

CCIP: Response to Questions Pertaining to Core Standards

In the background research for our complex care management standards, we examined a number of model programs that have excelled in the provision of care for individuals with exceptional care management needs, often with multiple social determinant risks such as unstable housing or joblessness. Unlike the complex care management standards that are the focus of CCIP, these programs may be comprised of teams and care plans that are *not* centered on the medical home (e.g., programs targeting individuals with serious and persistent mental illness, chronic substance abuse, developmental disabilities, or populations that require a range of long term services and supports). Although we have learned a great deal from our examination of these programs, it is important to emphasize that our focus in CCIP is on those individuals for whom the core primary care team is the foundation for the care management process and the source of continuous support when the comprehensive care team is no longer required.

Many of the innovative care management models around the country identify the needs of patients who are considered complex (The Center for Health Care Strategies, Inc., 2014). Although none of the programs reviewed are exactly the same, they share a similar intensive care management design. The intensive care management models tend to consist of a care management team that deploys similar tools (e.g., needs assessments and care plans) to provide intensive care management. Often the core objective of a care management team is to focus on in-person care management and the integration of primary care and community resources.

Successful care management is accomplished when individuals are engaged in their care, feel supported by their providers, and have their full range of clinical and non-clinical needs addressed. The common tools used by these teams include needs assessments and care plans. The needs assessments are used to identify clinical, social, and behavioral health needs. A person-centered care plan supports the individual in achieving care goals by ensuring transparency, portability, and continuity of information about health conditions, personal preferences, and goals of care (Spencer A, 2015) (Samuelson, 2015) (Hawthorne, 2015) (Health, 2014). At a high level the following **program design** is commonly used:

1. Identify the focus population;
2. Connect the individual to a comprehensive care team¹ charged with providing intensive care management;
3. Conduct a person-centered (see Appendix E for a list of definitions) needs assessment that informs the development of a care plan, with a focus on the individual's non-clinical (i.e.; social and behavioral) needs;
4. Execute the care plan, ensure updates are communicated to the care team, connect the individual to needed clinical and non-clinical services, and support the individual to transition to routine primary care team follow-up and self-directed care management; and
5. Track the individual, periodically reassess, and reconnect with the individual if needed.

A set of **design questions** was used to inform the creation of comprehensive care management standards for CCIP. The design questions included the following:

¹ Programs use multiple names for their care management teams, including: community care teams, integrated care delivery teams, community health teams, etc.

1. How should networks identify complex patients?
2. Who will the core members of the comprehensive care team be? What will be their roles?
3. How will the network build the comprehensive care team workforce?
4. What type of training will comprehensive care teams and primary care practices require?
5. What will the needs assessment and care plan look like? How will they be administered?
6. How will the comprehensive care team support the patient to successfully meet the care plan goals?
7. How can networks monitor an individual’s health status after they transition to self-directed care management?
8. How will the networks monitor the effectiveness of the intensive care management intervention?
9. How will patient and caregiver preferences and input be incorporated into the care plan?

In answering these questions, the PTF drew on best practices identified in related state and national programs and their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut.

Individuals with Complex Needs

The PTF considered the following questions drawing on best practices identified in related state and national programs and their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut.

Review of State and National Programs

The PTF considered several models across the country with the similar objective of transforming how healthcare is delivered to better address the non-clinical determinants of health (i.e.; social and environmental circumstance and behavioral choices). The Center for Health Care Strategies, Inc. examined programs intended to address high-needs patients across 26 states, many of which use the Medicaid Health Home model as a basis for creating these programs. While the Medicaid Health Home model is commonly used, there are some programs that have been developed locally due to an identified need (Center for Health Care Strategies, Inc., 2015). Early adopters of Medicaid Health Homes include Iowa, Missouri, New York, North Carolina, Oregon, and Rhode Island. The most well-known examples of locally developed solutions are the Camden Coalition and Hennepin County (Center for Health Care Strategies, Inc., 2015) (Coalition, 2015) (Health, 2014) (The Center for Health Care Strategies, Inc., 2014).

The early adopters of the Medicaid Health Homes and other programs such as the Camden Coalition and Hennepin County revealed the following design choices to be the most effective:

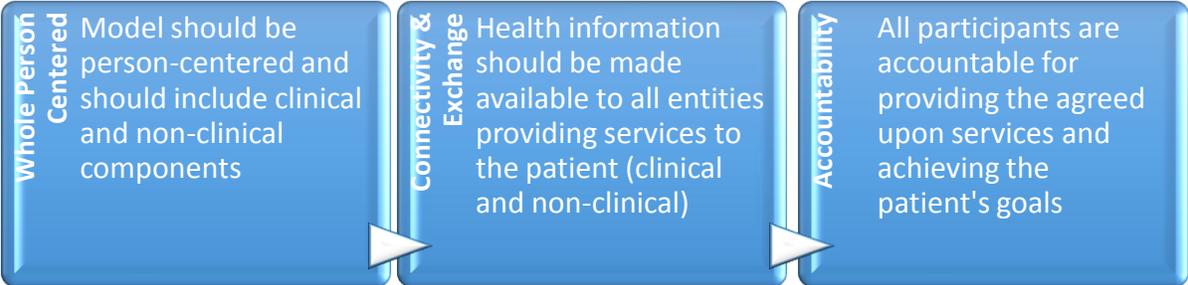
#	Design Feature	Examples
1	Careful definition of the focus population	<ul style="list-style-type: none"> • NY Health Home: Intensive care management to “high-need” individuals • Rhode Island Health Home: Adult behavioral health needs

2	Design of services to meet the needs of the focus population	<ul style="list-style-type: none"> • Hennepin: care team supporting patient is determined based on risk assessment • Multiple Health Homes: identify care team members to meet with patient face-to-face in the home to better suit their needs
3	Real time access to data that supports effective care coordination	<ul style="list-style-type: none"> • Camden Coalition and Hennepin: Local health information exchange that includes data from all local healthcare providers and is made available to all relevant care team members • New York Health Home: have to meet state established technology standards • Multiple Health Homes: methods to alert health homes about admissions and discharges from hospitals and EDs
4	Accountability for services provided with community-based organizations	<ul style="list-style-type: none"> • Multiple Health Homes: set clear performance requirements and provide support to meet those requirements • Camden Coalition: scorecard reviewed with care team on monthly basis to identify opportunities for improvement
5	Support provided to achieve cultural change	<ul style="list-style-type: none"> • Iowa Health Home: care clinician role intended to support health homes transform how they deliver care to be a health home

Reference: (Coalition, 2015) (The Center for Health Care Strategies, Inc., 2014) (Health, 2014)

Beyond the framework of the model, early adopters noted that flexibility within the Health Home implementation guidelines to tailor the design and reimbursement of services to meet their respective local needs was an important success factor. The PTF attempted to replicate that balance of providing evidence-based standards for CCIP interventions with flexibility to cater to local needs.

The PTF’s review of program design features of the programs across the country suggested that there should be **three design guiding principles** for CCIP in Connecticut:



1. How should networks identify complex patients?

Current programs use a variety of techniques to identify patients such as:

- Physician referral
- Individually selecting patients in the primary care or acute setting after displaying certain “warning signs”
- Basic analytics that identifies patients based on level of risk (risk stratification)
- Advanced analytics to predict who is at risk of poor outcomes (predictive modeling) (Depriest A, 2015) (see Appendix E for definitions).

The analytics may be based on claims data, EHR data, or a combination of the two. EHR data provides the advantage of including real time clinical information such as a change in conditions, lab values, diagnostic tests and procedures. Regardless of the method used, the most important elements in identifying complex patients are a combination of clinical, social, and behavioral risk factors along with service utilization. Clinical and social factors should include any physical, functional, or cognitive challenges that are not otherwise identified as medical conditions.

While predictive analytics using a combination of EHR and claims data is the most advanced approach to identifying complex patients, PTF members thought it likely that many of the Advanced Networks and FQHCs in Connecticut do not have that capability today. It is assumed that they will have access to claims data through Medicaid and private payers to do some basic utilization-based risk stratification. Taking this into consideration, the PTF determined that the networks should use basic analytic tools to do risk stratification that accounts for utilization and the clinical, social, and behavioral risk factors as indicated in the claims data while attempting to progress toward more advanced predictive analytics as technology and capacity allow.

2. Who are the core members of the comprehensive care team be? What are their roles?

The care management teams across the programs that we reviewed are tailored to meet the needs, preferences, values, lifestyle, and goals of their patients. For this reason, these teams may vary in membership. However, there are core roles common across most teams that include: a case manager, a clinically focused care coordinator, and a community focused care coordinator who connects individuals to needed social services and provides culturally and linguistically aligned self-care management education. Additionally, most teams have a care manager who oversees the team’s activities and integration into the primary care team. While the above roles are common features of all teams, teams also have additional members as needed that reflect the specific needs of the individual patients (Spencer A, 2015) (Takach M, 2013).

The PTF agreed that these roles should be core to the CCIP complex patient intervention. The PTF also agreed that the initial needs assessment must take into account patient and caregiver input, thereby informing whether additional team members/functions should be added and/or made available when needed (e.g., a pharmacist or dietician). Given the common occurrence of behavioral health needs amongst complex patients (Brown D, 2014), the PTF felt strongly that the team should either have a team member who is also a licensed behavioral healthcare specialist or, at a minimum, should provide timely access to a licensed behavioral healthcare specialist.

Aside from the behavioral health specialist, the PTF elected not to require specific credentials for any of the care team members. The PTF acknowledged that many networks have employees today that fulfill case management and care coordination roles and that these roles are filled by individuals of varied credentials according to the local needs of the patient population. To allow for networks to re-purpose current employees to fulfill the CCIP requirements, the PTF decided that the care management, care coordination, and overall management function can be fulfilled by any individual with training in that area and that there should be a dedicated care manager for each patient. However, the PTF will not require that the individuals have a specified set of credentials. Given the unique role of the Community Health Worker (CHW, see Appendix E for definition) in supporting the non-clinical needs of patients and the importance of this to the objectives of CCIP, it will be the only function that has to be fulfilled by a designated individual. To make sure there is clarity amongst all team members about each of their roles and responsibilities on this team, the Advanced Network and FQHC will be expected to develop written job descriptions outlining how each member will fulfill their specified function.

3. How will the network engage the necessary workforce?

Advanced Networks and FQHCs participating in CCIP will likely vary in their readiness to enable comprehensive care teams. Some networks will already have the staff resources for a comprehensive care team in place, but these teams may be organized differently around the patient. The networks will also vary in structure. Some networks will be vertically integrated with other healthcare entities (e.g., a hospital) while others will be a collection of physician practices. Given the variations in structure between networks and the state of readiness of networks to build a comprehensive care team, the PTF agreed that the strategy chosen to build the comprehensive care teams and how they are operationalized should be decided by the networks.

Since the CHW will be the one key care team member less likely to be employed today, the PTF felt that the decision as to whether to employ or contract for these services should be left up to the network. Regardless of this decision, the key responsibilities of the CHW should be made explicitly clear. Similarly, the PTF also encourages networks to determine an appropriate and manageable caseload for the comprehensive care team to ensure effective deployment of that team. Determining the case load for the comprehensive care team will support developing a strategy and operational plan that is most efficient for the network.

4. What type of training will care team members require?

Existing programs focus training on team-based care and the associated work-flow redesign. Assembling a comprehensive care team to provide care management will either introduce new positions that did not previously exist or re-define the scope of work of existing team members. An effective comprehensive care team will need to be appropriately integrated into the primary care practice through re-designed workflows and practice-wide understanding and support of the values, principles, and goals of the comprehensive care team's work (Spencer A, 2015).

The only team member with more specific training needs is the community health worker (CHW). A community health worker is defined as a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" (American Public Health Association, 2015). [CHWs play a unique role building trusting relationships with individuals with whom they work, connecting the individuals to needed services, and providing culturally and linguistically](#)

[aligned self-care management education. CHWs are generally provided training to do this, including: how to build trusting relationships, how to identify patient behavioral and social needs and connect individuals to relevant supportive services, how to provide health education to support behavior change, and how to advocate on behalf of the individuals whom they support](#) (Boston, 2007).

Better integrating primary care with community care through the use of a comprehensive care team may be a paradigm shift for many primary care practices. Team-based training that supports this shift and clarifies roles and responsibilities for providers participating in the new care model should be required. In addition, the PTF agreed that, since Connecticut does not currently have CHW credentialing or certification networks, it will be required that all CHWs are appropriately trained, as defined by the network, to provide the needed support to patients.

The PTF noted that many complex patients will have behavioral health needs and represent a variety of cultural backgrounds. Accordingly, the PTF recommended that members of the comprehensive care team have basic behavioral health training and meet culturally and linguistically appropriate care delivery standards. The technical assistance vendor can assist networks with identifying appropriate training programs and processes for networks.

5. What will the needs assessment and care plan look like? How will they be administered?

Needs assessments across programs may be as simple as a brief intake form (Coalition, 2015) to involving complex eco-mapping with historical context on the patient's needs including the use of previous patient medical records and claims data to gain a better understanding of past healthcare utilization (Samuelson, 2015) (Spencer A, 2015). Regardless of the historical depth of the needs assessments, an effective process should cover clinical/physical, behavioral, and social needs and take into consideration the individual's cultural characteristics and linguistic needs (Spencer A, 2015). Person-centered care plans are driven by the patient and may also include the input of their natural supports (see Appendix E for definition) and caregivers to address health needs. Care plans should clearly articulate the patient's goals, who on the care team is responsible for supporting the patient to meet those goals, timeframes for achieving the stated goals, and the patient/caregiver responsibilities for improving self-management (Coalition, 2015) (Kansas Medicaid, 2015). The person-centered care plan is intended to be incorporated into the primary care setting with the comprehensive care team coordinating to address the individual's non-clinical needs.

The PTF agreed that the needs assessment should draw on historical and current needs as well as a care plan that clearly articulates goals and timeframes within which to reach those goals. However, the PTF was primarily concerned that the standards around the needs assessment and care plan be person-centered. In addition to recommending standards for needs assessments and care plans in line with other programs, the PTF articulates standards for how the Advanced Networks and FQHCs can ensure person-centered orientation of the needs assessments and care plans. The most important factor to ensure person-centered orientation of that assessment is the patient's input into what programmatic features will work best given cultural, linguistic, and other preferences. The person-centered orientation of the assessment and corresponding plan explicitly connects patient needs with non-clinical services and the patient's stated clinical outcome and lifestyle goals.

6. How will the comprehensive care team support the individual to successfully meet the care plan goals?

Examples from models across the country show that some care teams maintain defined schedules for checking in with the patient as well as mechanisms to connect with individuals when additional support is needed (Coalition, 2015). Meanwhile, others frequently check in with patients in a less formalized manner as needed to support carrying out the care plan (Takach M, 2013) (DiPietro, 2015). The most important components to successful care coordination include: (1) engaging the patient to determine satisfaction and comfort with the care plan; (2) the regular monitoring of care plan progress with both the patient and other providers; and (3) frequent communication with the clinical and non-clinical service providers touching the patient through the seamless exchange of necessary healthcare information.

It is important that the monitoring and exchange of information occur at several levels: (1) between the individual and their families and other care team members; (2) within the care team and needed social support services; and, (3) across the entire spectrum of services and supports to enable effective transitions of care (Agency for Healthcare Research and Quality, 2012). This is facilitated by frequent check-ins with the patient to monitor their progress according to the patient's wishes, but technology solutions can also support the seamless communication of pertinent healthcare information between care teams across the healthcare continuum. Regardless of the technology solutions, more formal linkages should be developed between clinical and non-clinical service providers in terms of familiarity of the other organization's mission, structure, and processes (Takach M, 2013) (The Center for Health Care Strategies, Inc., 2014).

The PTF felt it important for teams to establish pre-determined check-ins with individuals to monitor progress on their care coordination plans as well as have mechanisms to support individuals outside of the pre-determined schedule (e.g., establish processes for the individual to reach out when support is needed and technology solutions to alert the team when an individual is in the hospital or emergency department and may need additional care team support). This allows for consistency from both the patient's and provider's points of view to engage one another. It also provides additional support for the patient to seek assistance when needed. Additionally the PTF felt it important to establish standards supporting seamless communication through technology and for the networks to create linkages to community resources. However, the PTF acknowledged that networks would likely have different needs and preferences in regards to technology solutions and thus did not specify a technology solution as part of the standards. Because of the variation in needs, resources, and preferences, the PTF decided that establishing better integration of shared community resources should happen at a broader network level, not only in relation to the focus populations².

7. How can networks monitor an individual's health status after they transition to self-directed care management?

Many of the programs reviewed did not have specific mechanisms in place to monitor individuals after they move to more self-directed care management and assume more responsibility for their own care plan. However, many care management teams express a desire for a mechanism to alert them to a patient in crisis either through the individual reaching out to the care team or via statewide technology (e.g., an admission discharge and transfer system – see Appendix E for definition). In this case, there

² Please see section on Community Consensus & Linkages for Community Health Board standards for further explanation of rationale and context.

would at least be a mechanism for the care team to reconnect with the patient (DiPietro, 2015) (Lessler, 2014).

While it is uncommon for programs to have robust technology mechanisms around these types of alerts, the PTF felt it was important to provide guidance on how to monitor individuals and reconnect them with the comprehensive care team when necessary. Other programs suggested that it is important for the individual to reconnect with a known member of the care team when an individual does resume care (Samuelson, 2015). The PTF therefore suggested that the networks work with Peer Support specialists (see Appendix E for definition) to support individual transitions and serve as the contact if there is a need to reconnect to the comprehensive care team. In addition, the networks will be required to develop processes related to monitoring mechanisms for these patients who are self-managing their care so the care team can be alerted that an individual may be in crisis.

8. How will the networks monitor the effectiveness of the care management interventions?

Care teams are often embedded in broader programs, which has complicated the monitoring of the effectiveness of care management programs. For example, Vermont's Blueprint for Health recently compared outcomes of different primary care practices between practices that have a Community Health Team (CHT)—Vermont's version of a comprehensive care team—and practices without a CHT to assess its effectiveness. However, the study could not attribute the improved outcomes to the CHT. Vermont is currently working on ways to link their clinical and claims data to be able to analyze performance specific to patients working with the CHTs. Other programs have used a number of process metrics to monitor performance (e.g., number of patient contacts with community care team) and outcome metrics such as ED and hospital utilization pre/post community care team intervention (Depriest A, 2015).

The PTF felt that monitoring the effectiveness of the CCIP interventions should incorporate both an assessment of the overall effectiveness of the interventions as well as monitoring for process improvement through tracking intervention specific process metrics.

In addition, to hold individuals responsible for carrying out interventions accountable for meeting the specified goals, the PTF recommends standards around reporting on performance and providing a forum to share performance with relevant care providers to identify opportunities for improvement. In particular the PTF felt that learning collaboratives across practices could be a useful tool in reporting effective care management protocols. These types of collaborative efforts have been effective in other programs, such as the Camden Coalition, for identifying improvement opportunities.

9. How will patient and caregiver preferences and input be incorporated into the care plan?

There are several ways that care teams across the country engage patients and caregivers to incorporate their preferences into the care plan. The most important factor in successful patient and caregiver engagement is ensuring that the providers interacting with the patient are capable of communicating in a manner that is culturally sensitive, that is easily understood (e.g., avoiding overly "medicalized" terminology regarding care plans, diagnosis, and treatment), and that encourages the patient to reflect on their own goals and values. Many of these skills are learned over time. And, as the networks will be starting from different points in terms of resources and capabilities, the PTF is not suggesting specific

training programs. The PTF is, however, recommending that each network determine how it can best train its providers to engage patients and caregivers appropriately.

In addition, the PTF recommends building in certain processes and markers to flag patient and caregiver preferences for each provider that accesses the patient's record. Some programs place the patient's goals and preferences at the very top of the care plan so that it is the first thing providers see. Whatever the mechanism, the PTF strongly urges networks to identify whatever mechanism works best given their resources and capabilities so that patient/caregiver preferences are known and respected.

Patients Experiencing Equity Gaps

The PTF considered the best practices emerging from other CHW programs and research trials in addition to members' expertise and experiences as providers, payers, and consumers of healthcare in Connecticut.

1. How will the network build the CHW workforce?

The randomized controlled trials that have tested the use of CHWs to provide more culturally sensitive support often deploy CHWs to work in a specified healthcare setting (e.g., lactation support in the hospital post-childbirth, primary care practice to represent social and behavioral needs of individuals with chronic illnesses, etc.). To adhere to the protocols of a research study, the CHWs were often deployed to the practices or hospitals for a limited time period to conduct the study versus having the CHWs permanently employed by the provider. Since CCIP is a longer-term intervention, contracting for CHW services to address equity gaps may be beneficial because different disparities will require CHWs of different backgrounds and different disease specific training. Given this and the desire to give the networks freedoms to establish a process to meet their needs, the standards will require that the networks define an approach to build the CHW workforce, but will not specify how (i.e.; employ vs. contract).

Some studies also utilize a CHW field supervisor to support the provision of care in the community and facilitate integration into the primary care setting (Perez-Escamilla R, 2014). The PTF believes this role is important and recommends it for Advanced Networks and FQHCs in Connecticut working with CHWs.

As with the complex patient intervention, the PTF felt that the introduction of CHWs into the primary care team would represent a paradigm shift in how care is delivered and will likely require training to reorient the primary care team to a new workflow, orient the primary team to new roles and responsibilities, and identify the goals of the CHW program. The PTF also agreed that the CHWs will require disease specific training for the equity gap that is being addressed as well as training that has a greater emphasis on effective communication methods like motivational interviewing, health education and behavior change to support self-care management. These communication methods enable the CHW to interact with patients in a way that positively engages them as partners in their own healthcare.

2. How will the network identify patients who will benefit from more culturally attuned support?

Research trials tend to have two basic criteria for identifying eligible patients: (1) they belong to the sub-population that is experiencing a disparity (e.g., Latino, low-income, disabled, etc.) and (2) they have the clinical condition for which a disparity has been identified (e.g., type two diabetes with poor A1c control,

high blood pressure, etc.) (Anderson AK, 2005) (Perez-Escamilla R, 2014) (The Institute for Clinical and Economic Review, 2013).

The PTF therefore recommends these basic criteria, but it also encourages the incorporation of social or behavioral risk factors and health literacy and/or language barriers. Consistent with the goals and objectives of CCIP, many sub-optimal health outcomes are directly related to these non-clinical factors, and the PTF encourages networks to engage their communities to identify those factors that may be contributing to those care gaps. The transformation vendor and the Community Health Collaborative efforts can play a role in engaging those key community resources to determine the social or behavioral risks prevalent in the community. CHWs play a significant role in connecting patients to needed services and tailoring disease related and self-care management education to meet health literacy and language needs. Thus, the inclusion of these elements as criteria for connecting patients to a CHW will help identify patients who will receive the greatest benefit from the intervention.

3. What will the care plan and needs assessment look like? And how will they be administered?

The needs assessment for patients with equity gaps usually takes into account the historical and current challenges with self-care management, predominately taking into consideration socioeconomic risk factors, preferred language, and health literacy (Perez-Escamilla R, 2014). The PTF also strongly encourages engaging the patients and caregivers to incorporate personal preferences and values as well as family, social and cultural characteristics. This is the only way to ensure person-centeredness and will be a major driver in ensuring success.

The care plan for individuals experiencing equity gaps is generally referred to as a self-care management plan because the goal of the plan is to support the individual in gaining needed self-care management skills. As with any care plan it is informed by the needs assessment, the personal preferences, values, and goals of patients and caregivers, and will have clear goals and timeframes in which to accomplish those goals. The self-care management plan differs from the care coordination plan for patients with complex needs in that it has a greater focus on providing culturally attuned health behavior change support with associated action steps that reflect an individual's readiness for change (Perez-Escamilla R, 2014). The PTF agreed the care plan should have a focus on needed behavior change given the large role behavior often plays in the management of chronic conditions and also wanted to ensure person-centeredness by making it clear within the standards that the plan must be developed in collaboration with the patient to incorporate personal goals and preferences.

The needs assessment and self-care management plan will be completed by the CHW in collaboration with the patient. In research trials this is often done in the home (Anderson AK, 2005) (Perez-Escamilla R, 2014), but the PTF felt it was important that the individual determine the location that is most convenient and in which they are comfortable. The plan will then be incorporated into the primary care plan and the plan of care coordinated with the primary care provider.

4. How will the CHW successfully support the individual to meet the self-care management goals?

Research trials have specific CHW touch points with the individual in their home over a set period of time (e.g., home visits monthly for 18 months) as well as weekly meetings with the individual's healthcare management team. During the CHWs interactions with the patient the self-care management

plan is often revisited and updated to reflect the individual's progress (Anderson AK, 2005) (Perez-Escamilla R, 2014).

The PTF agreed that having a set schedule for in-person visits and interactions with the individual's primary care team should be required, but the schedule with which these visits occurred should be determined by the Advanced Network or FQHC in consultation with the patient according to their preferences and any social or cultural traditions.

As with the patients with complex needs, seamless communication is required for between the individual's primary care team, the CHW, and any relevant social support services. The PTF acknowledged and recommended the need for a technological solution to solve for seamless communication, but it did not specify what that solution should be.

The Community Health Collaborative standards of CCIP will help to develop relationships with social support services to aid the CHWs in seamlessly connecting individuals to needed support.

Patients with Unidentified Behavioral Health Needs

In answering the following questions, the PTF drew on existing research as well as the CT SIM Behavioral Health Design Group (BHDG), which is comprised of a number of behavioral health subject matter experts and patient representatives in the state.

1. What tools should be used to screen for behavioral health needs in the primary care setting?

Given the intent of this specific CCIP intervention, to broadly identify any previously unidentified behavioral health need, the BHDG discussed the need for the recommended screening tool(s) to be comprehensive enough to flag an array of needs. The PTF requires that the screening tool(s) assess the patient for depression, anxiety, substance abuse, and trauma at a minimum.

With the exception of depression, for which there is a nationally recognized screening tool (PHQ-9), the BHDG and PTF wanted to provide networks the freedom to choose any standardized and validated tool for other behavioral health needs for two reasons: (1) Outside of depression there are no tools nationally recognized as being the “gold standard” for screening, and the data gained from networks over time implementing different screening tools may provide useful insight into a future standard; and, (2) Different tools may be more prone to self-administration than others. The BHDG and PTF felt it was important that networks be able to decide whether or not tools would be self-administered or administered by an individual in the practice. The PTF also felt it was important to note that the screening tool is intended solely to flag potential behavioral health needs and not to diagnose patients. Therefore, if the tool is administered by someone in the practice, it would not have to be a licensed behavioral health specialist. The PTF recommended that individuals are screened every two years and that networks develop processes for all routine primary care visits to identify if a re-screening is needed. The recommendation for screening with the PHQ-9 is also intended to align with the SIM Quality Council’s recommendation that “Depression Remission at Twelve Months,” which requires use of the PHQ-9 for the 12 month re-assessment.

2. How to determine if an individual should be treated in the primary care setting or referred to a behavioral health provider?

The primary considerations for whether or not an individual can be treated within the primary care setting include: (1) the specific behavioral health need and the severity of that need; (2) the comfort level of the primary care provider in managing the condition and the medication regimen; and (3) the patient/caregiver’s comfort level, ability, and preference on treatment location. When it is possible that the individual be treated in either the primary care or a behavioral healthcare setting, the BHDG and PTF believe that networks should focus on the individual’s choices and preferences, engaging the patient to ensure that they have the adequate education and support to make that decision.

Regardless of whether or not individuals are provided behavioral healthcare within the primary care setting or referred elsewhere, the PTF felt it was important that proper training is provided to the primary care providers on behavioral health promotion (e.g., behavioral health resources in the community), detection, diagnosis, patient engagement, and when referrals are necessary.

3. What type of relationship will be required between the primary care providers and the behavioral health providers to ensure that referral processes, protocols and expectations are met?

The BHDG and the PTF recommends that the Advanced Network/FQHC execute at least one Memorandum of Understanding (MOU) with a behavioral health clinic and/or practice to promote accountability. Both providers are thus required to follow the MOU specified protocols and processes. The BHDG and PTF also recommends that processes and protocols are developed for referrals going to practices without an MOU as well. This will be necessary because likely one behavioral health clinic and/or practice will not be able to address all behavioral health needs and, the individual being referred should have the freedom to choose where to receive their behavioral healthcare and not be bound to the provider with which their primary care provider has an MOU.

4. How will the referral be tracked and the communication loop closed?

The BHDG and PTF recommend that the MOU and other agreements specify three things: (1) how relevant healthcare information will be exchanged between the primary care providers and the behavioral healthcare providers; (2) an individual responsible for tracking the referral; and (3) exploring technological solutions to automate confirmation that a referral has been completed. The BHDG and PTF also recommend that the behavioral health provider make the care plan available to the primary care provider to be incorporated into the primary care electronic medical record. The care plan should specify what role the primary care provider can play in the care plan.