coordinators must be supervised by a Certified BHH Care Director or Care Manager.
2. Supervision must include a minimum of two direct personal observations of randomly selected patient interactions per month.
3. Supervisor must review client records monthly.
4. Direct supervision is available as needed to provide guidance in problem solving or case specific objectives.
5. Supervision documentation must be maintained.
6. Supervision documentation must include the date, time, manner, subject matter, and duration of direct supervision.
7. Record must also include name and credentials of personnel performing supervision.
8. The maximum Care Director/Manager to Care Coordinator ratio is 1:10.

g) Client Ratio

1. The maximum client to Care Coordinator ratio is 40:1 for Tier 2 clients and 20:1 for Tier 3 clients.

h) Competency Exam

1. Must pass established competency exam to become certified as a BHH Care Coordinator;
2. To be eligible to sit for the competency exam, an individuals must complete the initial forty hour training, and
3. Each individual will be allowed to sit for the exam up to three times before being required to repeat the forty hour initial training.

B. Care Director/Manager

The Care Director/Manager is responsible for supervising the BHH Care Coordinators, facilitating problem-solving with the Care Coordinators, operating the BHH, and reviewing the Integrated Care Plan. The Care Director is charged with establishing relationships with providers, support service providers, Patient Centered Medical Homes (PCMHs), and other related service providers. The Care Director is responsible for managing budgetary, operational oversight, and other administrative duties of the BHH.

a) Description

1. Maintains awareness of and interacts with key services to ensure they are meeting clients' needs;
2. Provides regular education on client access to services especially at transition points
3. Establishes process to ensure prompt informing on unplanned care to BHH team;
4. Regularly check-in with client to identify and understand potential risks to plan adherence and create preventative measures;
5. Develops community relationships;

6. Responsible for oversight of BHH operations;
7. Manages budget for BHH operations;
8. Maintains client data for all reporting purposes;
9. Completes all data and outcome reports, and
10. Supervises Care Coordinators.

b) *Education and Experience*

1. Minimum of Master's degree in Psychology, Social Work, or related field;
2. Minimum of three years of related behavioral health experience;
3. Minimum of three years of supervisory experience in behavioral health, and
4. Minimum of three years of administration, operational and managerial experience.

c) *Training*

1. Minimum of twenty four hours of initial training;
2. An additional ten hours of training must be completed within one year of certification, and
3. All training must be facilitated or approved by DBHS or designee and aligned with outlined required competencies.

d) *Required Competencies*

1. Knowledge of mental illnesses, substance abuse, suicidality, and treatment modalities;
2. Knowledge of recovery and resiliency treatment in mental illness and substance abuse;
3. Knowledge of chronic medical illnesses;
4. Knowledge of developmental tasks involved in social and emotional development associated with specific ages;
5. Knowledge of barriers to treatment and development;
6. Understanding of the importance of collaboration in service planning to support holistic client recovery/resiliency focused treatment;
7. Knowledge of operational best practices;
8. Knowledge of administrational best practices, and
9. Knowledge of financial best practices.

e) *Continuing Education*

1. Must complete 20 hours of Continuing Education annually
2. All continuing Education hours must be facilitated or approved by DBHS or designee and aligned with outlined required competencies.

f) *Supervision*

1. The Care Director must be supervised by the behavioral health agency's Clinical Director.
2. The Clinical Director must meet with the Care Director on a monthly basis to review goals, outcomes, and barriers.

g) *Competency Exam*

1. Must pass established competency exam to become certified as a BHH Care Director/Manager;
2. To be eligible to sit for the competency exam, an individuals must complete the initial twenty four hour training, and
3. Each individual will be allowed to sit for the exam up to three times before being required to repeat the twenty four hour initial training.

h) Care Manager Role

1. Based on established ratios, if a BHH exceeds ten Care Coordinators, the BHH must employ a Care Manager to assist in supervision of Care Coordinators and administrative duties.
2. Care Managers must be certified as a Care Director by DBHS or designee.
3. Care Managers must be supervised by the BHH Certified Care Director.
4. Care Managers must meet the following Education and Experience requirements:
   - Minimum of Master's degree in Psychology, Social Work, or related field;
   - Minimum of three years of related behavioral health experience, and
   - Minimum of three years of supervisory experience in behavioral health.

XV. PERFORMING PROVIDER APPLICATIONS

1. Applicants must submit:
   - Completed application form, see Appendix C, Form 3: Application for BHH Performing Provider Certification and
   - Copies of pertinent/required certifications and licenses, i.e. licensure or certification by State boards to provide behavioral health services.
2. Applicants must submit the completed application to:

   DHS Division of Behavioral Health Services
   Attn: Division Director
   305 S. Palm Street
   Little Rock, Arkansas 72205

3. BHH Performing Provider Certification is not transferable or assignable.

XVI. PERFORMING PROVIDER APPLICATION REVIEW TIMELINE

1. DBHS will review BHH Performing Provider applications within 90 calendar days after DBHS receives a completed application. DBHS will return incomplete applications to senders to review.
2. DBHS will furnish certificates via postal or electronic mail within ten calendar days of issuing a site certification.

XVII. PERFORMING PROVIDER RECERTIFICATION PROCEDURE

1. The BHH Performing Provider Certification expires annually.
2. DBHS must receive the Performing Provider's Recertification form fifteen business days before the Certification expiration date. See Appendix D for Form 4: Application for Performing Provider Recertification.
3. In addition to the Performing Provider Recertification form, the Recertification packet must include proof of the completion of DBHS or designee approved Continuing Education Credits.
4. Applicants must submit the completed application to:

   DHS Division of Behavioral Health Services
   Attn: Division Director

305 S. Palm Street
Little Rock, Arkansas 72205

XVIII. APPENDICES

Appendix A
FORM 1: APPLICATION FOR BHH CERTIFICATION

To be completed upon initial application for BHH Certification

NAME OF PROGRAM:	
Chief Executive Officer:	
Administrative Address:	
City:	
Zip Code:	County:
Telephone:	Fax:
Email:	
Website:	
Date of Initial Certification as DBHS BHA:	

As the Chief Executive Officer of the agency named above, I attest that all information contained in this form and the attachments is correct and complete.

Signature of Chief Executive Officer Date

Name of Chief Executive Officer printed or typed

Appendix B
FORM 2: APPLICATION FOR BHH RECERTIFICATION

To be completed for BHH Recertification

NAME OF PROGRAM:	
Chief Executive Officer:	
Administrative Address:	
City:	
Zip Code:	County:
Telephone:	Fax:
Email:	
Website:	
Date of Most Recent Certification as DBHS BHA:	

As the Chief Executive Officer of the agency named above, I attest that all information contained in this form and the attachments is correct and complete.

Signature of Chief Executive Officer Date

Name of Chief Executive Officer printed or typed

Appendix C

FORM 3: APPLICATION FOR PERFORMING PROVIDERS CERTIFICATION

To be completed upon initial application for BHH Performing Providers Certification

Name:	
BHH Agency Name:	
Administrative Address:	
City:	
Zip Code:	County:
Telephone:	Fax:
Email:	

Please select the certification type:

- ☐ Care Coordinator
- ☐ Care Manager
- ☐ Care Director

I attest that all information contained in this form and the attachments is correct and complete.

Signature of Applicant Date

Name of Applicant printed or typed

Appendix D

FORM 4: APPLICATION FOR PERFORMING PROVIDER RECERTIFICATION

To be completed for BHH Performing Provider Recertification

Name:	
BHH Agency Name:	
Administrative Address:	
City:	
Zip Code:	County:
Telephone:	Fax:
Email:	

Please select the certification type:

- ☐ Care Coordinator
- ☐ Care Manager
- ☐ Care Director

I attest that all information contained in this form and the attachments is correct and complete.

Signature of Applicant Date

Name of Applicant printed or typed