DDCHCS — Rating Scale Cover Sheet

Program Identification

Date_____ Rater(s) _____ Time Spent (Hours) _____

Agency Name _____

Program Name _____

Contact Person 1) _____ 2) _____

Telephone _____ FAX_____ Email _____

Address _____ State _____ Zip Code _____

Region _____ Program ID _____ Assessment Type _____ Time Period _____

(RUCA category Code) *(10 digit code)* *(DDCAT, DDCMHT, DDCHCS)* *1= Baseline; 2 = 1st-follow-up; 3= 2nd follow-up; 4= 3rd follow-up; etc*

Program Characteristics

Payments received (program)

____Self-pay
____Private health insurance
____Medicaid
____Medicare
____State financed insurance
____Military insurance

Other funding sources

____Other public funds
____Other funds

Sources used/
Total # of sources used:

____Chart review
____Observe treatment session
____Team meeting observation
____Interview with program director
____Program manual review
____Interview with other service providers (please specify)
____Agency brochure review
____Physical site tour
____Supervision observation
____Interview with clinicians
____Client interviews: #

Primary focus of agency

____Addiction treatment services
____Mental health (MH) services
____Mix of addiction & MH services
____General health services
____Hospital

Size of program

____# of admissions/last fiscal year
____Capacity (highest # serviceable)
____Average length of stay (in days)
____Planned length of stay (in days)
____# of unduplicated clients/year

Agency type

____Private
____Public
____Non-Profit
____Government operated
____Veterans Health Administration

Level of care

ASAM-PPC-2R (Addiction)
____I. Outpatient
____II. IOP/Partial Hospital
____III. Residential/Inpatient
____IV. Medically Managed Intensive Inpatient
____OMT: Opioid Maintenance
____D: Detoxification

Mental Health
____Outpatient
____Partial hospital/Day program
____Inpatient

Health Care Setting
____Outpatient
____Inpatient hospital
____Acute care/emergency

continued

Exclusive program / Admission criteria requirement

____Adolescents
____Co-occurring MH & SU disorders
____HIV/AIDs
____Gay & Lesbian
____Seniors/Elders
____Pregnant/post-partum
____Women
____Residential setting for patients & their children
____Men
____DUI/DWI
____Criminal justice clients
____Adult General

Practice/Specialty:

____General internal medicine
____General internal medicine-adult only
____Pediatrics
____Emergency department
____Family practice
____Specialty practice (specify all that apply)_____
____Federally-qualified health center

Format for behavioral health services (note with "SA" if true for substance abuse (SA) disorders; "MH" if true for mental health (MH) disorders; or "COD" if true for both SA and MH disorders):

____Medical staff designed to deliver all behavioral interventions (integrated at clinician level)
____Medical staff identify positive cases and refer to integrated specialized behavioral health providers in house (integrated at program level)*
____Medical staff refer identified patients to other program off site but within same agency (coordinated)
____Medical staff refer identified patients to other program off site not within same agency (collaborative)
____Medical staff refer identified patients to community services
____Other:

***Discipline and number of onsite integrated behavioral health providers**

____MD
____APRN
____PhD/PsyD
____RN/BSN
____MA/MS
____LADC/CADC
____Other; Specify

DDCHCS — Rating Scale

	1–HCOS	2	3–DDC	4	5–DDE
I. Program Structure					
1A. Primary treatment focus as stated in mission statement. What is the agency's mission statement? In addition to medical care, does it leave open the potential to address MH and/or SA problems? Does it explicitly state any behavioral health goals?	Medical care only.	Primary focus is medical care, SA or MH is treated.	Generic focus on health and well-being.		Primary focus on health, with explicit mention of physical and emotional/ behavioral elements.
IB. Organizational certification and licensure. What does licensure or certification permit? Are there impediments to providing either MH or SA treatment services? Are these impediments real?	Permits only medical services.	Has no actual barrier to treatment of SA or MH, but staff report regulatory barriers.	Has no barrier to treating either SA or MH within the context of medical treatment.	Is certified and/or licensed to provide medical care and treatment of either MH or SA.	Is certified and/or licensed to provide both medical care and treatment of MH, SA, and co-occurring disorders.
IC. Coordination and collaboration with specialty MH or SA treatment services. How and where are MH or SA treatment services provided? Through loose relationships or integrated on site? Are these relationships formalized and documented?	No document of formal coordination or collaboration.	Vague, undocumented, or informal relationship with MH and/or SA agencies, or consulting with staff members from that agency.	Formalized and documented coordination or collaboration with either a MH or SA treatment agency.	Formalized coordination and collaboration, and the availability of case management staff, or staff exchange programs (variably used) with both an MH and SA treatment agency.	Most services for MH, SA, and co-occurring disorders are integrated within the existing program, or routine use of case management staff or staff exchange programs.

Table Header Key	
1-HCOS	Health Care Only Services
3-DDC	Dual Diagnosis Capable
5-DDE	Dual Diagnosis Enhanced

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
ID. Financial incentives. How do billing structures limit or incentivize services for persons with MH or SA disorders?	Can only bill for medical services.	Can bill for either MH or SA, but not both.	Could bill for both SA and MH, but staff report there to be barriers. – Or – Partial reimbursement for MH or SA services available.		Can bill for SA or MH treatments; can bill for combination and/or integration of MH/SA care for co-occurring patients.
II. Program Milieu					
IIA. Routine expectation of and welcome to treatment for both disorders. How are clients with MH, SA, or co-occurring disorders expected and welcomed? How is this reflected in agency documents?	Expects medical cases only, refer or deflect persons with MH, SA, or co-occurring disorders or symptoms.	Documented to expect either SA disorders or MH disorders (e.g., admission criteria, target population), but have informal procedure to allow some persons with co-occurring disorders to be admitted.	Expects SA and MH, but not co-occurring (i.e., the SA and MH with the same patient). Co-occurring not treated.	Program formally defined like DDC but clinicians and program informally expects and treats both SA and MH disorders, not well documented.	Clinicians and program expect and treat co-occurring disorders, well documented.
IIB. Display and distribution of literature and patient educational materials. What kind of information is posted on walls, on display in waiting areas, and included in patient and family handouts and printed materials?	Information relating to medical issues only.		Available for MH and SA disorders with equivalent distribution.	Available for both MH and SA disorders, but not equivalently distributed.	Available for both MH and SA disorders, as well as the interaction between both MH and SA disorders. Distribution is equivalent.
III. Clinical Process: Assessment					
IIIA. Routine screening methods for SA and MH symptoms. Are there routines or systems to screen for MH problems? Are standardized screening instruments used?	No formal screening for MH or SA problems.	Some consistent but non-standardized history questions asked for either MH or SA problems.	Formal screening for either MH or SA problems.	Standardized, formal screening instruments for SA and MH, but made independently and not coordinated.	Standardized or formal instruments for SA and MH problems, including co-occurring disorders, with established psychometric properties.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
IIIB. Routine assessment if screened positive for SA or MH symptoms. If a patient screens positive, are more detailed assessments triggered? Are these assessments formalized and integrated into routine protocols?	No assessment follow-up to positive screens for either MH or SA.	Variable, clinician driven follow-up to positive screens for either SA or MH problem.	Assessment of MH or SA disorders as necessary and typically occurs.	Informal assessment of both MH and SA disorders occurs but with some variation.	Standardized or formal integrated assessment for MH and SA, and/or co-occurring disorders is routine in all cases.
IIIC. MH and SA diagnoses made and documented. If assessments are conducted, are MH and SA diagnoses made and recorded?	Neither SA nor MH diagnoses are made or recorded.	SA or MH diagnoses are made but variably.	Either SA or MH diagnoses are made routinely.	Co-occurring diagnoses are made variably and recorded in chart, or made routinely but not in the same chart (no coordination between SA and MH diagnostic).	Standard and routine diagnoses regarding SA, MH, and co-occurring disorders consistently made and recorded.
IIID. °MH and SA history reflected in medical record. Are the chronologies and treatment courses of these disorders gathered and recorded?	Medical history only.	Variable collection of SA or MH history only.	Routine documentation of either MH or SA disorder history in record in narrative section.	Variable recording of history and chronology of course of both disorders.	Specific section in record devoted to history and chronology of course of both disorders and the interaction between them is examined temporally.
IIIE. Access re: SA and MH symptom acuity: low, moderate, high. What happens to patients who present for services with stable MH or SA problems, or who are not intoxicated or in acute distress? What happens to patients who present with unstable MH symptoms or who are intoxicated or in withdrawal?	Continued access to services for persons with no to low acuity in MH or SA symptoms.	Continued access to services for persons with low to moderate acuity in either SA or MH conditions, but not both.	Continued access to services for persons with low to moderate acuity in both MH and SA problems, but who are primarily stable.	Continued access to services for persons who may be acute in either MH or SA problems, but not both.	Continued access to services for persons with moderate to high acuity, including those unstable in their MH condition and SA disorder.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
IIIF. Access re: Severity of persistence and disability: low, moderate, high. What happens to patients who present with histories or reports of severe and/ or persistent MH problems or SA, including alcohol or drug use disorders?	Continued access to services for persons with no to low severity of persistence of disability from either MH and SA disorders or co-occurring disorders.		Continued access to services for persons with low to moderate severity in either SA or MH disorder.	Continued access to services for persons with low to moderate severity in both MH and SA.	Continued access to services for persons with moderate to high severity of SA, MH, and co-occurring disorder.
IIIG. Stage-wise treatment-initial. Is the stage of motivation assessed and documented? How does it influence treatment or how a patient is approached?	Not assessed or documented.	Assessed and documented variably by individual clinician, focus either SA and/or MH motivation for treatment.	Routinely assessed and documented stage of motivation for either SA or MH treatment.	Variable assessment of stage of motivation for both SA and MH treatment.	Formal measure used and routinely documented, focus on both SA and MH motivation for treatment.
IV. Clinical Process: Treatment					
IVA. Treatment plans. Do treatment plans show an equivalent and integrated focus on both SA and MH disorders (along with medical conditions)? Or, is there a focus on medical disorders alone?	Address medical disorder only (neither MH nor SA listed).	Routine mention of medical disorders as primary, variable mention of MH or SA disorders.	Routine mention of medical disorders as primary, and routinely either MH or SA disorders as secondary.	MH and SA disorders variably mentioned.	Integrated treatment plan: Co-occurring SA and MH problems, like medical problems, can be listed as primary.
IVB. Assess and monitor interactive courses of both disorders. Are changes and/or progress with status and symptoms of MH and SA problems followed (and noted)?	No attention or documentation of progress with either MH or SA disorders.	Variable reports of progress on either MH or SA disorders by individual clinicians.	A systematic clinical focus in narrative (treatment plan or progress note) on either MH or SA disorders.	Variable focus on interaction between SA and MH disorders or systematic focus on both MH and SA, but not the interaction.	Clear, detailed, and systematic focus on change in both SA and MH disorders, and their interaction.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
IVC. Procedures for MH and SA emergencies and crisis management. Are there definite protocols for MH crises, for SA-related crises, or for persons at high risk for either?	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations for one but not both disorders (to local MH/SA agency or ER).	Variable guidelines and capability for both disorders.	Routine capability, or a process to ascertain risk with ongoing co-occurring disorders; maintain in present medical service unless commitment is warranted.
IVD. Stage-wise treatment-ongoing. Is stage of motivation assessed on an ongoing basis for both SA and MH problem change? Can treatment be revised based upon changes in motivation?	Not assessed or explicit in treatment plan.	Stage or motivation documented variably by individual clinician in treatment plan.	Stage or motivation routinely incorporated into individualized plan for either SA or MH issues, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan for both SA and MH issues, and some appreciation for specific stage-wise treatments.	Stage or motivation for both MH and SA problems routinely incorporated into individualized plan, and formally prescribed and delivered stage-wise treatments.
IVE. Policies and procedures for medication evaluation, management, monitoring and compliance. Are medications acceptable? Are certain medications unacceptable? Are medications for MH disorders (e.g. anti-psychotics, anti-depressants, etc) or SA disorders (acamprosate, naltrexone, disulfiram, etc) routine and integrated?	No psychotropic or SA medications are available.	Variable use of psychotropic or addiction medication by specific prescriber.	Present, coordinated policies regarding psychotropic medications or those for addictive disorders. Some types of medications are routinely available. Policies are provided to guide prescribing. Monitoring of the medication is largely provided by the prescriber.	Psychotropic and alcohol use disorder medications prescribed with a policy in force.	Present, coordinated policies regarding all types of medications for SA and MH disorders. There is access to providers with both these specialties on the treatment team.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
IVF. Specialized psychosocial interventions with co-occurring content. Are therapies available that focus on medical issues only, or that focus on MH, SA or co-occurring disorders?	Neither MH nor SA problems are addressed.	Interventions for either SA or MH problems based on judgment by individual clinician; irregular penetration into routine services.	Either MH or SA intervention in program format as generalized intervention, e.g. stress management; More regular penetration into routine services. Routine clinician adaptation of an evidence-based co-occurring treatment.	Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.	Routine co-occurring symptom management groups. Individual therapies focused on specific co-occurring disorders. Systematic adaptation of an evidence-based co-occurring treatment.
IVG. Patient education about SA or MH disorder & treatments, or co-occurring SA and MH disorder and treatments. Is patient education information available on how SA impacts a MH disorder and vice versa? Is information available about how either influences the course of medical problems, medications, or medical procedures?	For medical problems only.	Variably for either SA or MH disorder.	Present for either SA or MH disorder in generic format and content, and delivered in individual and/or group formats.	Present for SA and MH but variably for co-occurring disorders.	Present and routinely delivered specific content for specific disorder comorbidities, and protocols for individual and/or group formats.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
IVH. Family education and support. Do family members receive educational information available on how SA impacts a MH disorder and vice versa? Is information available about how either influences the course of medical problems, medications, or medical procedures? What kind of support is available for family members or loved ones?	For medical problems only.	Variably for either MH or SA problem or by individual clinical judgment.	Either MH or SA problems/ issues regularly but informally incorporated into family education or support sessions. Available as needed.	Family education and support offered on site for families on SA and MH issues but variably on co-occurring issues.	Routine and systematic co-occurring disorder family group integrated into standard program format. Accessed by the majority of families with co-occurring disorder family member.
IVI. Specialized interventions to facilitate use of peer recovery support groups. Is there any effort to facilitate a connection to peer recovery group support? How are these linkages made? Is there any consideration for persons with co-occurring disorders in making these connections?	None used to facilitate either use of SA or MH peer support.		Present, generic format on site, but no specific or intentional facilitation based on co-occurring disorders. More routine facilitation of traditional peer support groups; referrals to combinations of support groups for co-occurring patients.		Routine and specific to need of co-occurring persons, special programs on site, routinely targeted to specific issues, either to traditional peer support groups or those specific to both (e.g., DRA).

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
IVJ. Peer recovery supports for patients with CODs. Are peer supports and/or role models (patient advocates, volunteers) available for patients with MH and SA disorders? If so, are they on or off site, integrated with routine protocol?	Not present, or if present not recommended.	Off site, recommended variably.	Present, off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus, but primarily either SA (AA, NA) or MH peer recovery.	Present, off site, integrated into plan, and routinely documented with co-occurring focus.	Present, on site, facilitated and integrated into program (e.g., alumni groups; mentors; patient advocates). Routinely used and documented with co-occurring focus.
IVK. Practices and policies for schedule IV medications (narcotics), or other medications with abuse liability, balance needs and risks for persons with MH and SA disorders.	No to limited and restrictive use of narcotic or other medications with abuse potential for persons with MH and SA.	Variable use of narcotic and other medications with abuse liability but some sensitivity to abuse potential for persons with MH and SA.	Fairly consistent use of narcotic and other medications with considerations for abuse potential for persons with MH and SA, but no formal policy.	Policy for narcotic and other medications with abuse potential for persons with MH and SA, but not routinely followed, or providers unaware of its existence.	Clear policy that is implemented and monitored for narcotic or other medications with abuse potential for persons with MH and SA.
V. Continuity of Care					
VA. Co-occurring disorder addressed in discharge planning process. Is recovery from both SA and MH disorders considered when developing a discharge and/or transfer plan? How is linkage insured?	Not addressed.	Variably addressed by individual clinicians.	Either MH or SA is systematically addressed as secondary in planning process for off-site referral.	Both MH and SA are addressed, but not systematically.	Both disorders seen as primary, and plans made and insured, on site, or by arrangement - off site, at least 80% of the time.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
VB. Capacity to maintain treatment continuity for persons with SA or MH related behaviors. Is treatment terminated or suspended for intoxicated, drug-seeking, non-compliant, disruptive, or obstreperous behavior?	No mechanism for managing ongoing care of either MH or SA needs when medical treatment is treatment is terminated.	No formal protocol to manage either MH or SA needs once program is terminated, but some individual clinicians may provide extended care until appropriate linkage takes place. Variable documentation.	No formal protocol to manage either MH or SA needs once program is terminated, but when indicated, most individual clinicians provide extended care until appropriate linkage takes place; routine documentation.	Formal protocol to both MH and SA needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage co-occurring needs indefinitely and consistent documented evidence that this is routinely practiced, typically within the same program or agency.
VC. Focus on ongoing recovery issues for both disorders. Are SA and MH disorders seen as acute or chronic, short term or long term, primary or secondary? How is recovery envisioned and planned?	No.	Individual clinician determined.	Routine focus is on resolution of medical issues; co-occurring issues are viewed only as potential complicating issues for medical recovery.	Routine focus on either SA or MH management and recovery but not as interactive co-occurring conditions.	Routine focus on SA recovery and MH illness management and recovery, both seen as primary and ongoing.
VD. Facilitation of peer recovery support groups for COD is documented. Is the potential for peer support linkage anticipated and planned? How is it dealt with?	No.	Rarely, but addressed by individual clinicians.	Yes, routine and systematic focus on either SA or MH peer support community connection (engagement in meetings or functions off site).	Yes, variable, but not routine or systematic, focus on both SA and MH peer support community connection (engagement in meetings or functions off site).	Yes, routine and systematic, at least 80% of the time with focus on co-occurring disorders peer support community connection (engagement in meetings or functions off site).
VE. Sufficient supply and compliance plan for medications is documented. How is the need for medications post this treatment episode and after discharge with this provider dealt with?	No medications in plan.		Yes, 30-day or supply for either psychotropic or SA medications to next appointment off site.		Maintains psychotropic and SA medication management needs in program with provider.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
VI. Staffing					
VIA. Psychiatrist or other physician. What is the relationship with a psychiatrist or SA specialist (addiction medicine; certification in addiction psychiatry) or other expert medication prescriber (e.g., ARNP).	No board certified or specialized psychotropic or SA medicine prescriber or prescribing.	No board certified or specialized psychotropic or SA medicine prescriber but prescribing takes place.	Routine prescriber use of SA or psychotropic medication.	Board certified or specialized psychotropic or SA medicine prescriber.	Board certified or specialized psychotropic or SA medicine prescriber on site for clinical, supervision, treatment team, and/or administration.
VIB. On-site staff with MH and SA treatment (co-occurring) certification, licensure or expertise. Are any staff licensed or certified to provide MH or SA counseling services?	None.	1-24% of clinical staff members can provide MH and SA counseling services and have appropriate expertise.	25-33% of clinical staff members can provide MH and SA counseling services and have appropriate expertise.	34-49% of clinical staff members can provide MH and SA counseling services and have appropriate expertise.	50% or more of clinical staff members can provide MH and SA counseling services and have appropriate expertise.
VIC. Access to MH and SA supervision or consultation. What is the arrangement for existing staff to receive supervision/ consultation regarding their patients' co-occurring MH and SA problems?	No.	Yes, variable supervision in MH or SA treatments.	Yes, routine supervision in either MH or SA treatments.	Yes, routine supervision in MH or SA treatments but variable supervision in integrated treatments.	Yes, routine supervision in MH and SA treatments, as well as integrated treatments.

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
VID. Supervision, case management, or utilization review procedures emphasize and support COD treatment. Is there a protocol to review the progress or process of treatments (or outcomes) for persons with co-occurring SA and MH disorder?	No.	Variable, by off-site consultant, undocumented.	Yes, on site, documented as needed (PRN) and with co-occurring disorder issues.		Yes. Documented, routine and systematic coverage of co-occurring issues.
VIE. Peer/alumni supports are available with COD. Are role models available for persons with co-occurring SA and MH disorders (volunteers, peer supports, advocates)?	No.		Present, but as part of community, and routinely available to program patients, either thru informal relationships or more formal connections such as thru peer support service groups (e.g. AA hospital and institutional committees; NAMI).		Present, on site, either as paid staff, volunteers, or routinely available program "alumni."

DDCHCS — Rating Scale

	1 – HCOS	2	3 – DDC	4	5 – DDE
VII. Training					
VIIA. Basic training in prevalence, common signs and symptoms, screening and assessment for co-occurring SA and MH symptoms and disorders. What percentage of all staff members have a basic knowledge of co-occurring disorders? What percentage know how to screen and assess for these disorders? Is this training organized and documented?	No staff exposed to basic information (0% trained).	Variably exposed to basic information, not documented as part of systematic training plan, but encouraged by management (1 to 24% of staff trained).	Trained in basic knowledge and skill with MH or SA per agency strategic training plan (25 to 50% of staff trained).	Trained in MH or SA knowledge and skills per agency strategic training plan, but variable on co-occurring MH and SA (51-79% of staff trained).	New employee in-service and/or annual renewal of knowledge and skill on co-occurring MH and SA (80% or more of staff trained).
VIIB. Clinical staff who deliver behavioral health services have specialized training in knowledge and skill in treatments for co-occurring MH and SA. Who is trained in the more advanced approaches to persons with co-occurring disorders? (Advanced approaches include: medications, brief interventions, family interventions, other treatments). Is this training organized and documented?	No behavioral health staff have advanced training (0% trained).	Behavioral health staff variably trained, no systematic agency training plan or individual staff member election (1 to 24% of clinical staff trained).	Certain behavioral health staff trained, encouraged by management and with systematic training plan (25 to 50% of clinical staff trained).	Many behavioral health staff trained and monitored by agency strategic training plan (51-79% of clinical staff trained).	Most behavioral health staff trained and periodically monitored by agency strategic training plan (80% or more of clinical staff trained).

Site Visit Notes

DDCHCS — Scoring Summary

Program: _____ Date of Review: _____

Type: _____

Reviewer(s): _____

I. Program Structure

A. _____
B. _____
C. _____
D. _____

Sum Total = _____
/4 = ***SCORE*** _____

II. Program Milieu

A. _____
B. _____

Sum Total = _____
/2 = ***SCORE*** _____

III. Clinical Process: Assessment

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

Sum Total = _____
/7 = ***SCORE*** _____

IV. Clinical Process: Treatment

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H. _____
I. _____
J. _____
K. _____

Sum Total = _____
/11 = ***SCORE*** _____

V. Continuity of Care

A. _____
B. _____
C. _____
D. _____
E. _____

Sum Total = _____
/5 = ***SCORE*** _____

VI. Staffing

A. _____
B. _____
C. _____
D. _____
E. _____

Sum Total = _____
/5 = ***SCORE*** _____

VII. Training

A. _____
B. _____

Sum Total = _____
/2 = ***SCORE*** _____

DDCAT Index Program Category: Criterion Method

% CRITERIA MET FOR HCOS (# of "1" or > /36)_____100%

% CRITERIA MET FOR DDC (# of "3" or > scores/36) _____

% CRITERIA MET FOR DDE (# of "5" scores/36) _____

HIGHEST LEVEL OF DD CAPABILITY (80% or more)_____