DMAS Behavioral Health Services Redesign Provider Readiness Survey

July 21, 2025

Survey closes on: August 8, 2025

* Required

Basic Information and Services Currently Provided

1. Full name (First and Last Name) *

Enter your answer

2. Work Title/Role *

3. Agency Name (must match DMAS enrollment system) *

Enter your answer

4. Address (Address Line 1, Address Line 2, City, State, Zip Code) - Must match DMAS enrollment system. *

5. Primary National Provider Identifier (NPI#) *

The value must be a number

6. Enter any Other NPIs Used By Your Agency to bill Medicaid CMHRS. (separate with commas) *

7. Phone number *

8. E-mail address *

Please enter an email

9. How many full-time **independently** Licensed Mental Health Professionals (LMHP) does your agency employ, if any?(physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner) *

Please enter a whole number

10. Full Name of LMHP and Department of Health Professions License #. If multiple, provide the Full Name and DHP License # for the director/supervisor. *

11. What current Community Mental Health Rehabilitative Services (CMHRS) does your agency have a DBHDS license for and provide? (check all that apply) *

- [ ] Intensive In-Home Services (IIHS) (H2012)
- [ ] Mental Health Case Management (MHCM) (H0023)
- [ ] Mental Health Skill Building (MHSS) (H0046)
- [ ] Psychosocial Rehabilitation (PSR) (H2017)
- [ ] Therapeutic Day Treatment (TDT) (H2016) - in-school
- [ ] Therapeutic Day Treatment (H2016 UG) - after-school
- [ ] Therapeutic Day Treatment (H2016 U7) - non-school based summer program
- [ ] None

12. Please provide your DBHDS license# for IIHS.

13. Please provide your DBHDS license# for MHSS.

14. Please provide your DBHDS license# for PSR.

15. Please provide your DBHDS license# for TDT.

16. In what setting(s) does your agency provide Intensive-In Home? (check all that apply) *

- [ ] Home
- [ ] Community
- [ ] Office
- [ ] Do not provide IIHS.
- [ ] Other

17. In what setting(s) does your agency provide Mental Health Skill Building? (check all that apply) *

- [ ] Home
- [ ] Community
- [ ] Office
- [ ] Do not provide MHSS.
- [ ] Other

18. In what setting(s) does your agency provide Psychosocial Rehabilitation? (check all that apply) *

- [ ] Home
- [ ] Community
- [ ] Office
- [ ] Do not provide PSR.
- [ ] Other

19. What modality(ies) does your agency use to provide Intensive In-home? (check all that apply) *

- [ ] Individual Psychotherapy
- [ ] Group Psychotherapy
- [ ] Individual Skill Building
- [ ] Group Skill Building
- [ ] Not Applicable
- [ ] Other

20. What modality(ies) does your agency use to provide Therapeutic Day Treatment? (check all that apply) *

- [ ] Individual Psychotherapy
- [ ] Group Psychotherapy
- [ ] Individual Skill Building
- [ ] Group Skill Building
- [ ] Not Applicable
- [ ] Other

21. What modality(ies) does your agency use to provide Mental Health Skill Building (DBHDS License Name: Mental Health Community Support Service)? (check all that apply) *

- [ ] Individual Skill Building
- [ ] Group Skill Building
- [ ] Not Applicable
- [ ] Other

22. Does your agency provide 24/7 on-call crisis support for Intensive In-home Services (H2012)?

- ◯ Yes
- ◯ No

23. What professional type provides the IIHS on-call crisis support? (check all that apply)

- [ ] Licensed Mental Health Professional
- [ ] Qualified Mental Health Professional
- [ ] Other

24. Does your agency provide 24/7 on-call crisis support for Therapeutic Day Treatment (H2016)?

- ◯ Yes
- ◯ No

25. What professional type provides the TDT on-call crisis support? (check all that apply)

- [ ] Licensed Mental Health Professional
- [ ] Qualified Mental Health Professional
- [ ] Other

Interest and Readiness to Transition to CPST/New Services

26. Does your agency plan on providing any of the new behavioral health services that are replacing CMHRS? *

- ◯ Yes
- ◯ No

27. Which new behavioral health service(s) does your agency plan to provide? (check all that apply)

- ☐ Community Psychiatic Support and Treatment (CPST) - Community/Adults, Tier 1
- ☐ Community Psychiatic Support and Treatment (CPST) - Community/Adults, Tier 2
- ☐ Community Psychiatic Support and Treatment (CPST) - Community/Youth, Tier 1
- ☐ Community Psychiatic Support and Treatment (CPST) - Community/Youth, Tier 2
- ☐ Community Psychiatic Support and Treatment (CPST) - School Setting/Youth, Tier 1
- ☐ Community Psychiatic Support and Treatment (CPST) - School Setting/Youth, Tier 2
- ☐ Clubhouse Model of Psychosocial Rehabilitation
- ☐ Coordinated Specialty Care (CSC)

28. CPST agencies will be required to have a fully licensed, full time LMHP clinical director. Which statement best describes your agency's readiness?

- ◯ We already have a clinical director who is fully licensed
- ◯ We have at least one fully licensed staff who is full time. They are not currently in the role of "clinical director" but we can easily meet the criteria by 7/1/2025
- ◯ We have no fully licensed staff who are full time currently, but are prepared to hire a clinical director in order to become licensed for the service transition 7/1/2025
- ◯ We have no fully licensed staff who are full time and are not prepared to do so.

29. What are the barriers to hiring a full-time Licensed Mental Health Professional Clinical Director? (check all that apply)

- [ ] Financial
- [ ] Geography
- [ ] Burnout and staff turn over
- [ ] Other

30. Some CPST components must be provided by a licensed or licensed eligible staff, including assessments, treatment planning, and counseling. In total (including those considered for earlier items), how many licensed AND license-eligible staff work full time at your agency?

31. Is your agency accredited by one of the following entities: The Joint Commission, Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), or Det Norske Veritas Healthcare (DNV)? *

- ◯ Yes
- ◯ No

32. If you agency is not accredited, does your agency plan on becoming accredited by one of these entities (The Joint Commission, Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), Det Norske Veritas Healthcare (DNV) in the future?

- ◯ Yes
- ◯ No

33. Which non-profit accreditation entity are you considering?

- ◯ Commission on Accreditation of Rehabilitation Facilities (CARF)
- ◯ Council on Accreditation (COA)
- ◯ Det Norske Veritas Healthcare (DNV)
- ◯ The Joint Commission

34. Which accrediting body is your agency accredited? The Joint Commission, Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), or Det Norske Veritas Healthcare (DNV)? (check all that apply)

- [ ] The Joint Commission (TJC)
- [ ] Council on Accreditation (COA)
- [ ] Commission on Accreditation of Rehabilitation Facilities (CARF),
- [ ] Det Norske Veritas Healthcare (DNV)
- [ ] Other

Evidence-Based Practices (EBP)

35. Which of the following EBPs is your agency trained in? (check all that apply) *

- [ ] Assertive Community Treatment (ACT
- [ ] Brief Strategic Family Therapy (BSFT)
- [ ] Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- [ ] Cognitive Behavioral Therapy for Psychosis (CBTp)
- [ ] Coordinated Specialty Care (CSC)
- [ ] Eye Movement Reprocessing and Desensitization (EMDR)
- [ ] Functional Family Therapy (FFT)
- [ ] High Fidelity Wraparound (HFW)
- [ ] Multisystemic Therapy (MST)
- [ ] Parent Child Interaction Therapy (PCIT)
- [ ] Trauma-Informed Cognitive Behavioral Therapy (TF-CBT)
- [ ] None

36. Please list any other Evidence Based Practices (EBP), Protocols, or Specific Approaches your staff are trained in. If possible, provide specific numbers for each EBP.

37. Rate the USEFULNESS of training in the following topics from 1 (not useful) to 5 (extremely useful) *

	1 - Not useful	2 - Somewhat useful	3 - Moderately useful	4 - Very Useful	5 - Extremely useful
How to bill different funding sources for EBPs.	◯	◯	◯	◯	◯
How to choose the optimal EBPs for your organization.	◯	◯	◯	◯	◯
How to recruit and retain staff for EBPs.	◯	◯	◯	◯	◯
Basic overview on EBPs	◯	◯	◯	◯	◯
How to educate referral sources and stakeholders on EBPs.	◯	◯	◯	◯	◯

38. Share EBP-related topics for which training would be useful to you. *

39. What about the *business* of providing EBPs does your organization excel at?

40. What, if any, parts of the *business* of providing EBPs are most difficult for your organization?

41. What are the biggest challenges preventing your agency from adopting new EBPs or growing your current EBP offerings? *

42. If the Center for Evidence-Based Partnerships (CEP-VA) could help you with *anything* EBP-related, what would you request? *

43. Rate the degree to which you agree with the following statements from 1 (strongly disagree) to 5 (strongly agree). *

	1 - Strongly Disagree	2 - Disagree	3 - Neutral	4 - Agree	5 - Strongly Agree
Offering EBPs is more trouble than it's worth.	◯	◯	◯	◯	◯
There are too few benefits or incentives for providers to offer EBPs.	◯	◯	◯	◯	◯
There are some small adjustments the state could implement to make EBPs much more attractive.	◯	◯	◯	◯	◯
The communities our organization serve desire EBPs.	◯	◯	◯	◯	◯
The communities we serve understand EBPs.	◯	◯	◯	◯	◯
The communities we serve would benefit from EBPs.	◯	◯	◯	◯	◯

44. How open would you say the following individuals at your agency are regarding prioritization of EBPs from 1 (not open) to 5 (extremely open)? *

	1 - Not Open	2 - Somewhat Open	3 - Neutral	4 - Open	5 - Extremely Open
Clinicians	◯	◯	◯	◯	◯
Supervisors/Managers	◯	◯	◯	◯	◯
Admin/ Leadership	◯	◯	◯	◯	◯

Training and Communication Needs

45. How many Qualified Mental Health Professionals (QMHPs) work at your agency, provide direct services and will need the general state training on CPST? *

The value must be a number

46. How many Qualified Mental Health Professionals (QMHPs) work at your agency, provide direct services and will need the YOUTH FOCUSED Specific Training? *

The value must be a number

47. How many Qualified Mental Health Professionals (QMHPs) work at your agency, provide direct services and will need the ADULT FOCUSED Specific Training? *

The value must be a number

48. How many FULL TIME AND PART TIME (total) licensed and license-eligible staff (total) work at your agency? *

The value must be a number

49. Of the licensed and license-eligible staff at your agency, how many would need to receive CHILD FOCUSED training? (enter 0 if you only provide adult services) *

The value must be a number

50. Of the licensed and license-eligible staff at your agency, how many would need to receive ADULT FOCUSED training? (enter 0 if you only provide child services) *

The value must be a number

51. Are any of your staff trained and certified (currently) to complete the Child and Adolescent Needs and Strengths (CANS) assessment? If so, how many? *

The value must be a number

52. Please provide the NAME for a single point of contact for training coordination for all adult training needs. (enter NA if no adult training needs) *

53. Please provide the EMAIL ADDRESS for a single point of contact for training coordination for all adult training needs. (enter NA if no adult training needs) *

Please enter an email

54. Please provide the NAME for a single point of contact for training coordination for all youth training needs. (enter NA if no youth training needs) *

Please enter an email

55. Please provide the EMAIL for a single point of contact for training coordination for all youth training needs. (enter NA if no youth training needs) *

56. Please ask any questions you would like us to address in future FAQs and webinars here:

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