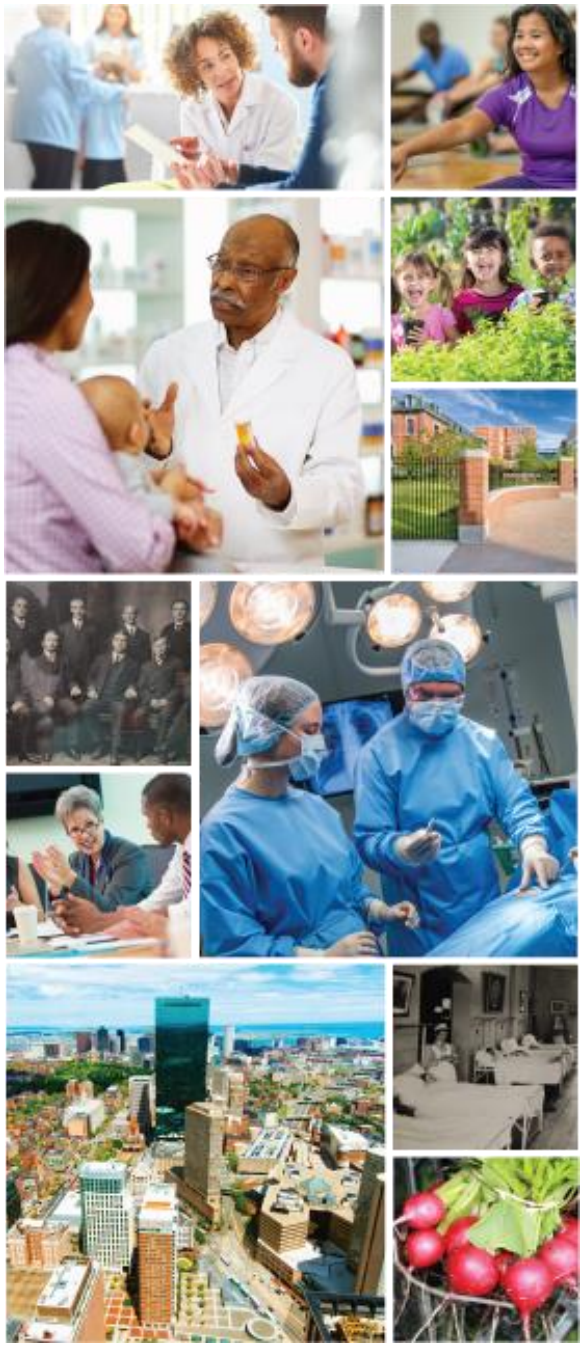


Boston Medical Center
HEALTH SYSTEM

MassHealth Primary Care Sub-Capitation Tier Requirements Overview

March 22nd & 29th, 2023

This is a living document and will be updated and maintained as we develop further understanding of the requirements. Please reach out to your ACO Operations Lead if you have questions.

Agenda

- **Overview**
  - Care Delivery
  - Administrative
  - Screening
  - LARCs
  - Behavioral Health
  - Pediatric Requirements

Primary Care Sub-Capitation Provider Collaboration Series Reminders

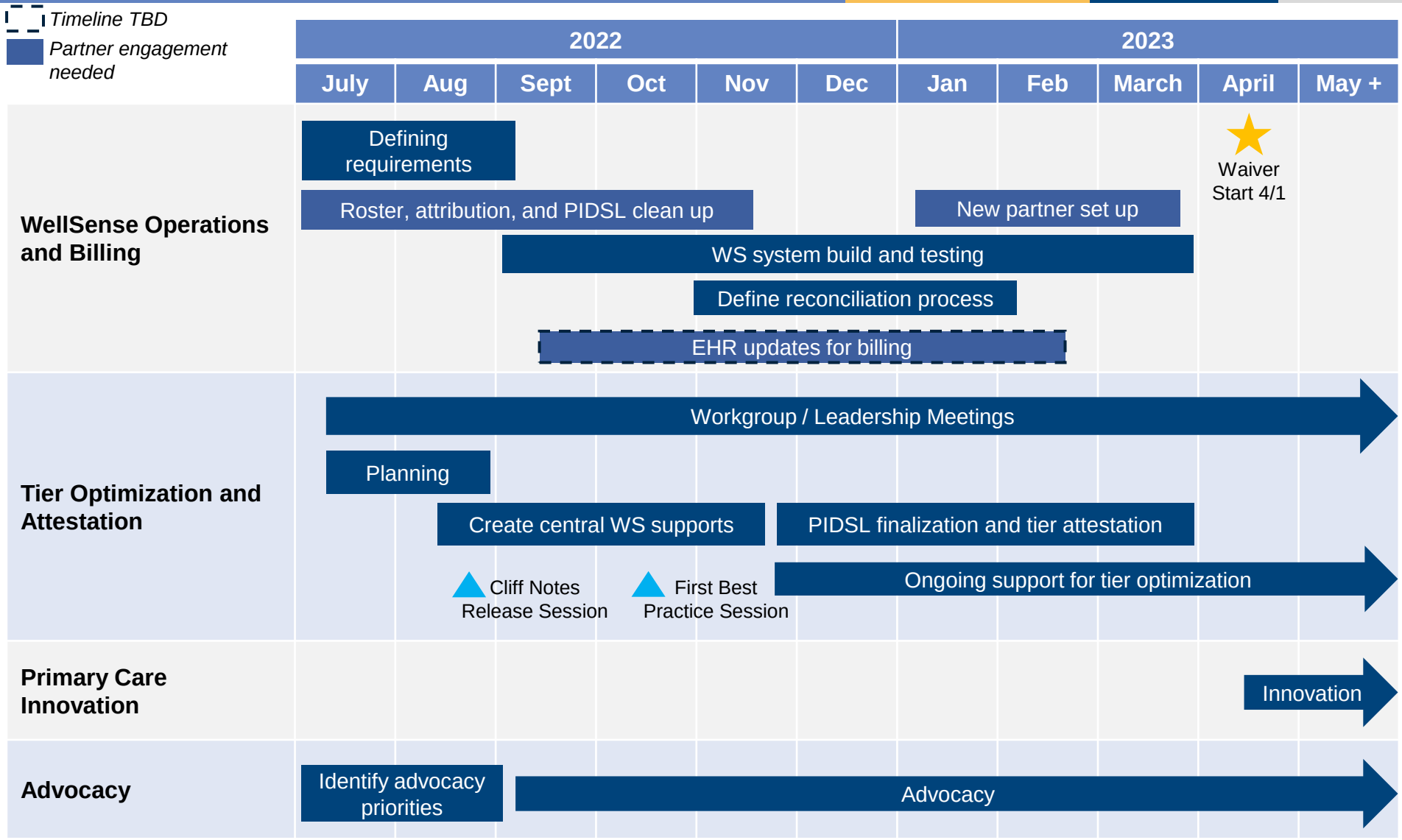
- The **intent of the series** is to allow BMCHS/WellSense to:
  - **Share** best practices, supports and/or services to assist with meeting requirements,
  - **Learn** from each other effective strategies and implementation efforts, and
  - **Disseminate** updates from MassHealth related to the PC Sub-Cap program.

- All content within this document should be considered **preliminary until further notice**.
  - We developed the following guidance based on our interpretation of the model contract provided in the RFR as well as any subsequent information received from MassHealth.
  - The planned interventions are in development and not finalized.

- Per MassHealth Contract guidance**, tier requirements must be met at the PID/SL level**. The PID/SL is the Provider ID and Service Location.[1]
  - All practices must meet Tier 1 requirements, at a minimum.
  - Some requirements must be accessible to Enrollees on-site if the Enrollee so chooses, without leaving the practice building, and some requirements may be met exclusively via a central or virtual resource, including being provided by the ACO, as indicated in each requirement description.

[1] BMCHS/WellSense is advocating to MassHealth regarding use of the PID/SL and offering recommendations for alternate methodologies.

BMCHS/WS developed an internal timeline to prepare for and implement the Primary Care Sub-Capitation program



Tentative timeline as of 7.21.2022. Any changes will be communicated to partners.

To ensure readiness of tier capabilities by 7/1, we will focus our review today and Tier 1 requirements and documentation

Overview

	TIER 1	TIER 2	TIER 3
	Requirement	Requirement	Requirement
Care Delivery	Traditional primary care	Brief intervention for BH conditions	One of: clinical pharmacist visits; group visits; educational liaison for pedi pts
	Referral to specialty care	Telehealth BH referral partner	E-consults available in 5+ specialties
	Care coordination	E-consults available in at least three (3) specialties	After-hours or weekend sessions (3+ sessions)
	Clinical Advice and Support Line	After-hours or weekend session availability (1+ sessions)	Three team-based staff roles
	Translation and Interpreter Services	Team-based staff role (3)	Maintain consulting BH clinician with prescribing capability
Admin.	Same-day urgent care capacity	Maintain consulting independent BH clinician	On-site staff with children, youth, family-specific expertise (FT) P
	No reduction in hours	On-site staff with children, youth, and family-specific expertise (part or full time) P	LARC provision, at least 1 option P
	Video telehealth capability	Provide SNAP and WIC assistance P	Active Buprenorphine Availability P
Screening	Health-Related Social Needs screening	Buprenorphine Waivered Practitioner (1) P	LARC provision, multiple options A
	BH and substance use disorder screening	LARC provision, at least one option A	Next-business-day MOUD induction and F/U A
	Postpartum depression screening	Active Buprenorphine Availability A	
	Oral health screening and referral	Active AUD Treatment Availability A	
LARCs	LARC provision, referral option		
Behavioral Health	BH referral with bi-directional communication, tracking, and monitoring		
	Use of Prescription Monitoring Program		
	BH medication management		
	Buprenorphine Waivered Practitioners (all) A		
Pediatric	Pediatric EPSDT screenings P		
	Pediatric SNAP and WIC screenings P		
	Establish & maintain relationships w/CBHI P		
	Coordination with MCPAP P		
	Coordination with M4M P		
	Fluoride varnish for pts 6 months to age 6 P		

KEY
"**P**" Indicates Pediatric Population-Specific
"**A**" Indicates Adult Population-Specific

Agenda

- **Overview**
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Recap of requirements: Traditional Primary Care

Care Delivery

Tier	Domain	Requirement	Description
1	Care Delivery	**Traditional primary care**	Provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.

Suggested Audit Documentation

- Documentation illustrating the comprehensive primary care services offered. Documentation should include how to access the services (e.g. telehealth, on-site).
- Examples:
  - Screenshot(s) of published/patient-facing website listing of services for the PIDSL
  - Any contracts that list services time (e.g. HRSA).

Recap of requirements: Referral to specialty care

Care Delivery

Tier	Domain	Requirement	Description
1	Care Delivery	**Referral to Specialty Care**	Be able to guide and coordinate referrals and request evaluation of a patient by clinicians outside of the primary care practice for specific concerns. Such referrals shall include the primary care practice's ability to communicate with and receive communications from the specialty practice, with the primary care practice continuing to serve as a central home of health care services for the patient. This includes sub-specialty medical, oral health, mental health, and substance use disorder referrals.

Suggested Audit Documentation

- Documented referral workflow, including (e.g.):
  - Who submits the referral
  - How referral is sent to the specialist
  - communication process between the specialist and the primary care practice (e.g. how do you close the loop?)

Recap of requirements: Care Coordination

Care Delivery

Tier	Domain	Requirement	Description
1	Care Delivery	**Care Coordination**	Participate in formalized practice-driven and/or ACO-driven care coordination that identifies patients at risk due to medical, BH, HRSN, psychosocial and/or other needs and deploys risk-stratified interventions and approaches to addressing patients' needs. Such approaches can include but are not limited to: communication and information-sharing between care team patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, pre-visit planning, post-hospitalization coordination, and assistance with patient self-management of chronic disease. Such approaches can also include connecting patients to community-based services, state agencies (e.g., Massachusetts Department of Children and Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of Mental Health [DMH], Massachusetts Department of Public Health [DPH], Massachusetts Department of Transitional Assistance [DTA], Massachusetts Department of Youth Services [DYS]), federal programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC]), other ACO programs such as the ACO Care Management, Community Partners and Flexible Services programs, and other supports and care management resources. These services may be provided by practice-based personnel directly, or by ACO- or system-level resources and care pathways that coordinate with the primary care practice. Such interventions shall be standardized and consistent workstreams for the practice and align with the greater ACO's strategies around physical health, BH, HRSN, and other care coordination. For more information on ACO expectations around care coordination, please refer to Section 2.6 of the Contract. Care coordination may be met exclusively via a central or virtual resource, including being provided by the ACO.

Suggested Audit Documentation

- Met by existing Case Management programs and baseline Care Coordination provided by WellSense.
- WellSense will provide:
    - Copy of available services and key points of contact to access/engage members in care coordination

Recap of requirements: Clinical Advice and Support Line

Care Delivery

Tier	Domain	Requirement	Description
1	Care Delivery	**Clinical Advice and Support Line**	Ensure patients are made aware of the availability of after-hours telephonic advice, either through the ACO's Clinical Advice and Support Line, or a resource provider by the practice. Clinical advice and support line services may be met exclusively via a central or virtual resource, including being provided by the ACO.

Suggested Audit Documentation

- WellSense Nurse Advice line meets this requirement
- WellSense team will provide:
  - Screenshot of WellSense website shows Nurse Advice Line (https://www.wellsense.org/contact-us)
  - Practice level marketing materials indicating phone number for clinical advice and support line

Recap of requirements: Access to Translation and Interpreter Services

Care Delivery

Tier	Domain	Requirement	Description
1	Structure and Staffing	**Access to Translation and Interpreter Services**	Provide interpreter services for attributed patients, in accordance with applicable state and federal laws, including options to accommodate preferred languages and the needs of enrollees who are deaf or hard of hearing. Such services shall be noted to be available in a patient's or their caregiver's preferred language and should come without additional cost to the patient.

Implementation & Suggested Audit Documentation

- WellSense requires all providers to be culturally competent in delivery care to members as defined in section 4.16 of the WellSense provider manual. To provide competent care means "having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities, as defined in the National Standards for Cultural and Linguistically Appropriate Services in Health Care" – National CLAS Standards
- We anticipate that many providers are offering interpretation services -- **if your practice is not providing these services**, please reach out and we will work with you to ensure this standard is met.
- Practices may consider handouts/materials in-practice advertising access to provider & patient resources for:
  - Multi-language interpretation
  - Needs of enrollees who are deaf or hard of hearing

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Recap of requirements: Same-day urgent care capacity

Administrative

Tier	Domain	Requirement	Description
1	Structure and Staffing	**Same-day urgent care capacity**	Make available time slots each day for urgent care needs for its patient population. While practices may offer some urgent care capacity virtually via telehealth, Enrollees must be able to access this requirement on-site.

Suggested Audit Documentation

- Copy of policy for making same day appointments available to patients, including how to determine which visits are telehealth or in-person

Recap of requirements: No Reduction in Hours

Administrative

Tier	Domain	Requirement	Description
1	Structure & Staffing	**No Reduction in Hours**	Relative to regular practice hours prior to engagement in the sub-capitation program, offer the same or increased number of total regular on-site operating hours and clinical sessions in which patients have been historically seen.

Suggested Audit Documentation

Documentation

- Option 1: Consider leveraging screenshots from your practice's website demonstrating practice hours
- Option 2: As applicable to your practice, potential to leverage HRSA forms which document practice hours
- Option 3: If your practice has marketing materials containing practice hours, you could leverage those, as well

Additionally – consider documenting practice hours before 4/1/2023 and after 4/1/2023 to demonstrate participation in the ACO program has not changed your practices hours

Recap of requirements: Traditional Primary Care

Administrative

Tier	Domain	Requirement	Description
1	Structure and Staffing	**Video telehealth capability**	Have the ability to conduct visits with practice staff using a synchronous audio-video telehealth modality in lieu of an in-person patient encounter

Suggested Audit Documentation

- Document platform leveraged for telehealth at your practice, or
- Copy of agreement with telehealth vendor, or
- Copy of the practice telehealth policy

Agenda

- **Overview**
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  - LARCs
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Recap of Behavioral Health Screening Requirements (Tier 1)

Screening

Tier	Requirement	Population	Description
1	Behavioral health (BH) and substance use disorder screening	Adults	Conduct an annual and universal practice-based screening of attributed patients ≥21 years of age. Such a screen shall at minimum assess for depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting mental health disorders using an age-appropriate, evidence-based, standardized screening tool. When any screening is positive, the practice shall respond with appropriate interventions and/or referrals. See below under this Section 1, subsection C for screening expectations for any attributed patients younger than 21 years of age per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocol and schedule. While practices may offer some BH and substance use screening virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Postpartum Depression Screening	Postpartum within 12 months of delivery	If caring for infants in the first year of life **or** for postpartum individuals who are within 12 months of delivery, screen for postpartum depression using an evidence-based and validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS). For individuals who have a positive screen for postpartum depression, the practice shall be able to provide referral, or follow-up, and/or care coordination for the patient. Care coordination models shall be evidence-based (examples of such models include PRISM - Program In Support of Moms and ROSE - Reach Out Stay Strong Essentials for mothers of newborns). While practices may offer some postpartum depression screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

Suggested Audit Documentation

- Copies of screening tools reflecting all required domains (depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting mental health disorders)
- Workflows for screening and follow-up/referral in case of positive screen
- Workflows of identifying patients due for annual screenings

Implementation Strategy: BH and SUD (behavioral health and substance use disorder) screening

Screening

Implementation Recommendations

Option 1: To meet requirements

Utilize the following screening tools:

- For depression: **PHQ-2** (2 questions), followed by **PHQ-9** (9 questions) if positive as defined either
  - "Yes" to either PHQ-2 question
  - Total PHQ-2 score ≥ 2 or ≥ 3
- For tobacco use, unhealthy alcohol use, and other substance use: **NIDA Quick Screen** (4 questions)
  - Any answer other than "No" indicates risk
- For preexisting mental health disorders: Ask "Do you have any preexisting mental health or substance use disorder diagnoses?"

Option 2: Alternative and additional tools

- For depression: Screen all patients with **PHQ-9**
- For alcohol and substance use follow-up:
  - Alcohol: **AUDIT** (10 questions)
  - Other substances: **DAST-10** (10 questions)
- Other:
  - For suicidality (e.g., if PHQ-9 Question 9 ≥ 1): **C-SSRS** (The Columbia Protocol) (up to 6 questions)
  - For anxiety: **GAD-2** (2 questions), followed by **GAD-7** (7 questions) if positive as defined either Total GAD-2 score ≥ 2 or ≥ 3

Operational Considerations

- Timing: Decide when the course of a visit the patient will be screened for BH and SUD (for example: in the waiting room, during rooming, or during the PCP encounter) **Note: an on-site screening must be offered**
- Staffing: Decide who will perform the screening (for example: by patient as a pen & paper or electronic self-assessment, by medical assistant, by nurse, or by PCP)
- Documentation: Decide where the screening will be documented within the EMR and by whom
- Eligibility: Decide how the practice will track which patients for whom screening has been completed and which patients are due for screening

Resources & Supports

- NIDA Quick Screen
- PHQ-2 and PHQ-9
- C-SSRS (The Columbia Protocol)
- GAD-2 and GAD-7
- AUDIT-10
- DAST-10

Backup: Interpreting BH and SUD screening instrument results

PHQ-9 (Patient Health Questionnaire-9)

Total score	Depression severity
1-4	Minimal
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

GAD-7 (Generalized Anxiety Disorder-7)

Level of Anxiety Severity GAD-7 Scale Score
Minimal
0-4 (n = 1182)
Mild
5-9 (n = 511)
Moderate
10-14 (n = 264)
Severe
5-21 (n = 171)

AUDIT-10 (Alcohol Use Disorders Identification Test)

Box 6

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

DAST-10 (Drug Abuse Screening Test 10-item)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Backup: NIDA Quick Screen

NIDA (National Institute on Drug Abuse) Quick Screen

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **<u>In the past year</u>, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

Backup: Criteria for diagnosis of SUD (includes alcohol and opioid use disorders)

Screening

Table 3: *DSM-5 Diagnostic* Criteria for Diagnosing and Classifying Substance Use Disorders [a,b,c]

Criteria Type	Descriptions
Impaired control over substance use (*DSM-5* criteria 1 to 4)	• Consuming the substance in larger amounts and for a longer amount of time than intended. • Persistent desire to cut down or regulate use. The individual may have unsuccessfully attempted to stop in the past. • Spending a great deal of time obtaining, using, or recovering from the effects of substance use. • Experiencing craving, a pressing desire to use the substance.
Social impairment (*DSM-5* criteria 5 to 7)	• Substance use impairs ability to fulfill major obligations at work, school, or home. • Continued use of the substance despite it causing significant social or interpersonal problems. • Reduction or discontinuation of recreational, social, or occupational activities because of substance use.
Risky use (*DSM-5* criteria 8 and 9)	• Recurrent substance use in physically unsafe environments. • Persistent substance use despite knowledge that it may cause or exacerbate physical or psychological problems.
Pharmacologic (*DSM-5* criteria 10 and 11)	• **Tolerance:** Individual requires increasingly higher doses of the substance to achieve the desired effect, or the usual dose has a reduced effect; individuals may build tolerance to specific symptoms at different rates. • **Withdrawal:** A collection of signs and symptoms that occurs when blood and tissue levels of the substance decrease. Individuals are likely to seek the substance to relieve symptoms. No documented withdrawal symptoms from hallucinogens, PCP, or inhalants. • **Note:** Individuals can have an SUD with prescription medications, so tolerance and withdrawal (criteria 10 and 11) in the context of appropriate medical treatment do *not* count as criteria for an SUD.

Abbreviations: *DSM-5, Diagnostic and Statistical Manual of Mental Disorders–5*; PCP, phencyclidine; SUD, substance use disorder.

Notes:

a. Adapted from [APA 2013].

b. SUDs are classified as mild, moderate, or severe based on how many of the 11 criteria are fulfilled: mild, any 2 or 3 criteria; moderate, any 4 or 5 criteria; severe, any 6 or more criteria.

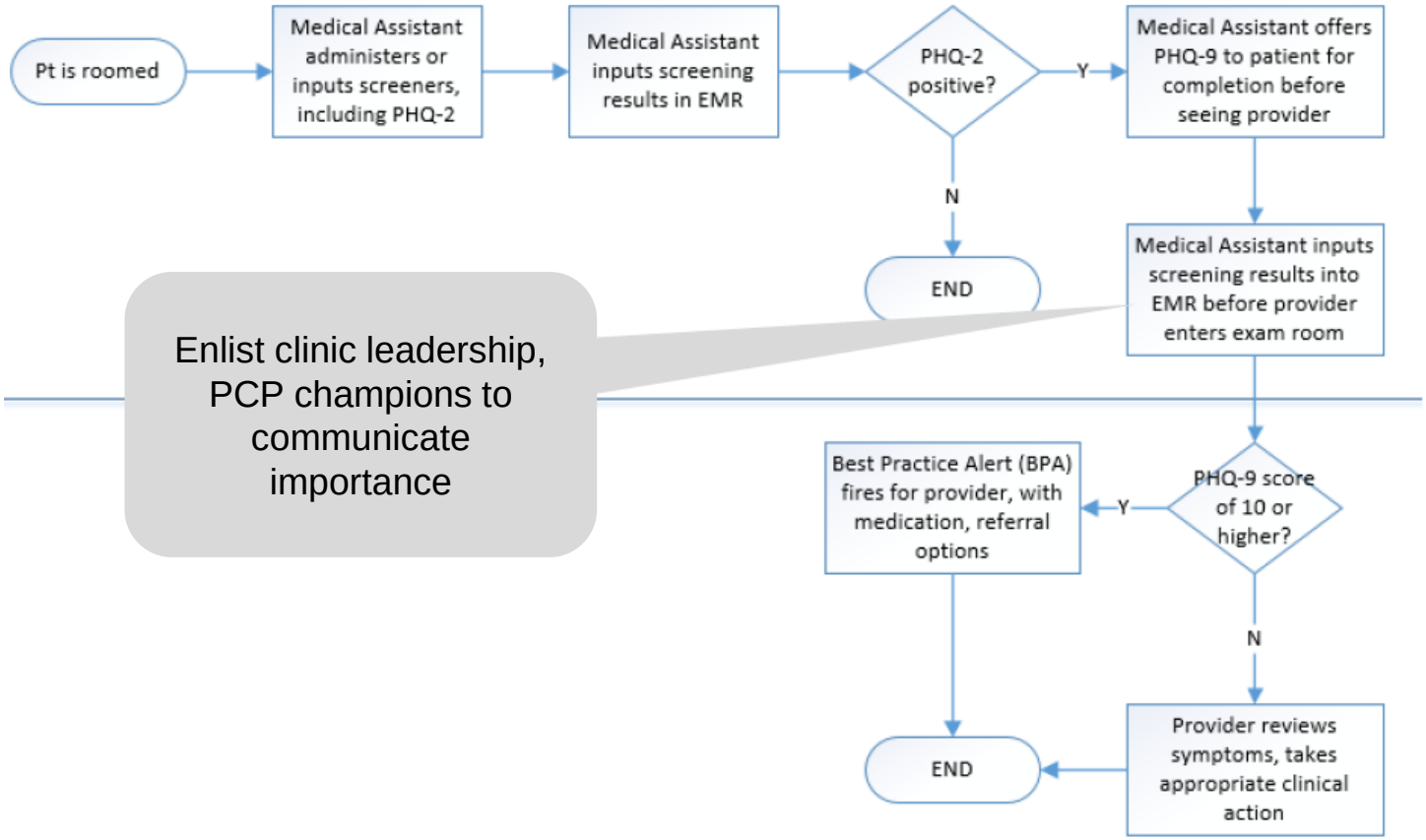
c. Please consult the *DSM-5* for substance-specific diagnostic information.

Source: https://www.ncbi.nlm.nih.gov/books/

Sample depression screening workflow from BMC General Internal Medicine

Screening

Medical Assistant



PCP

Adapting screening for the virtual environment: Example from BMC General Internal Medicine

	MA screening	PCP	Integrated BH clinician (may not be available in all practices)
Pre-COVID-19	Medical assistant screens for depression, unhealthy substance use during rooming	Decision supports: Best Practice Alert triggers if patient screens positive; documentation templates ("dotphrases") and BH website available in EMR	Integrated BH clinician available for "warm handoff" via page: Triage, assessment, BH intakes. EMR-based referral also available
Changes due to COVID-19	No current systemic screening; workflows in process for in-person and electronic patient portal ("MyChart") screens	Best Practice Alert does not trigger without screening; documentation templates ("dotphrases") and website remain available	Integrated BH clinician available **telephonically** via page for triage, assessment, BH intakes. EMR-based referral remains available

Implementation Strategy: Postpartum Depression Screening

Note: For all primary care practices (adult and pediatrics)

Screening

Implementation Recommendations

Option 1: To meet requirements

Adult and Pedi practices screen postpartum individuals within 12 months of delivery using the following screening tools:

- **PHQ-2** (2 questions), followed by **PHQ-9** (9 questions) if positive as defined either
  - "Yes" to either PHQ-2 question
  - Total PHQ-2 score ≥ 2 or ≥ 3

Option 2: Alternative and additional tools

- **PHQ-9** (9 questions)
- **EPDS** ("Edinburgh") (10 questions)
- For suicidality (e.g., if PHQ-9 Question 9 ≥ 1 or EPDS Question 10 ≥ 1): **C-SSRS** (The Columbia Protocol) (up to 6 questions)

Operational Considerations

- Timing: Decide when the course of a visit the patient will be screened for BH and SUD (for example: in the waiting room, during rooming, or during the PCP encounter) **Note: an on-site screening must be offered**
- Staffing: Decide who will perform the screening (for example: by patient as a pen & paper or electronic self-assessment, by medical assistant, by nurse, or by PCP)
- Documentation: Decide where the screening will be documented within the EMR and by whom
- Eligibility: Decide how the practice will identify patients eligible for screening (within 12 months of delivery **or** infants ≤ 1 year old) and track that screening has been completed
  - EMR build: Consider EMR alert for postpartum status or ≤ 1 year old to perform depression screening
  - Provider education to screen for new caregiver status
  - **Note: Routine population-wide depression screening will capture most postpartum individuals**

Resources & Supports

- PHQ-2 and PHQ-9
- EPDS
- C-SSRS (The Columbia Protocol)
- Evidence for the use of PHQ-2 postpartum: Gjerdingen 2009, Chae 2012
- MCPAP for Moms recommendations

We will discuss BH and SUD management/treatment further at next session, 11/3

Implementation Strategy: Postpartum Depression Screening

Screening

For pediatrics practices: Expectation to arrange follow-up ***for the parent screened***

- Requirement: "the practice shall be able to provide **referral, or follow-up, and/or care coordination** for the patient"
- American Academy of Pediatrics 2019 Policy Statement *Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice*: see sidebar
- Options to meet requirements:
  - Referral to postpartum individual's PCP / obstetrician
  - Referral to local outpatient mental health providers
  - Follow-up on referral
  - MCPAP For Moms support as needed

At the very least, management will require support and demystification. Management of PPD includes:

- demystification (reducing guilt and shame by emphasizing how common these feelings are);
- support resources (family and community); and
- referrals for the mother (to a mental health professional or the mother's PCC or obstetrician), for the mother-infant dyad, for the child (for targeted promotion of social-emotional development and early intervention [EI]), and for the mother who is breastfeeding (for lactation support from an experienced provider).

Regardless of the referral arrangement, a key component is a follow-up with the mother to be certain that she is receiving treatment and that depressive symptoms are decreased. Such follow-up could be conducted by a designated referral person on the practice staff.

We will discuss BH and SUD management/treatment further at next session, 11/3

Recap of HRSN Screening Requirements (Tier 1)

Screening

Requirement	Population	Description
Health-Related Social Needs (HRSN) screening	All Members	Conduct universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool, and shall have the ability to provide a regularly-updated inventory of relevant community-based resources to those with positive screens. Pediatric screening questions shall be reviewed by the ACO's designated Pediatric Expert. HRSN screening may be met exclusively via a central or virtual resource, including being provided by the ACO.

Suggested Audit Documentation

- Documented workflow / process map illustrating how and who screens at the practice
- Copy of the screener utilized (e.g. hard copy screener or screenshot of EHR template)

- *Pediatrics:* Evidence of pediatric review of the screening tool via email of approval or sign off from pediatric expert

Implementation Strategy: HRSN Screening

Screening

Implementation Recommendations

- Implement an evidence based tool to implement at your practice. Some examples include THRIVE and PRAPARE.
- Both of these tools have been verified by pediatric experts at the ACO.
- Develop a bank of resources for each domain in the event a patient screens positive or refer to an existing bank such as Find Help (formerly Aunt Bertha).

Operational Considerations

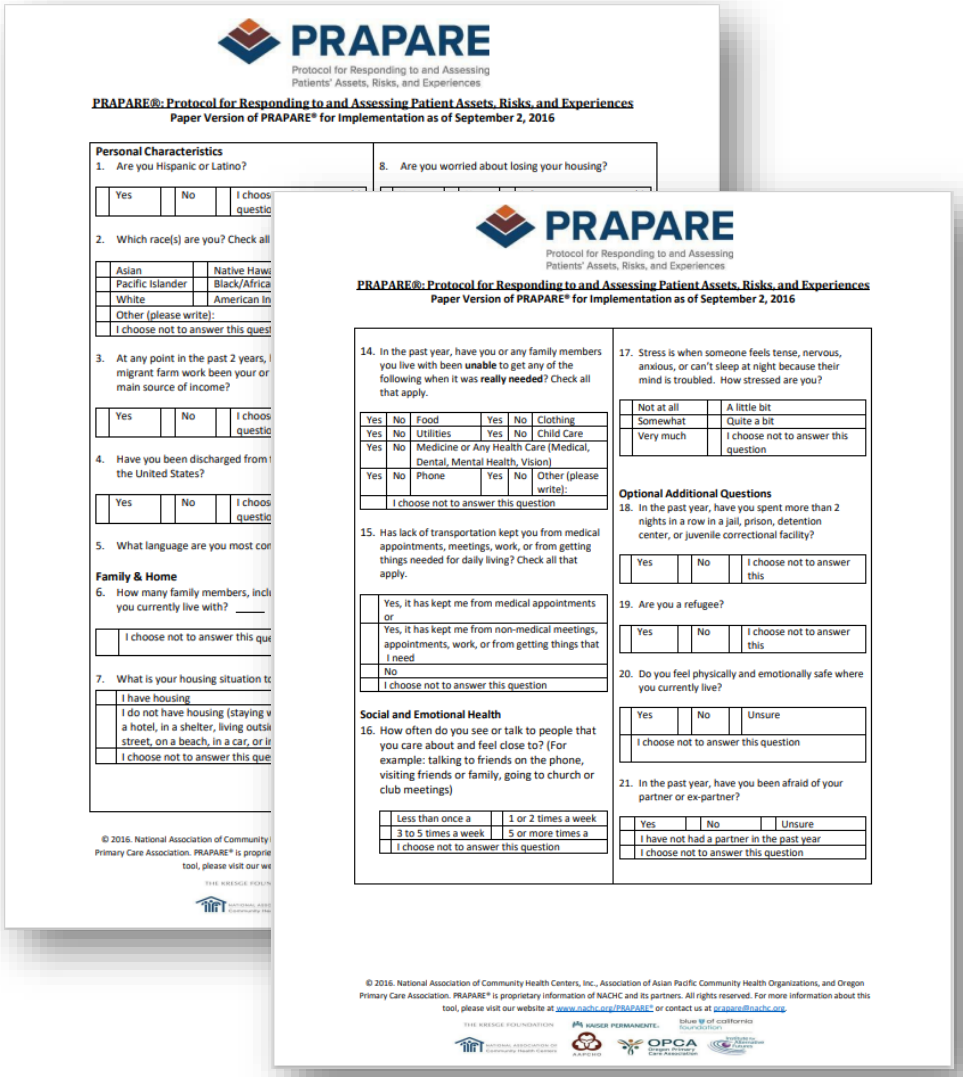
- Tool: Select a tool that best fits your population and practice. You may consider choosing a tool that is pre-built in your EHR if it eases virtual administration, or may choose to print the tool for completion by patients.
- Staffing: Decide who will perform each screening and at which point during the clinic visit (e.g. the member may respond via a patient portal prior to the visit, in the waiting room, or the MA may assess during rooming)
- Documentation: Screening can happen on paper, virtually via a patient portal, by phone, or on paper. Determine which method of screening works best for your practice and patient population.
- Health Equity: Ensure screeners are available in the language spoken by members or ask for translation services assistance.
- Referral Resources:
  - Decide how the practice will track which patients for whom screening has been completed and which patients are due for screening.
  - Identify whether resource will exist as a ‘letter’ or ‘resource template’ in the EHR, through utilization of Find Help, or if members will be referred to a clinic resource such as a Resource Navigator for support.

Support & Resources

- PRAPARE screening tool
- BMC THRIVE
- Find Help (formerly Aunt Bertha)
- Joint Commission screening tool reference

Examples of HRSN screening tools

Screening



PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

Yes	No	I choos… questio…

2. Which race(s) are you? Check all

Asian	Native Hawa…
Pacific Islander	Black/Africa…
White	American In…
Other (please write):	
I choose not to answer this quest…	

3. At any point in the past 2 years, … migrant farm work been your or … main source of income?

Yes	No	I choos… questio…

4. Have you been discharged from … the United States?

Yes	No	I choos… questio…

5. What language are you most cor…

Family & Home

6. How many family members, incl… you currently live with? ____

I choose not to answer this que…

7. What is your housing situation t…

I have housing
I do not have housing (staying … a hotel, in a shelter, living outsi… street, on a beach, in a car, or i…
I choose not to answer this que…

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PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
		I choose not to answer this question			

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

Yes, it has kept me from medical appointments or
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
No
I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Less than once a …	1 or 2 times a week
3 to 5 times a week	5 or more times a …
I choose not to answer this question	

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

Not at all	A little bit
Somewhat	Quite a bit
Very much	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes	No	I choose not to answer this

19. Are you a refugee?

Yes	No	I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

Yes	No	Unsure
I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

Yes	No	Unsure
I have not had a partner in the past year		
I choose not to answer this question		

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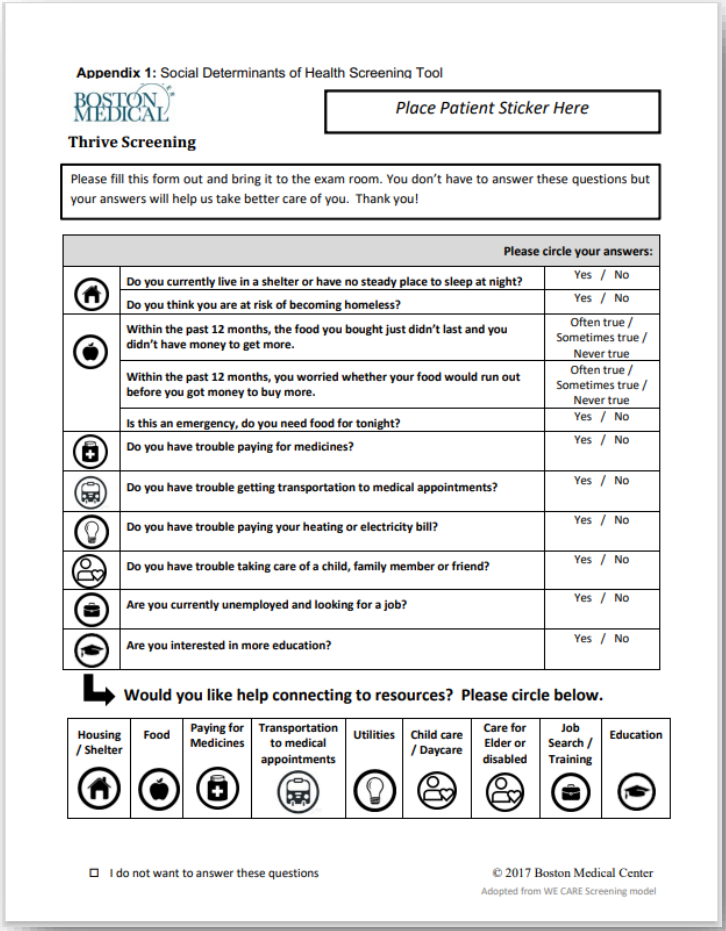

Appendix 1: Social Determinants of Health Screening Tool

BOSTON MEDICAL

Place Patient Sticker Here

Thrive Screening

Please fill this form out and bring it to the exam room. You don't have to answer these questions but your answers will help us take better care of you. Thank you!

		Please circle your answers:
	Do you currently live in a shelter or have no steady place to sleep at night?	Yes / No
	Do you think you are at risk of becoming homeless?	Yes / No
	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true / Sometimes true / Never true
	Within the past 12 months, you worried whether your food would run out before you got money to buy more.	Often true / Sometimes true / Never true
	Is this an emergency, do you need food for tonight?	Yes / No
	Do you have trouble paying for medicines?	Yes / No
	Do you have trouble getting transportation to medical appointments?	Yes / No
	Do you have trouble paying your heating or electricity bill?	Yes / No
	Do you have trouble taking care of a child, family member or friend?	Yes / No
	Are you currently unemployed and looking for a job?	Yes / No
	Are you interested in more education?	Yes / No

Would you like help connecting to resources? Please circle below.

Housing / Shelter	Food	Paying for Medicines	Transportation to medical appointments	Utilities	Child care / Daycare	Care for Elder or disabled	Job Search / Training	Education

☐ I do not want to answer these questions

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Adopted from WE CARE Screening model

Recap of Oral Health Screening and Referral Requirements (Tier 1)

Screening

Requirement	Population	Description
Oral Health Screening & Referral	All Members	Conduct an annual (every 12 months) structured oral health screening for attributed patients. For example, a clinic tool may use the National Health and Nutrition Examination Survey Oral Health Questionnaire. An on-site dental exam for attributed patients shall meet this requirement. An assessment screening shall clearly define what constitutes a positive screening result versus a negative result and shall assess if the patient currently has access to an oral health provider or a regular and reliable source for oral health needs. Additionally, retain and provide to patients (and/or their parents/caregivers) a list of local and reasonably-accessible oral health providers who are within the MassHealth network for their particular patients. This information shall be updated at least annually for any openings/closings or additions/removals of MassHealth coverage of these providers. Such a list shall be provided to patients with a positive oral health screen and those without an oral health provider. Such a list may be adapted from materials provided by MassHealth of practices and providers currently enrolled in the program. While practices may offer some oral health screenings and referrals virtually via telehealth, Enrollees must be able to access this requirement on-site.

Suggested Audit Documentation

- Documented workflow or process map for screening patients for oral health (e.g. how to know a patient is due for screening, who screens, what template/questions are used to screen, how is a patient referred, etc.)
- Copy of paper screening or screenshot of template in EHR
- Screenshot of completed EHR template to show evidence of the workflow in action
- List of dental referral resources, explanation of how this is provided to patients

We recommend a two-question oral health screener

- No mandated screening tool as per MassHealth
- Screening can be done using 1-2 questions
- Screening has to be documented appropriately to be counted as completed
- Screening and referral can be offered virtually via telehealth/patient portal, enrollees must be able to assess this requirement on-site

Adult Screening Questions

- Did you have a dental visit in the last 12 months? Yes/No
  - No will indicate a positive screen
- Did you have a dental problem in the last 6 months? Yes/No
  - Yes will indicate a positive screen

Pediatric Screening Questions

- Did your child have a dental visit in the last 12 months for preventive dental care such as check-ups/dental cleaning? Yes/No
  - No will indicate a positive screen
- Was there a time your child needed dental care in the last 12 months but was not received? Yes/No
  - Yes will indicate a positive screen

Implementation Strategy: Oral Health Screen

Screening

Implementation Recommendations

Option 1: In-person	Option 2: Remote
▪ Screening question(s) asked by MA during rooming process ▪ Responses input into EHR and shared with PCP ▪ PCP discusses with patient if findings are positive ▪ Standardized handout or AVS dot phrase provided to patient at visit close	▪ Patient completes screening question(s) within patient portal as part of pre-visit intake ▪ Standardized handout or AVS dot phrase provided to patient at visit close (and accessible within patient portal)

Operational Considerations

- Health equity: Are screening questions translated into multiple languages, or is real-time interpretation use for patients who speak a language other than English?
- Timing: Determine where in the clinic visit to screen. Determine if screening can be incorporated in the fluoride varnish workflow for pediatric patients.
- Staffing: Decide which member of the care team can deliver the screening and document the referral.

Resources & Supports

- MassHealth: Dental Provider Finder
- MassHealth patient education one-pager (can be found on Box or MoveIt)
- DentaQuest

We will discuss oral health screening and fluoride application further at upcoming session, 11/10.

Sample/Language For After Visit Summary & Paper Resource For Patient

Screening

MassHealth covers most dental treatment including exams and cleanings, fillings, and even dentures. It does not pay for implants.

If you are having dental pain, please call our clinic so we can help.

These dental clinics are near you. You can call to make an appointment. There may be a wait before you can have a visit.

https://provider.masshealth-dental.net/MH_Find_a_Provider#/home__ or scan the QR code

You can also get care from a dental school. They may have lower prices for treatments your insurance doesn't cover. They also accept MassHealth

Harvard School of Dental Medicine, 188 Longwood Avenue, (617) 432-1434

Tufts School of Dental Medicine, 1 Kneeland Street, (617) 636-6828

Boston University School of Dental Medicine, 635 Albany Street, (617) 358-8300

Boston Medical Center has a dental clinic just for pulling teeth. They do not make appointments - you must call the same day to have a visit.

Boston Medical Center

Yawkey Ambulatory Care Center

850 Harrison Avenue, 6th Floor

Boston, MA 02118

(617) 414-2243

Referral Resources

- MassHealth: Provides coverage for most oral health services without copay
  - Includes dental exam, x ray, cleaning, filling, extraction, some root canal and crown treatment, treatment for periodontal disease, and dentures (once every 7 years)
- MassHealth database of pediatric and adult dentists (searchable by geographic distance and language) https://provider.masshealth-dental.net/MH_Find_a_Provider#/home
- DentaQuest: Members can have remote care coordination assistance https://www.masshealth-dental.net/MassHealth/media/Docs/MassHealth-ORM.pdf
- Three dental schools in Massachusetts: BU, Harvard, and Tufts
  - All accept MassHealth
  - Harvard School of Dental Medicine, 188 Longwood Avenue, (617) 432-1434
  - Tufts School of Dental Medicine, 1 Kneeland Street, (617) 636-6828
  - Boston University School of Dental Medicine, 635 Albany Street, (617) 358-8300
- Boston Medical Center: Dental clinic just for pulling teeth
  - Have to call same day to have a visit, no appointments available

Boston Medical Center
Yawkey Ambulatory Care Center
850 Harrison Avenue, 6th Floor
Boston, MA 02118
Call: 617.414.ACHE (2243)

Resources Available in English, Spanish, Portuguese, and Vietnamese

Screening

FIND A MASSHEALTH PROVIDER

MassHealth has a network of dental providers who are available to treat your dental needs. You can find a dental provider via our website or by calling customer service.

MassHealth Website
We've made it easy for you to find a dentist quickly in your area.

- Go to: www.masshealth-dental.net
- Click on Find a Provider
- Fill in the information requested, such as your zip code, city, or town
- You can also search for a dental specialist

How do I find the MassHealth website?
To reach the MassHealth website you can type www.masshealth-dental.net into your browser or scan the QR code below.

SCAN ME

Dental Customer Service: 1-800-207-5019
Dental customer service representatives can give you a current list of dentists who are enrolled in MassHealth. If you need extra help finding a dentist, the dental customer service representative may connect you to an intervention service specialist.

TTY: 1-800-466-7566
(for people with partial or total hearing loss)

Hours: 8 a.m. to 6 p.m.

Days: Monday through Friday

DentaQuest MassHealth

COMO ENCONTRAR UM PROVEDOR MASSHEALTH

A MassHealth tem uma rede de prestadores de serviços odontológicos que estão disponíveis para atender suas necessidades odontológicas. Encontre um provedor odontológico no nosso site ou ligue para o atendimento ao cliente.

Site do MassHealth
Encontre rapidamente um dentista na sua área.

- Vá para: www.masshealth-dental.net
- Clique em Encontrar Provedor
- Forneça as informações solicitadas, como ZIP (CEP) ou cidade
- É possível pesquisar também por especialidade odontológica

Como posso encontrar o site da MassHealth?
Para acessar o site da MassHealth, digite www.masshealth-dental.net no seu navegador ou faça a leitura do código QR abaixo.

LEIA-ME

Serviço ao Cliente Odontológico: 1-800-207-5019
Os representantes de atendimento ao cliente odontológico podem fornecer uma lista atualizada de dentistas da rede MassHealth. Para mais ajuda para encontrar um dentista, um representante do serviço de atendimento ao cliente odontológico pode conectá-lo com um especialista do serviço de intervenção.

TTY: 1-800-466-7566
(para pessoas com perda auditiva parcial ou total)

Horas: 8h às 18h

Dias: De Segunda a Sexta-feira

DentaQuest MassHealth

BUSCAR UN PROVEEDOR DE MASSHEALTH

MassHealth tiene una red de proveedores dentales que están disponibles para tratar sus necesidades dentales. Puede buscar un proveedor dental en nuestro sitio web o también puede comunicarse con nuestro departamento de servicio al cliente.

Sitio web de MassHealth:
Hemos facilitado el proceso para que busque un dentista rápidamente en su área.

- Vaya a: www.masshealth-dental.net.
- Haga clic en "Buscar un proveedor".
- Llene la información que se solicita, por ejemplo, su código postal, ciudad o pueblo.
- También puede buscar un especialista dental.

¿Cómo encuentro el sitio web de MassHealth?
Para llegar al sitio web de MassHealth, escriba www.masshealth-dental.net en su navegador o escanee el código QR que está abajo.

ESCANÉAME

Departamento de servicios dentales para clientes: 1-800-207-5019
Los representantes del departamento de servicios dentales para clientes pueden darle una lista actualizada de los dentistas que están inscritos en MassHealth. Si necesita ayuda adicional para buscar un dentista, un representante del departamento de servicio dentales para clientes puede ponerlo en contacto con un especialista del servicio de intervención.

TTY: 1-800-466-7566
(para personas con sordera parcial o total)

Horario: de 8 a.m. a 6 p.m.

Días: lunes a viernes

DentaQuest MassHealth

TÌM NHA SĨ CỦA MASSHEALTH

MassHealth có một hệ thống nha khoa sẵn sàng để lo cho các nhu cầu nha khoa của quý vị. Quý vị có thể tìm nha sĩ qua mạng lưới của chúng tôi hoặc gọi dịch vụ khách hàng.

Mạng lưới của MassHealth
Chúng tôi giúp quý vị tìm nha sĩ trong khu vực của quý vị nhanh chóng và dễ dàng.

- Vào: www.masshealth-dental.net
- Bấm vào "Find a Provider" (Tìm nha sĩ)
- Điền thông tin yêu cầu, như bưu chánh, thành phố, hoặc tỉnh
- Quý vị cũng có thể tìm nha sĩ chuyên khoa

Làm thế nào để tôi có thể tìm mạng lưới của MassHealth?
Để tìm mạng lưới của MassHealth, quý vị có thể đánh vào www.masshealth-dental.net trên trình duyệt của mình hoặc quét mã QR dưới đây.

QUÉT TÔI

Dịch Vụ Khách Hàng Nha Khoa: 1-800-207-5019
Dịch vụ khách hàng nha khoa có thể cho quý vị biết danh sách các nha sĩ đang ghi danh với MassHealth. Nếu quý vị cần được giúp đỡ thêm để tìm nha sĩ, đại diện dịch vụ khách hàng nha khoa có thể kết nối quý vị với một dịch vụ giúp đỡ đặc biệt.

TTY: 1-800-466-7566
(cho những người bị lãng tai hoặc bị điếc)

Giờ mở cửa: 8:00 sáng đến 6:00 chiều.

Ngày: Thứ Hai đến Thứ Sáu

DentaQuest MassHealth

Agenda

- **Overview**
  - Care Delivery
  - Administrative
  - Screening
  - **LARCs**
  - Behavioral Health
  - Pediatric Requirements

Recap of Requirements: LARC provision, referral option

Requirement	Domain	Description
LARC provision, referral option	Care Delivery	**Referral Option:** Have the **ability to discuss options for LARC** (e.g., intrauterine device or subdermal implant) with relevant patients and **refer patients** seeking such options to known in-network providers who can place these for the patient. Providers may also, rather than referring patients, provide and place these directly for patients within the primary care practice.

Suggested Audit Documentation

- Examples of patient facing education materials about LARC
- Workflow for referring patients to LARC providers
- Consider maintaining a list (e.g. screenshot of list incorporated into the EHR) of referral providers

Implementation Strategy: Discussion and Referral Capability

LARC Option	Type	Brand	FDA approved for
Intrauterine Device (IUD)	Copper IUD	ParaGard	10 years
	Hormonal IUD	Mirena	8 years
		Liletta	6 years
		Kyleena	5 years
		Skyla	3 years
Implant	Subdermal	Nexplanon	3 years

Operational Considerations

- Groups are likely already meeting this requirement as part of daily primary care operations
- Check-in on capacity for patient-centered contraception counseling
- Consider the education materials available to patients and ensure they include LARC
- Verify referral options for patients interested in LARC placement

Resources & Supports

- Even if not required, we encourage all providers to do a baseline training such as the ACOG's LARC Video Series, to build comfort and skills
- Review ACOG guidance on Patient-Centered Contraceptive Counseling
- Review ACOG guidance on Counseling Adolescents About Contraception
- Reproductive Access has patient facing materials on LARC and all forms of contraception in multiple languages (English, Spanish, Chinese, Vietnamese, Hindi)

Patient facing resources from Reproductive Access

IUD Information

What is the IUD?	The IUD (Intrauterine Device) is a plastic rod with 2 arms and a string. It is inserted into the uterus to prevent pregnancy. It is about the size of a quarter. There are 5 types of IUD in the US: the copper IUD and 4 hormonal (levonorgestrel) IUDs. To choose the right one for you, see the "Which IUD Is Right for Me?" chart on the other side.
How well does the IUD work?	The IUD works better than the pill, the patch, the ring, and the shot. IUD users don't need to think about birth control before or during sex, and they don't need refills each month. The IUD prevents pregnancy more than 99% of the time.
Is the IUD safe?	Yes. Serious problems with the IUD are rare, and most happen during the first few days. You can use any IUD while breastfeeding.
Can I get an IUD if I've never had a baby?	Yes. IUDs are a great choice even if you have not had a baby.
How is the IUD inserted?	After putting a speculum in your vagina, a clinician inserts the IUD into your uterus. Many clinicians give pain medicine first. You may have cramps and spotting for a short time after insertion.
Does the IUD have side effects?	Yes. Most side effects improve after a few months. See other side for details.
Does the IUD cause infections?	No.
Does the IUD protect against HIV and other sexually transmitted infections?	No, the IUD **does not** protect you from sexually transmitted infections. Unless you and your partner have sex only with each other, you should use a condom every time you have sex, even with the IUD in place.
Do I need to check the IUD?	No.
Does the IUD cause an abortion?	No. The IUD prevents sperm from fertilizing eggs.
How do I stop using the IUD?	Your clinician can remove your IUD at any time. If you prefer, you may be able to remove the IUD yourself. You can get pregnant right after the IUD is removed.

Reproductive Health Access Project / October 2022 www.reproductiveaccess.org

Which IUD is right for me?

	Copper IUD 	Hormonal IUDs 	Hormonal IUDs 
Brand names	ParaGard®	Mirena®, Liletta®	Kyleena®, Skyla®
When does the IUD start working?	The copper IUD starts working right away.	These hormonal IUDs start working right away.	These hormonal IUDs start working 7 days after insertion. Use condoms or another back-up method of birth control for the first 7 days after the IUD is inserted to prevent pregnancy.
How do you use it?	It must be placed in the uterus by a clinician. It's usually removed by a clinician. It can be removed at any time.	It must be placed in the uterus by a clinician. It's usually removed by a clinician. It can be removed at any time.	It must be placed in the uterus by a clinician. It's usually removed by a clinician. It can be removed at any time.
How long does it last?	The copper IUD works for 12 years.	Mirena and Liletta work for 8 years.	Skyla works for 3 years. Kyleena works for 5 years.
Does it contain hormones?	No.	Yes. There is a low dose of levonorgestrel but no estrogen. Some people who take testosterone prefer to avoid methods that contain estrogen.	Yes. There is a low dose of levonorgestrel but no estrogen. Some people who take testosterone prefer to avoid methods that contain estrogen.
Effects on bleeding and cramps	Heavier periods Cramps for a few months after insertion Stronger cramps with your period Longer periods	Spotting Cramps for a few months after insertion Lighter periods or no periods after a few months – this is safe.	Spotting Cramps for a few months after insertion Lighter periods or no periods after a few months – this is safe.
Things to know	May lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) Can be used as emergency contraception: prevents pregnancy when inserted up to 5 days after unprotected sex	May lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS) Can be used as emergency contraception: prevents pregnancy when inserted up to 5 days after unprotected sex	May lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome (PCOS)
Cost	The cost varies based on insurance coverage. Most insurance providers completely cover the cost the IUD. If the IUD is not covered by your insurance, it may cost up to several hundred dollars.	The cost varies based on insurance coverage. Most insurance providers completely cover the cost of the IUD. If the IUD is not covered by your insurance, it may cost up to several hundred dollars. There may be grants or programs to cover the cost of the device if you do not have insurance coverage.	The cost varies based on insurance coverage. Most insurance providers completely cover the cost of the IUD. If the IUD is not covered by your insurance, it may cost up to several hundred dollars.

Reproductive Health Access Project / October 2022 www.reproductiveaccess.org

See "LARC Resources – Patient Materials" slide for more patient resources

Agenda

- **Overview**
  - Care Delivery
  - Administrative
  - Screening
  - LARCs
  - **Behavioral Health**
  - Pediatric Requirements

Recap of requirements: BH referrals

Tier	Population	Requirement	Description
1	Adult	BH Referrals & bi-directional communication, tracking, monitoring	BH referral with bi-directional communication, tracking, and monitoring: retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs. The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other. The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times. In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit.

Suggested Audit Documentation

- List of local BH providers that accept MassHealth, with contact information and indicator of whether accepting new referrals, across required provider types (psychotherapy/counseling, psychopharmacology, and intensive outpatient / partial hospital programs)
- Workflow that shows referral and tracking/follow-up process (note: referral may be made by PCP, other clinic staff, or patient as a self-referral via provider list)
- Workflow for bi-directional communication – e.g. process for obtaining consent for release of information (ROI) (including a form to obtain consent for ROI)

Review of *Tier 1 and 2 requirements*: Achieving compliance

Exact requirement language	Path to compliance
"Retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs"	Maintain a list of local providers: Use the Excel spreadsheet tool as instructed above, or use your own site's preexisting list of local BH resources
"The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other."	Have a process for obtaining consent for release of information with external providers • Note: There are no requirements surrounding which patients, which clinical situations, or how often communication with BH providers is conducted
"The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times."	All 29 CBHCs are expected to have bandwidth for urgent, same-day, and same-week patient care • Note: Sites may use the "Notes (for group/ practice use)" column to track bandwidth
"In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit."	Ensure the site has a policy for providers to track referrals in patient's EMR (e.g., as part of the plan for a patient's BH condition) • Note: Sites and PCPs may always use the Behavioral Health Help Line (BHHL) 833-773-2445 for referral support
"Include at least one (1) BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network."	All 29 CBHCs are expected to have telehealth capability • Note: Sites may use the "Notes (for group/ practice use)" column to track telehealth capability

Implementation Strategy: BH referrals

	Implementation Recommendations	
	Recommendations to Meet Minimum Requirement	**Note: Not required**

Tier 1	▪ **Referral "list"**: Maintain document to **"provide to patients"** with local BH providers of (a) psychotherapy, (b) psychopharmacology, **and** (c) intensive outpatient or partial hospitalization programs
	  ▪ List should include phone and/or fax info
	  ▪ Referral bandwidth: Ensure referral list document includes an indicator of whether provider is accepting new referrals
	  ▪ Note: CBHCs (coming Jan 2023) are expected to offer timely access with minimal wait times for (a) and (b) +/- (c)
	▪ **"Bi-directional communication"**: Ensure practice has a method of obtaining consent for release of information (ROI) to/from other providers ("with whom the practice can conduct bi-directional communication")
	▪ **"Tracking and monitoring"**: Check with patients after referral to ensure they made contact w/ provider (e.g., at PCP f/u visit); can inform referral bandwidth of referral "list"
		▪ **Proactive patient tracking and monitoring**: Team member performing outreach to patients referred on whether they made contact with provider (e.g., after 1 month)
		▪ **Proactive BH provider bi-directional communication**: For BH providers with whom patients are shared, recurring contact regarding cases and referral bandwidth
		▪ EMR connectivity with BH providers

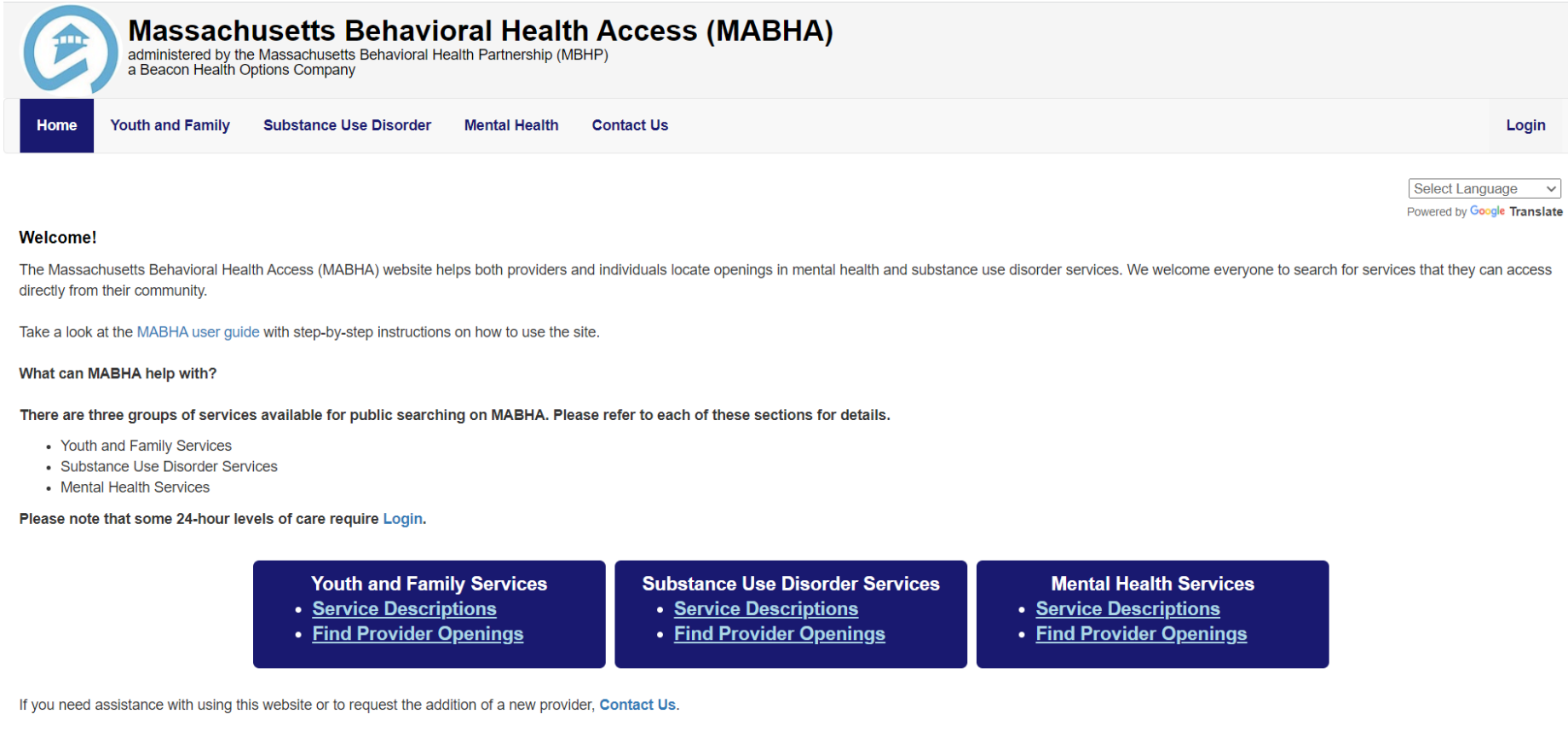
Operational Considerations

- Bi-directional communication follows similar principles to any clinical collaboration with any specialty providers (e.g., consent for release of information, HIPAA)
- **Areas of flexibility:** When/how often to engage in bi-directional communication, when/how often to track referrals, and when/how often to update information about referral bandwidth ("regularly")
- Note: Most BH providers continue to offer telehealth capability today

Resources & Supports

- BMCHS PHS team will work with each ACO in 2023 on resources with local BH network information
- All members and providers have access to MABHA and Beacon Provider Network directories (public sites)

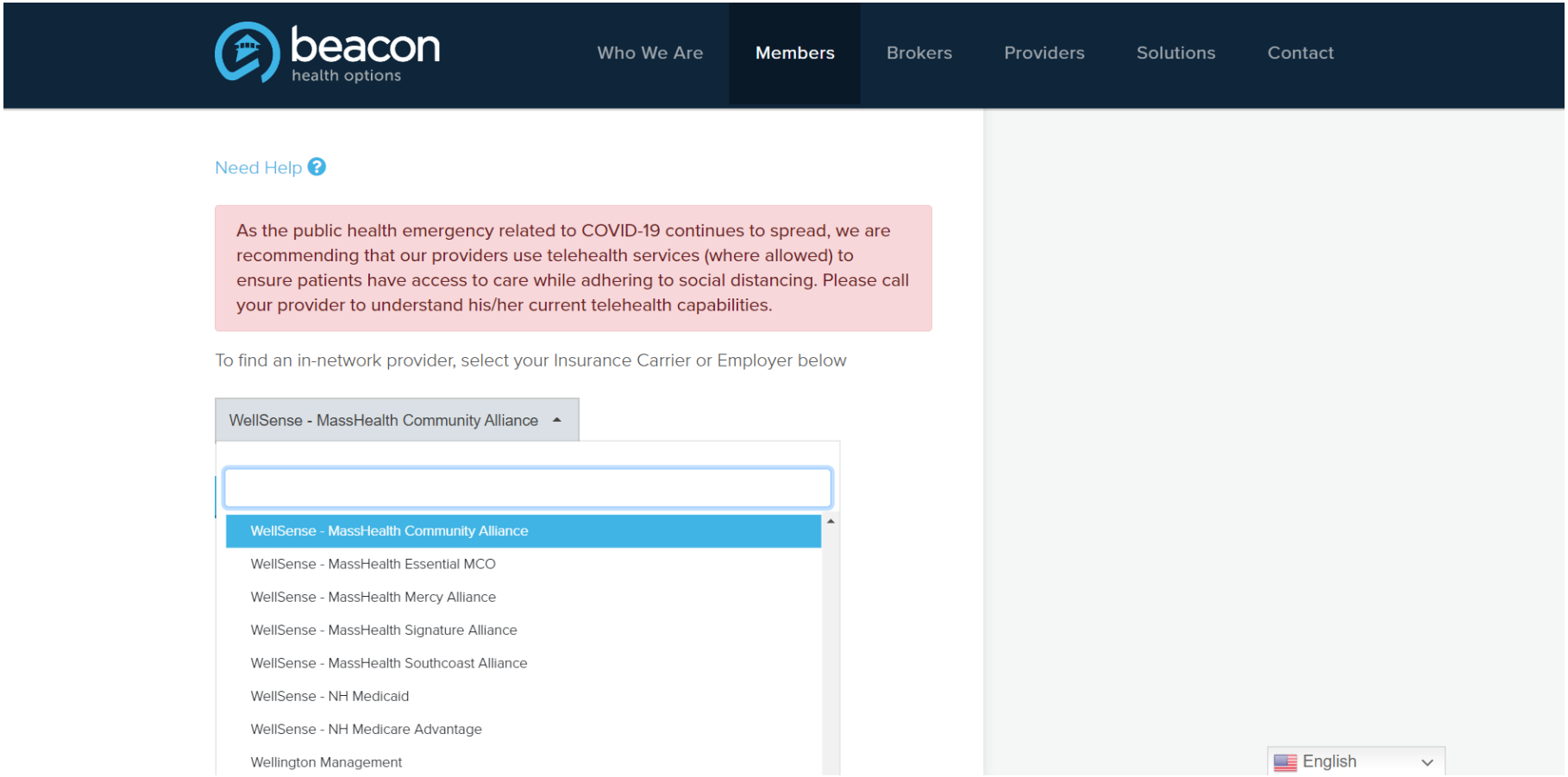
BH referrals: MABHA
https://www.mabhaccess.com/



BH referrals: Beacon Provider Network

https://www.beaconhealthoptions.com/find-a-provider/

Behavioral Health



Recap of requirements: BH Medication Management

Tier	Population	Requirement	Description
1	Adult	BH Medication Management	Prescribe, refill, and adjust medications for the treatment of common BH issues amenable to treatment in the primary care setting, including but not limited to major depressive disorder, generalized anxiety disorder, and attention deficit-hyperactivity disorder. Such services can occur independently or providers may receive assistance from available resources such as the Massachusetts Child Psychiatry Access Program (MCPAP), a clinical pharmacist, psychiatrist, psychiatric clinical nurse specialist, etc. While practices may offer some BH medication management virtually via telehealth, Enrollees must be able to access this requirement on-site.

Suggested Audit Documentation

EITHER:

1. Job description for PCPs for each PDSIL explicitly stating that BH medication management for major depressive disorder (MDD), generalized anxiety disorder (GAD), and attention deficit-hyperactivity disorder (ADHD) is required part of the job

OR:

2. list of PCPs and other prescribing providers in practice indicating which BH conditions each provider provides medication management for. At a minimum, at least one provider should offer treatment for major depressive disorder (MDD), generalized anxiety disorder (GAD), and attention deficit-hyperactivity disorder (ADHD). (Note: BMCHS believes that, generally, all PCPs should be able to provide medication management for all 3 conditions)

Implementation Strategy: BH Medication Management (Tier 1)

Implementation Recommendations

Option 1: PCP BH prescribing

- **On-site BH prescribing ("Prescribe, refill, and adjust")**: On-site provider team should include prescribers comfortable with prescribing for Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), and Attention Deficit Hyperactivity Disorder (ADHD)

Option 2: Additional specialty BH support

- **Consultant assistance**: On-site prescribers may consult with MCPAP and MCPAP For Moms, if relevant
  - See also **Coordination with MCPAP** and **Coordination with M4M** Tier 1 requirements
- **Consulting BH prescriber**: Some sites may have on-site, hybrid, or virtual specialty BH prescribers supporting BH prescribing (however, some on-site availability of BH medication management is required)
  - See also **Maintain consulting BH clinician with prescribing capability** Tier 3 requirement

Operational Considerations

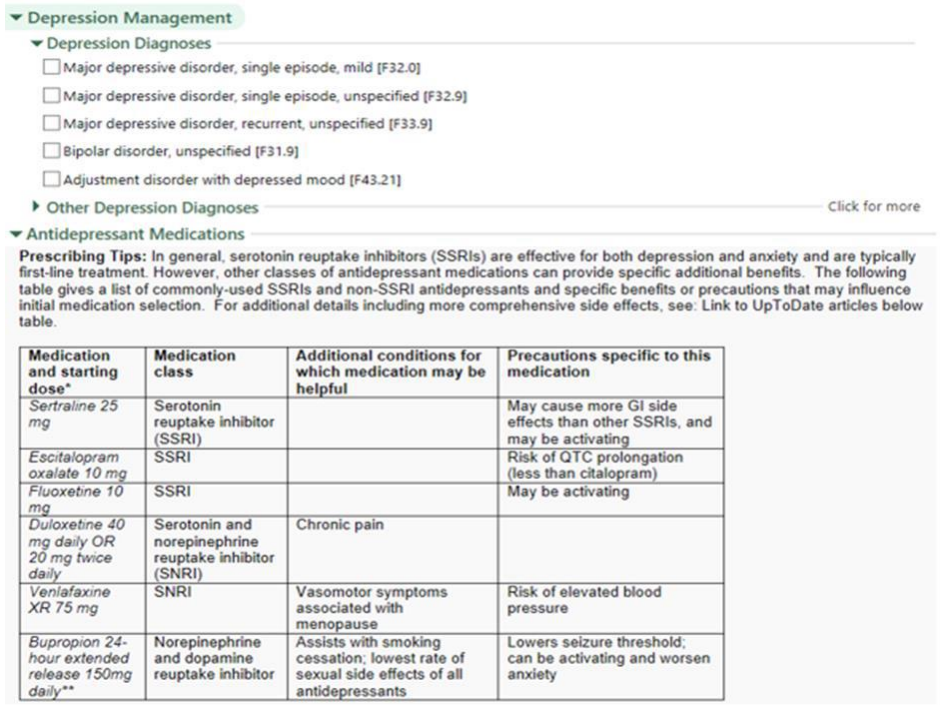
- Note: Medication management for ADHD does not necessarily require the use of controlled substances; bupropion, atomoxetine, clonidine, and guanfacine have evidence for use in ADHD

Resources & Supports

- BMCHS provider education resources on MDD available on Box.com or from your ACO Ops Lead
- BMCHS is open to offering additional training sessions pending ACO partner interest
- BMC Integration Steps: Integrated behavioral health trainings, including medication for depression and SUD
- Harvard Review of Psychiatry: ADHD in Primary Care

Optional: Supporting PCPs with BH medication management

- Consider provider trainings on BH diagnosis and management (please let your PHS Operations contacts know if this is of interest)
- Ensure all care team members (PCPs, support staff, care managers/coordinators, and others) are aware of appropriate external and internal behavioral health resources and when to use them
- Develop EMR decision support for providers in managing common conditions, such as depression (sample from BMC General Internal Medicine Best Practice Alert)



▾ Depression Management

▾ Depression Diagnoses

- ☐ Major depressive disorder, single episode, mild [F32.0]
- ☐ Major depressive disorder, single episode, unspecified [F32.9]
- ☐ Major depressive disorder, recurrent, unspecified [F33.9]
- ☐ Bipolar disorder, unspecified [F31.9]
- ☐ Adjustment disorder with depressed mood [F43.21]

▸ Other Depression Diagnoses — Click for more

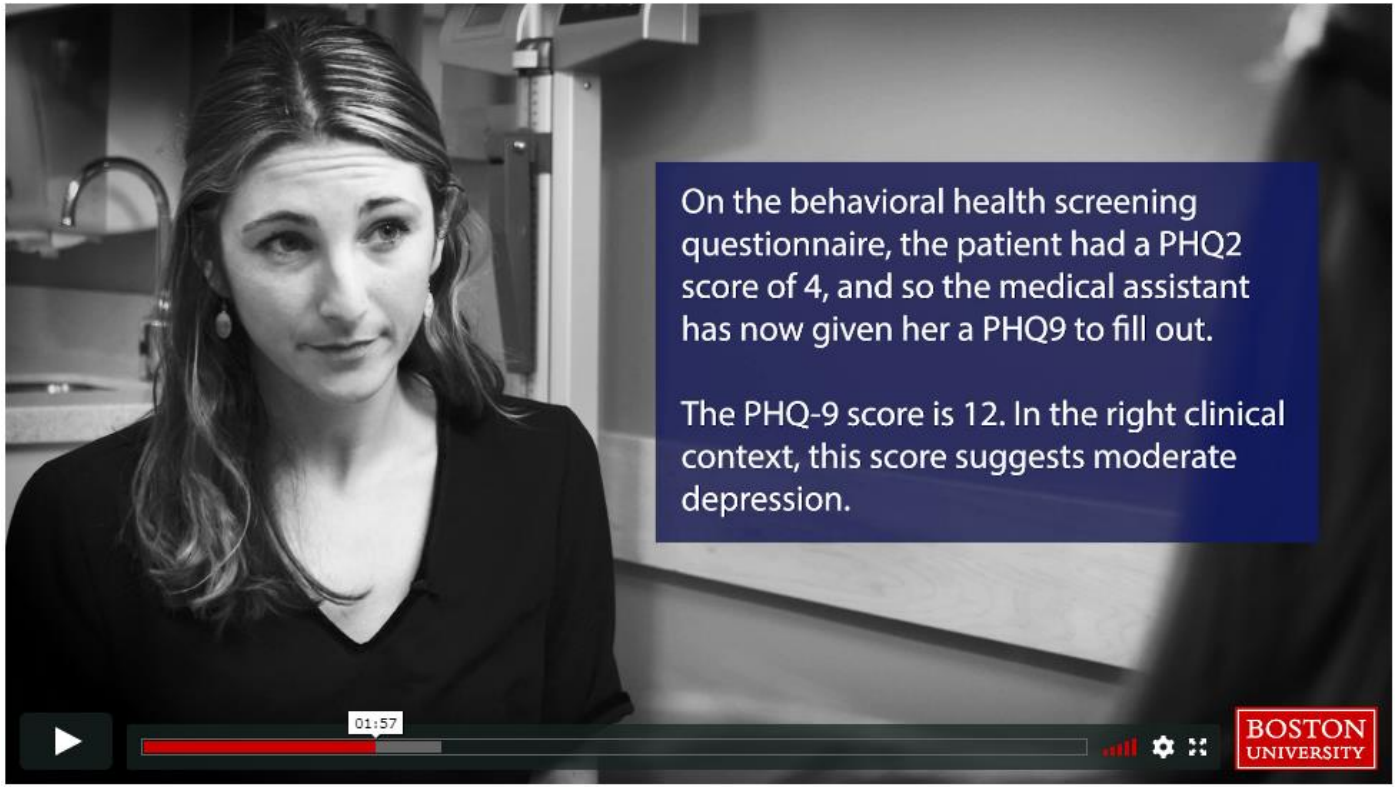
▾ Antidepressant Medications

Prescribing Tips: In general, serotonin reuptake inhibitors (SSRIs) are effective for both depression and anxiety and are typically first-line treatment. However, other classes of antidepressant medications can provide specific additional benefits. The following table gives a list of commonly-used SSRIs and non-SSRI antidepressants and specific benefits or precautions that may influence initial medication selection. For additional details including more comprehensive side effects, see: Link to UpToDate articles below table.

Medication and starting dose*	Medication class	Additional conditions for which medication may be helpful	Precautions specific to this medication
Sertraline 25 mg	Serotonin reuptake inhibitor (SSRI)		May cause more GI side effects than other SSRIs, and may be activating
Escitalopram oxalate 10 mg	SSRI		Risk of QTC prolongation (less than citalopram)
Fluoxetine 10 mg	SSRI		May be activating
Duloxetine 40 mg daily OR 20 mg twice daily	Serotonin and norepinephrine reuptake inhibitor (SNRI)	Chronic pain	
Venlafaxine XR 75 mg	SNRI	Vasomotor symptoms associated with menopause	Risk of elevated blood pressure
*Bupropion 24-hour extended release 150mg daily***	Norepinephrine and dopamine reuptake inhibitor	Assists with smoking cessation; lowest rate of sexual side effects of all antidepressants	Lowers seizure threshold; can be activating and worsen anxiety

BMC Integration Steps includes videos and other resources for primary care-based management of depression and SUD (including AUD, OUD)

https://integrationsteps.org/



Recap of requirements: Prescription Monitoring Program

Tier	Population	Requirement	Description
1	Adult	Prescription Monitoring Program	All prescribing personnel at the practice site shall have access to and regularly use the Massachusetts Prescription Awareness Tool (Mass PAT) in accordance with Commonwealth of Massachusetts General Law: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section24A.

Suggested Audit Documentation

- Copy of written notice/posted notice informing prescribing personnel of Mass PAT and policy for regular use within clinic (e.g., when prescribing any controlled substance)
- Ensuring all providers are enrolled in Mass PAT, in order to have access to tool (e.g., as part of onboarding process or PIDSL / Clinic policy)

Implementation Strategy: Prescription Monitoring Program (Tier 1)

Behavioral Health

Implementation Recommendations

Recommendations to Meet Minimum Requirement

- **Prescriber "access" to MassPAT**: Ensure all prescribers are registered for MassPAT
  - MassPAT registration takes 5-10 minutes online, must be performed by the prescriber, and requires the following information:
    - Professional email address
    - DEA Number
    - Professional License Number
    - Controlled Substance ID (MCSR Number)
- **"Regular use"**: Ensure the regular use of MassPAT, including via electronic/EMR reminders
  - Alternative: Ensure practice has a policy around the use of MassPAT when prescribing controlled substances

Additional Support Options

- **Prescriber access to MassPAT**: For EMRs that offer it, offer EMR integration of MassPAT (removes steps of opening and signing into MassPAT for provider)

Operational Considerations

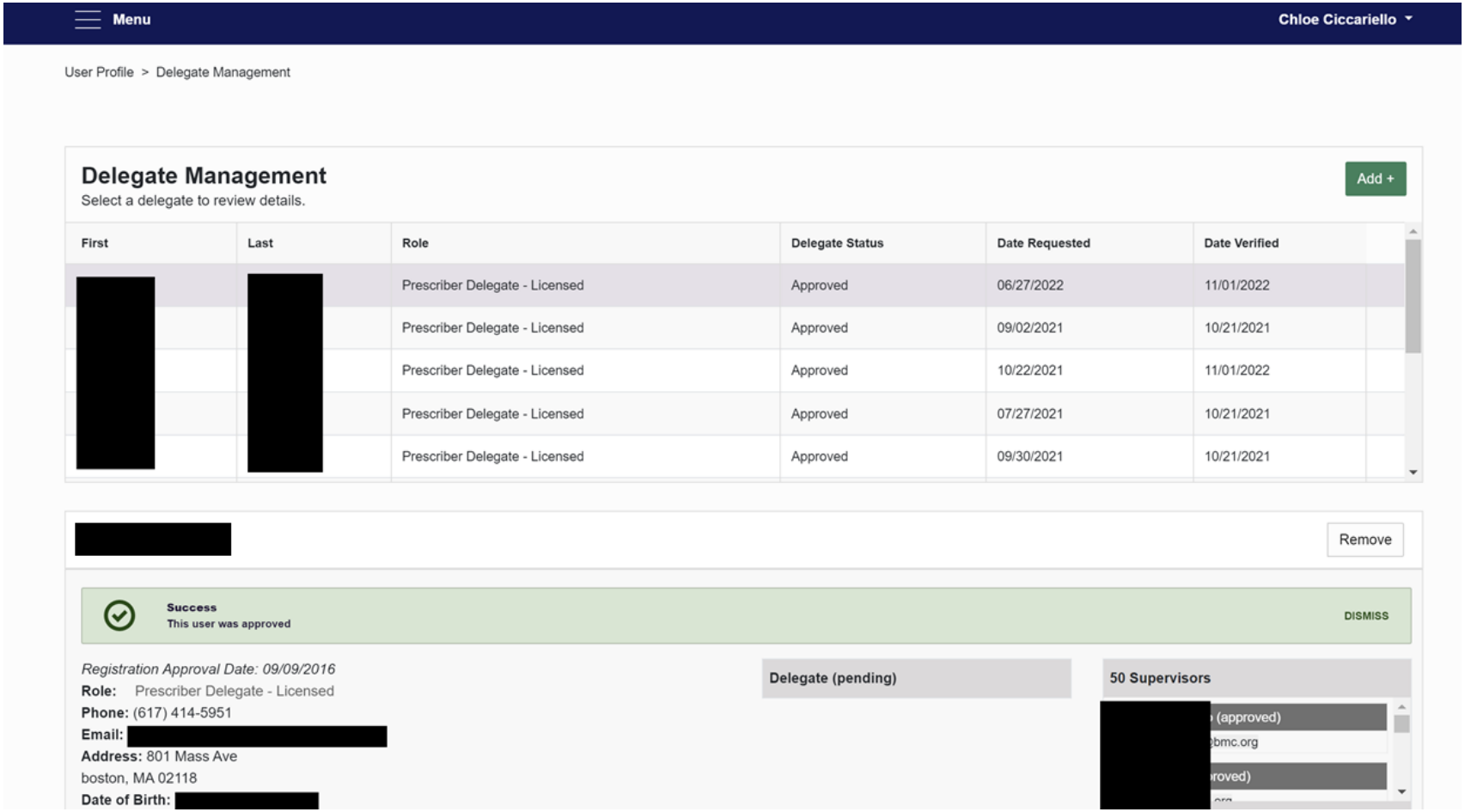
- Prescribers should be already registered for MassPAT
- E-prescribing software should ask prescribers to use MassPAT before the prescription of controlled substances
- "Delegated" RNs can check MassPAT on behalf of providers (see next page)
- Develop controlled substance best practices for your clinic that include checking MassPAT before prescribing controlled substances

Resources & Supports

- Registration for MassPAT

Example: Delegate Management enables RNs to review PMP/MassPAT on behalf of PCP

Behavioral Health



Please let your Ops team contacts know if additional operational guidance on this process would be helpful.

Recap of requirements: Adult Buprenorphine (Tier 1)

Tier	Population	Requirement	Description
1	Adult	Buprenorphine Waivered Practitioner Requirement	**All individual Primary Care Providers** must have the capability and credentialing to prescribe buprenorphine. This requirement can be met by prescribers either submitting the Substance Abuse and Mental Health Services Administration (SAMHSA) notice of intent (NOI) without additional training requirements, or via having a buprenorphine waiver. More information can be found here. The individual providers need not be actively prescribing buprenorphine to meet this requirement.

UPDATE:

- Recent passage of the federal MAT Act, as part of the Consolidated Appropriations Act of 2023 **removes the need for clinicians to obtain an X-waiver or Notification of Intent (NOI) in order to prescribe buprenorphine**
  - This change will result in increased access and decreased barriers to critical Medication-Assisted Treatment for MassHealth members, as well as patients across Massachusetts and the United States.
- To ensure the MassHealth Primary Care Sub-Capitation Program is aligned with the new federal expectations, the Primary Care Sub-Capitation Tier Criteria for Tier 1 Adults Buprenorphine Waiver Practitioner Requirement **are no longer in effect**
- MassHealth expects ACOs and practices will follow forthcoming CMS guidance on buprenorphine prescribing, including conducting any trainings related to DEA licensing. In addition, MassHealth expects ACOs to support their practices in **growing their capability to prescribe MAT, and to care for members with SUD**. Practices will not be required to submit new attestations.

Agenda

- **Overview**
  - Care Delivery
  - Administrative
  - Screening
  - LARCs
  - Behavioral Health
  - **Pediatric Requirements**

Recap of EPSDT Screening Requirements (Tier 1)

Pediatric

ESPDT: Early & Periodic Screening, Diagnostic and Treatment

Protocol & Schedule is in Appendix W of the MassHealth Provider Manual Series

Transmittal Letter ALL-233 | 12/2/2020

Requirement	Population	Description
EPSDT Screening	Pediatric Members; ALL practice types	Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT. While practices may offer some EPSDT screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

Suggested Audit Documentation

- Screenshot of EHR templates that include all of the required ESPDT screenings
- Copy of workflows in place to keep members/caregivers engaged in care (e.g. check out process to schedule next appointment, outreach process to identify members that are missing upcoming appointments)

*Please note that EPSDT requirements are **required for any MassHealth members 21 years of age or younger, regardless of the practice type**.*

Pediatrics includes practices serving members 21 years of age and younger.

Implementation Strategy: EPSDT Screening

Pediatric

Implementation Recommendations

Utilize the MassHealth Provider Manual to identify all relevant screening topics and expected timelines and tools for administration.

- Pediatric preventative healthcare visits should occur at a minimum of: newborn, 3-5 days and monthly at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, then yearly from three to 21 years.
- Those visits should include:
  - History (e.g. family history, immunization history, etc.)
  - Measurements (e.g. length, weight, height, etc.)
  - Sensory (vision, hearing)
  - Developmental / Behavioral Health (e.g. autism spectrum, psychosocial, tobacco, etc.)
  - Physical exam
  - Procedures (e.g. newborn blood, newborn bilirubin, lead exposure, etc.)
  - Oral health
  - Anticipatory guidance

Operational Considerations

- Scheduling: Determine if any schedule template changes need to be made to ensure ample time is allotted for the visit.
- Population Health: Identify workflows to keep members/caregivers engaged in care (e.g. check out process to schedule next appointment, outreach process to identify members that are missing upcoming appointments)
- Staffing: Decide who will perform each screening and at which point during the clinic visit (e.g. the MA may take measurements, the member/caregiver may complete a health history form in the waiting area)
- Documentation: Consider EHR documentation templates that include all of the required ESPDT screenings.
- Eligibility: Decide how the practice will track which patients for whom screening has been completed and which patients are due for screening

Support & Resources

EPSDT protocol & schedule: Appendix W of the MassHealth Provider Manual

Recap of requirements: Pediatric expertise and coordination

Pediatric

Tier	Population	Requirement	Description
1	Pedi	Coordinate with MCPAP	Enroll with MCPAP at https://www.mcpap.com/. The practice shall consult with and use the services of MCPAP to augment the BH expertise provided within the practice as a means to maintain the management of youth with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with child and adolescent psychiatrists working in the clinic or a neighboring site or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource, however, does not exempt the practice from enrolling with MCPAP.
1	***Pedi & Adult*** (*clarifying with MassHealth*)	Coordinate with M4M	If providing obstetrical services, enroll in the M4M program at https://www.mcpapformoms.org/. The practice shall consult with M4M to augment the BH expertise provided within the practice as a means to maintain the management of perinatal patients with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with a psychiatrist or appropriately trained Ob/Gyn of suitable expertise working in the clinic or a neighboring site, or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource however does not exempt the practice from enrolling with the M4M program. While practices may offer some coordination with MCPAP for Moms virtually via telehealth, Enrollees must be able to access this requirement on-site.

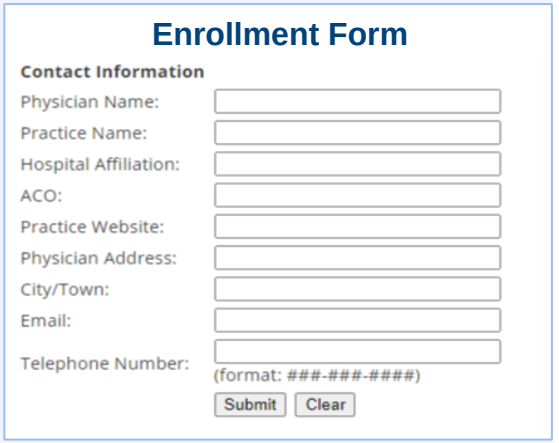
Suggested Audit Documentation

- Proof of MCPAP enrollment - eg email confirmation from MCPAP once form is submitted
- Proof of M4M enrollment - eg email confirmation from M4M once form is submitted

Implementation Strategy: Coordinating with MCPAP and M4M

Pediatric

	MCPAP (Massachusetts Child Psychiatry Access Program)	M4M (MCPAP for Moms)
Summary of Service	• Real-time provider-to-provider consultation on treating children with behavioral health and/or substance use disorder needs • Virtual counseling for pedi patients with SUD by an LICSW specializing in pediatric SUD	• Real-time provider-to-provider consultation (including OB, adult and peds PCPs, and psychiatrists) treating postpartum patients with behavioral health and/or substances use disorder needs
Enrollment Form	www.mcpap.com/Provider/EnrollInMcPAP.aspx	www.mcpapformoms.org/Providers/EnrollInMCPAPMOM.aspx#
Provider Phone #	• Western & Central MA: 844-926-2727 • Eastern MA – Boston South : 844-636-2727 • Eastern MA – Boston North: 855-627-2763	• 855-Mom-MCPAP (855-666-6272)
Implementation Recommendations	• **All pediatricians enroll in MCPAP** • **All PCPs providing obstetric services services (e.g., Family Medicine) enroll in M4M*** • Note: all adult, peds, OBGYN practices are *eligible* to enroll in M4M (but not required) • Submitting enrollment form for each provider is quick lift (<1min) that **can be completed by admin staff** • Provide guidance to care teams on how to access (up to providers if/when to "consult with and use" service) • Providers can still call MCPAP and M4M for patient consultations – even if not enrolled	



Enrollment Form

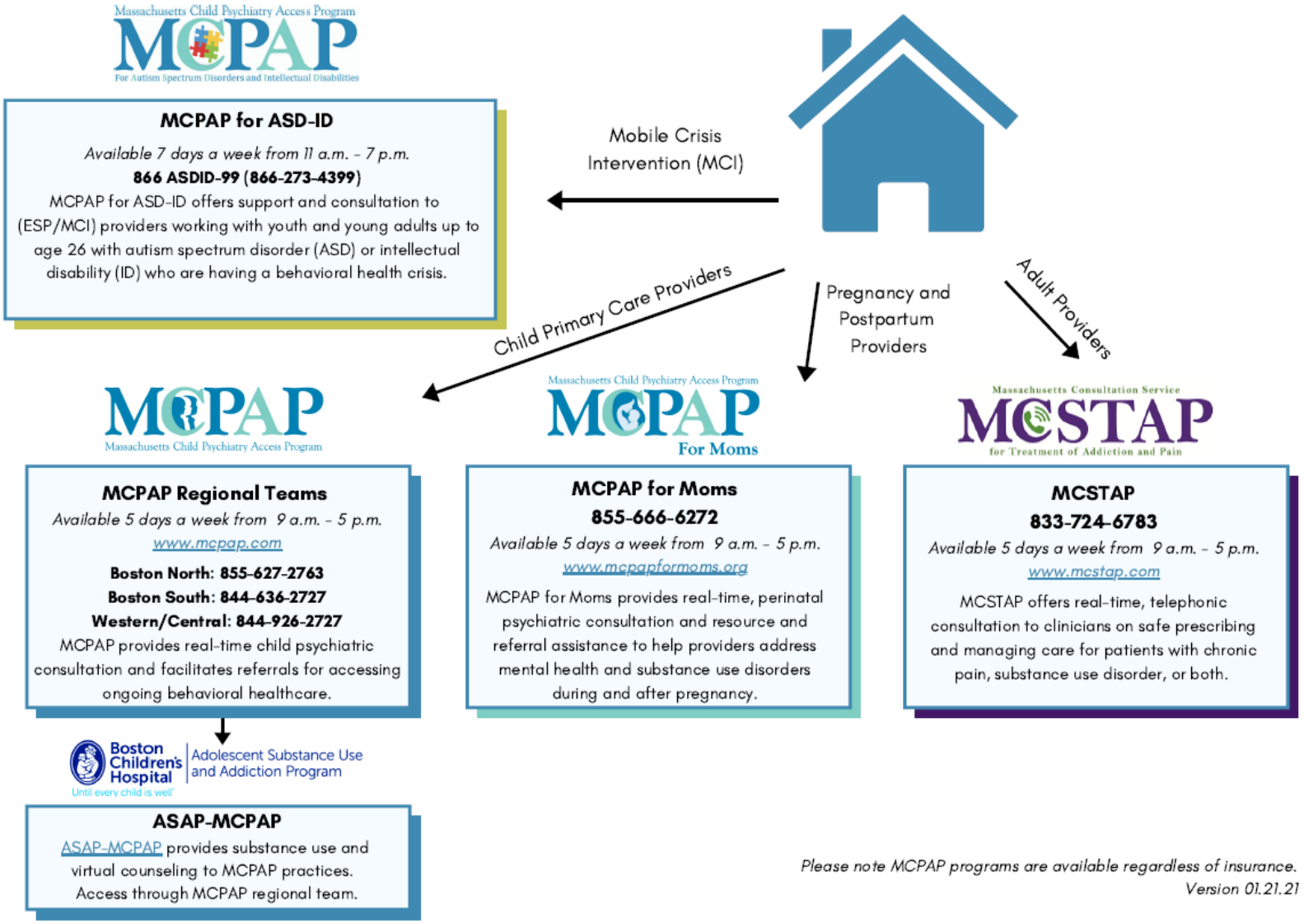
Contact Information

Physician Name:
Practice Name:
Hospital Affiliation:
ACO:
Practice Website:
Physician Address:
City/Town:
Email:
Telephone Number:
(format: ###-###-####)
Submit Clear

*We are seeking clarification from MassHealth on the intended population for this requirement

Pediatric

MCPAP Family of Consultation Programs



Please note MCPAP programs are available regardless of insurance.
Version 01.21.21

Recap of requirements: Children's Behavioral Health Initiative

Pediatric

Tier	Population	Requirement	Description
1	Pedi + Adult	Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI)	The practice shall identify its staff member(s) responsible for 1) communicating with and reporting to CBHI program in a closed-loop manner, and 2) maintaining a roster of children attributed to the practice who are receiving CBHI services.

Suggested Audit Documentation

- Name(s) and job description(s) for designated staff that fill CBHI liasion role
- Roster template for children referred to CBHI, used and maintained by CBHI liaison(s)

Implementation Strategy: Children's Behavioral Health Initiative (CBHI)

Pediatric

Summary of Services	• CBHI provides **multidisciplinary BH services** to children with MassHealth with an array of complex behavioral heath needs, and are provided through a statewide network of home & community-based service providers
	• CBHI Services include:
	  • "Hub" services (entry point for outpatient CBHI services): Intensive Care Coordination, In-Home Therapy, Outpatient Therapy
	  • Other services: Family Support and Training, Therapeutic Mentoring Services, In Home Behavioral Health Services, and Mobile Crisis Intervention

Implementation Recommendations *(Pedi practices only)*	• **Practices identify local agencies and other providers of CBHI services** and key contacts at each organization. Of note, only 32 CSAs (Community Service Agencies) offer Intensive Care Coordination across the state; these are nodes for many CBHI services
	• **"Communicating with and reporting to CBHI"**: Since there is no central CBHI organization, this should entail (a) placing referrals and (b) coordinating care and sharing clinical information with CBHI providers as needed
	  • Ensure CBHI referrals are documented in patients' plans; follow up as needed
	  • Ensure practice has a method of obtaining consent for release of information (ROI) to/from other providers
	• **Maintain "a roster"** of children referred for CBHI services, with identified key parties

Operational Considerations	• Note: CBHI liaison(s) should be the same staff used to meet Tier 2/3 requirement for staff with children, youth, and family-specific expertise – which entails CBHI liaising. • **Non-clinician staff member** may fulfill this requirement, but may also be performed by a clinician with dedicated non-clinical/administrative responsibilities • Practices can leverage centralized staff via telehealth – but must be onsite monthly.
Resources & Supports	• CBHI brochure: https://www.mass.gov/service-details/cbhi-brochures-and-companion-guide • Find CBHI providers: https://www.mabhaccess.com/Search.aspx and helplinema.org

CBHI brochure with description of services

Pediatric

Mobile Crisis Intervention *

MassHealth offers a Mobile Crisis Intervention service. A team trained to work with children and youth in crisis can meet you at your home, school, or another place in the community. An MCI team will show up within an hour of your call. The team can guide you and your child through a crisis and connect you with other services.

Find your local team now so you have the information when you need it. Call **(877) 382-1609**, anytime, day or night. Once you dial this number, a recorded voice will ask you to enter your zip code. Based on your zip code, you will be given the phone number of the closest Mobile Crisis Intervention team that serves you. Have a pen or pencil and piece of paper ready to write it down. Place the number in a location that is easy for you and your family to find when you need it.

Please note that calling MCI is not the same as calling 9-1-1.
If your child is in danger or is putting others in danger, call 9-1-1.

HOME- AND COMMUNITY-BASED SERVICES

Outpatient Therapy

Outpatient Therapy is often where families first look for help as this type of therapy can help with many kinds of challenges. A therapist will meet with your child, usually in an office setting. The therapist will work out a plan based on your child's strengths and needs and can help you get your child other needed services.

In-Home Therapy*

In-Home Therapy works with your whole family, not just your child, in your own home and community setting to strengthen relationships and support your child. In-Home Therapy can help your child and family resolve conflicts, learn new ways to talk to and understand each other, create new helpful routines, and find community resources.

Intensive Care Coordination

Intensive Care Coordination may be the right service for you if your child or teen has serious emotional or behavioral needs or if you need help getting all the service providers in your child's life to work together. A care coordinator helps bring everyone together to work toward common goals. You can choose who is on your team, including professionals such as therapists, social workers, teachers, and your personal supports, such as friends or relatives. You may also ask for a "Family Partner," a parent trained to help you make sure that your voice is heard. Together, the team will help you and your child reach your goals for your family.

Other Services

If your child gets Outpatient Therapy, In-Home Therapy, or Intensive Care Coordination and needs more help, they may also be able to get the following services:

In-Home Behavioral Services

Sometimes a child needs help changing behaviors that get in the way of their everyday life. An In-Home Behavioral team will work with you and your child to create a behavior plan that will help your child change these behaviors to improve their daily life.

Therapeutic Mentors

Some children and teens want to get along with others but need help learning how to connect with people. A Therapeutic Mentor can help your child learn social and communication skills and practice them in everyday settings.

Family Support and Training (Family Partners)

Family Partners guide parents and caregivers in helping their children reach their treatment goals. They are parents or caregivers of children with special needs—they've "been there," understand what families go through, and can share their experiences. Family Partners are not behavioral health professionals, but they understand child and family services and they can coach you as you work to meet your child's needs.

AUTISM SERVICES

Applied Behavior Analysis (ABA)

If your child has a diagnosis of autism, ABA helps by making a detailed behavior plan that you can use every day to help your child learn new behaviors that will help them in their daily life. Please note that your child cannot have ABA and In-Home Behavioral Services at the same time.

YOUTH SUBSTANCE-USE SERVICES

Structured Outpatient Addiction Program (SOAP)

Sometimes called Intensive Outpatient Program (IOP), SOAP is a day or evening substance-use treatment for people who don't need 24-hour care. If your child or teen is in SOAP, they are able to stay at home and keep up with daily life in school and the community. SOAP offers counseling, education, case management, and onsite monitoring.

Residential Rehabilitation Services (RRS)

RRS can help if your child needs more structure as they recover from addiction. RRS will provide ongoing education, counseling and support in a 24 hour home-like setting, also known as halfway houses. When your child is ready to leave, RRS will help them get ready to re-enter their home and community.

Youth Stabilization Services (YSS)

YSS will provide even more structure for your child dealing with addiction issues. It offers treatment and counseling in a 24 hour setting for youth up to the age of 21. YSS includes nursing care and access to psychiatric services.

Recap of requirements: SNAP and WIC

Pediatric

Tier	Population	Requirement	Description
1	Pediatrics	Pediatric SNAP and WIC screenings	Screen for SNAP and WIC eligibility, in accordance with Provider Manual Appendix W, if applicable: Practices shall also complete the medical referral form for WIC eligible patients. Patients and families deemed eligible for these programs should be referred to further resources in order to apply for and engage these programs. While practices may offer some SNAP and WIC screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
2	Pediatrics	Provide SNAP and WIC assistance	Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site

Breaking down the T1 requirement: Pediatric SNAP and WIC screenings

Pediatric

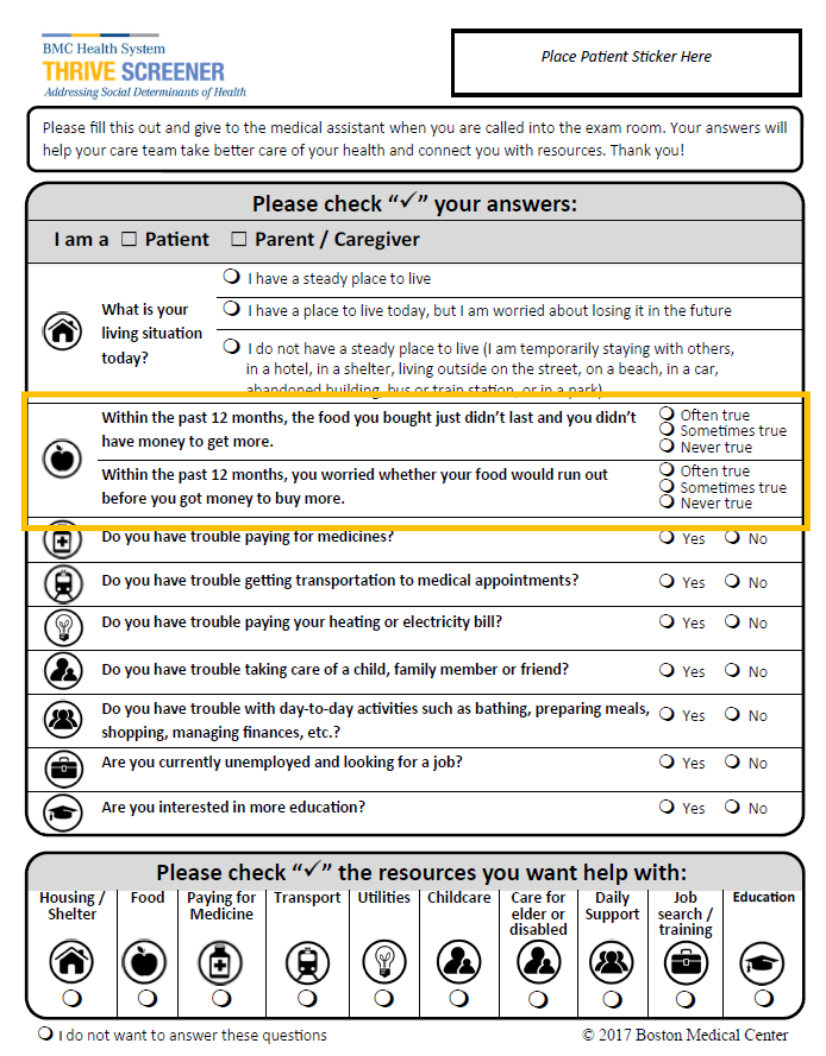
1. **Screen for SNAP/WIC eligibility** in accordance with Provider Manual Appendix W
   - MH verbally indicated that ***how*** **a practice screens can be determined by the practice**.
   - We encourage practices to **screen using questions about food insecurity** that should be in place on SDOH/HRSN screening tools.
   - Screening can be done via telehealth, but **must also be available on-site**. For example, your workflow may be do complete screenings via telehealth prior to a patient appointment. If a patient is unable to complete that screening, you must be able to screen them when they are physically in the practice.

> **MassHealth Provider Manual Appendix W**
>
> Make every effort to inform a potentially eligible member or the parent or guardian about the Women, Infants, and Children (WIC) nutrition program. A referral to WIC should be made using the WIC Medical Referral Form (MRF) from the Massachusetts WIC Program. In addition, the member, parent, or guardian may also be referred to the Supplemental Nutrition Assistance Program (SNAP), which is administered by the Department of Transitional Assistance.

2. If the patient is eligible for WIC, **complete the WIC medical referral form**.
3. If the patient is eligible for SNAP or WIC, **refer the member to additional resources to apply for and engage** in these programs.
   - The practice is not expected to make sure the patient follows through on this referral.

We recommend utilizing a SDOH/HRSN screening questionnaire that includes questions about food insecurity

Pediatric



BMC Health System
THRIVE SCREENER
Addressing Social Determinants of Health

Place Patient Sticker Here

Please fill this out and give to the medical assistant when you are called into the exam room. Your answers will help your care team take better care of your health and connect you with resources. Thank you!

Please check "✓" your answers:

I am a ☐ **Patient** ☐ **Parent / Caregiver**

What is your living situation today?
- ❍ I have a steady place to live
- ❍ I have a place to live today, but I am worried about losing it in the future
- ❍ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. ❍ Often true ❍ Sometimes true ❍ Never true

Within the past 12 months, you worried whether your food would run out before you got money to buy more. ❍ Often true ❍ Sometimes true ❍ Never true

Do you have trouble paying for medicines?	❍ Yes	❍ No
Do you have trouble getting transportation to medical appointments?	❍ Yes	❍ No
Do you have trouble paying your heating or electricity bill?	❍ Yes	❍ No
Do you have trouble taking care of a child, family member or friend?	❍ Yes	❍ No
Do you have trouble with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc.?	❍ Yes	❍ No
Are you currently unemployed and looking for a job?	❍ Yes	❍ No
Are you interested in more education?	❍ Yes	❍ No

Please check "✓" the resources you want help with:

Housing / Shelter	Food	Paying for Medicine	Transport	Utilities	Childcare	Care for elder or disabled	Daily Support	Job search / training	Education
❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

❍ I do not want to answer these questions

- Utilizing the SDOH/HRSN screening allows the practice to meet HRSN screening requirements in the contract while utilizing the food insecurity questions to identify patients who may be eligible for SNAP or WIC.
- BMCHS and many practice across the WellSense network utilize the BMCHS THRIVE Screener for SDOH/HRSN screening.
- Other tools MH recommended include:
  - AHC HRSN Screening Tool
  - AAFP Social Needs Screening Tool
  - Health Leads Screening Panel
  - PRAPARE
  - WellRx Questionnaire
- MH is not mandating any specific HRSN screening tool, but the contract does require screening for specific domains.

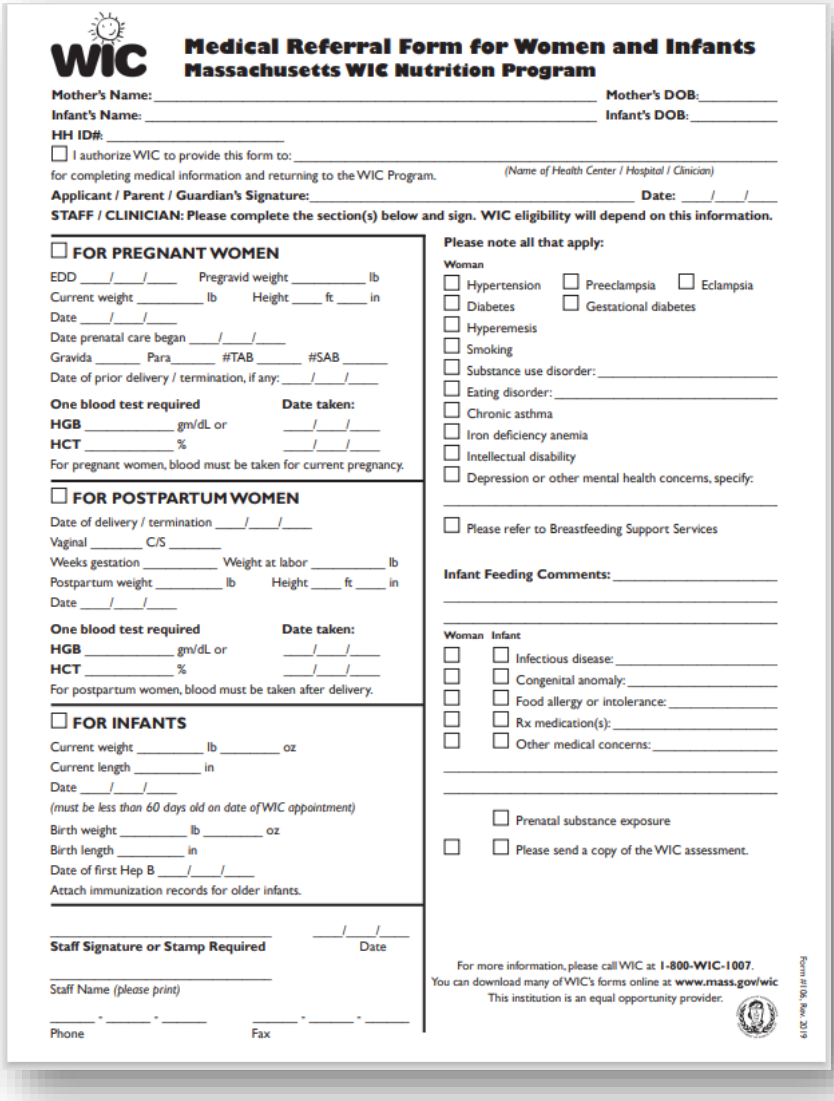
Consider adding the WIC medical referral form to the EHR to pre-populate some of the necessary data; Contact information can be added to an after visit summary

Pediatric

The medical referral forms can be added to the EHR to allow for expedited completion of the form with required data elements such as DOB, HGB, HCT, EDD.

The **after visit summary or similar patient education materials** could be pre-populated to include SNAP and WIC contact information. For example:

> ***Women, Infants & Children (WIC)*** *is a nutrition program that provides healthy foods, nutrition education, breastfeeding support, and referrals to healthcare and other services, free of charge, to Massachusetts families who qualify. If you would like to learn more, call 800-942-1007 or e-mail wicinfo.dph@massmail.state.ma.us.*
>
> ***Supplemental Nutrition Assistance Program (SNAP)*** provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency. *If you are interested in learning more, call 877-382-2363.*



WIC

Medical Referral Form for Women and Infants
Massachusetts WIC Nutrition Program

Mother's Name: _____ Mother's DOB: _____
Infant's Name: _____ Infant's DOB: _____
HH ID#: _____
☐ I authorize WIC to provide this form to: _____ (Name of Health Center / Hospital / Clinician)
for completing medical information and returning to the WIC Program.
Applicant / Parent / Guardian's Signature: _____ Date: ____/____/____
STAFF / CLINICIAN: Please complete the section(s) below and sign. WIC eligibility will depend on this information.

☐ **FOR PREGNANT WOMEN**
EDD ____/____/____ Pregravid weight _____ lb
Current weight _____ lb Height ____ ft ____ in
Date ____/____/____
Date prenatal care began ____/____/____
Gravida _____ Para _____ #TAB _____ #SAB _____
Date of prior delivery / termination, if any: ____/____/____
One blood test required **Date taken:**
HGB _____ gm/dL or ____/____/____
HCT _____ % ____/____/____
For pregnant women, blood must be taken for current pregnancy.

☐ **FOR POSTPARTUM WOMEN**
Date of delivery / termination ____/____/____
Vaginal _____ C/S _____
Weeks gestation _____ Weight at labor _____ lb
Postpartum weight _____ lb Height ____ ft ____ in
Date ____/____/____
One blood test required **Date taken:**
HGB _____ gm/dL or ____/____/____
HCT _____ % ____/____/____
For postpartum women, blood must be taken after delivery.

☐ **FOR INFANTS**
Current weight _____ lb _____ oz
Current length _____ in
Date ____/____/____
(must be less than 60 days old on date of WIC appointment)
Birth weight _____ lb _____ oz
Birth length _____ in
Date of first Hep B ____/____/____
Attach immunization records for older infants.

_____ ____/____/____
Staff Signature or Stamp Required Date
_____
Staff Name *(please print)*
___-___-___ ___-___-___
Phone Fax

Please note all that apply:
Woman
☐ Hypertension ☐ Preeclampsia ☐ Eclampsia
☐ Diabetes ☐ Gestational diabetes
☐ Hyperemesis
☐ Smoking
☐ Substance use disorder: _____
☐ Eating disorder: _____
☐ Chronic asthma
☐ Iron deficiency anemia
☐ Intellectual disability
☐ Depression or other mental health concerns, specify:
_____
☐ Please refer to Breastfeeding Support Services

Infant Feeding Comments: _____
_____
_____

Woman Infant
☐ ☐ Infectious disease: _____
☐ ☐ Congenital anomaly: _____
☐ ☐ Food allergy or intolerance: _____
☐ ☐ Rx medication(s): _____
☐ ☐ Other medical concerns: _____
_____
_____
☐ Prenatal substance exposure
☐ ☐ Please send a copy of the WIC assessment.

For more information, please call WIC at **1-800-WIC-1007**.
You can download many of WIC's forms online at **www.mass.gov/wic**
This institution is an equal opportunity provider.

Form #106, Rev. 2019

To meet tier 1 requirements, practices should refer members to additional resources to apply for SNAP and WIC

Pediatric

THRIVE Directory

- Utilize the **MASSTHRIVE Directory** to refer patients to appropriate resources.
- In addition to food and nutrition services, the MASSTHRIVE Directory also include supports for: education, financial assistance, housing and shelter, employment, caregiving, transportation, health, and legal aid.

SNAP & WIC Resources

- **SNAP:** Patients can apply for SNAP through https://dtaconnect.eohhs.mass.gov/.
  - Department of Transitional Assistance Phone: 877-382-2363
- **WIC:** Patients can verify WIC eligibility online here and complete an informational request form/application here.
  - WIC Phone: 800-942-1007
  - Email: wicinfo.dph@massmail.state.ma.us
  - Local WIC office contact information

MASSTHRIVE Massachusetts Community Resource Directory

Pediatric

Direct patients to MASSTHRIVE, our real-time community resource directory.

- Available via computer, tablet or phone at https://massthrive.org/

Resource info can be translated in >100 languages.

Implementation Strategy: SNAP & WIC Screening (Tier 1)

Pediatric

Implementation Recommendations

- Screening for SNAP and WIC is included in the ESPDT requirements in MassHealth Provider Manual Appendix W.
- Recommend utilizing the SDOH/HRSN screening tool food domain to screen patients for SNAP or WIC.
- Add medical referral forms to the EHR to ease the burden to the provider and member of manually completing the data.
- Add referral resources to an after visit summary or patient educational handout so the patient is aware of where and how they can engage additional resources to follow through.

Operational Considerations

- Virtual offering: Determine if your practice will choose to offer screening virtually. This is not a requirement, but is an option and should be considered if virtual pediatric preventative visits are offered.
- On-site offering: Identify a workflow for screening within the practice (e.g. HRSN screening question for food insecurity).
- Staffing: Decide who will perform the screening and at what point during the clinic visit that screening will occur.
- Documentation:
  - Determine how a positive screening will be flagged for additional support to SNAP and/or WIC.
  - Consider adding a template of referral resources to the EHR, which may be in the form of a letter, after visit summary, or other means used by your EHR to share patient education materials.
  - Consider adding the medical referral forms to the EHR to ease the burden of completion. These forms may be automatically populated with relevant data from the EHR.

Support & Resources

- Massachusetts SNAP Office
- Massachusetts WIC Medical Referral Forms
- Appendix W of the MassHealth Provider Manual

Fluoride varnish for pts 6 months to 6 years of age (Tier 1)

Pediatric

Requirement	Population	Description
Fluoride Varnish	Pediatric Population	Assess the need for fluoride varnish at all preventive visits from six (6) months to six (6) years old, and once teeth are present, must provide application of fluoride varnish on-site in the primary care office **at least twice per year** for all children, starting when the first tooth erupts and until the patient has another reliable source of dental care. For those pediatric patients who do not have a dental home, the practice must share a list of MassHealth dental providers with the parent/caregiver as noted below. (https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary) If there is a co-located dental office or evidence that the dental office has already provided this service, such may substitute in this requirement for the relevant patients who have access to or have accessed these resources. Enrollees must be able to access this fluoride varnish on-site.

Suggested Audit Documentation

- Documented workflow/process map for applying varnish (e.g. how to know a patient is due, who applies the varnish, education materials provided to patient, etc.)
- Evidence of EHR documentation showing the fluoride application
- Report showing patients who had fluoride applied
- Evidence of the list of MH dental providers that is shared with patients, how often it is updated

Establishing and Utilizing Fluoride Varnish In Your Office

Pediatric

Step 1: Schedule a meeting with clinic staff

- Explain fluoride varnish program
- Explain how using fluoride varnish will be beneficial to a child's oral health
- Explain the ease of doing a fluoride varnish application
- Fluoride Varnish is a MassHealth reimbursable service
- Encourage staff directly involved in patient care to take one of the training

Step 2: Select an Oral Health Office Champion

- Download the "Fluoride Varnish Training Manual for Massachusetts Health Care Professionals^"
- For Paper Medical Records: Print the "Fluoride Varnish Progress Note"(Appendix – Slide)
- For Electronic Health Record: Have the IT add "Fluoride Varnish Progress Note" to your EHR
- Order fluoride varnish through your local distributor – **0.25 ml** unidose for children under 6 and **0.4 ml** unidose for children 6 and older

Step 3: Add Billing Code to Your EHR

- Well Child Visit – Bill using **CPT service code 99188*** AND **ICD-10 code Z00.129**: **"Routine Child Health Check"**
- Any other visit – Bill using **CPT service code 99188*** AND **ICD-10 code Z41.8**: **"Need for Prophylactic Fluoride Administration"**
- Varnish application is billable for all children aged 6 months to 21 years
- **Reimbursement** is currently **$26** and **can be billed four times a year**
- Varnish application at a dentist's office is billed and administered separately and does not affect eligibility for varnish application during a medical visit either clinically or administratively

*CPT code 99188 in not included in the PC subcap list and it will be paid as fee for service

Establishing and Utilizing Fluoride Varnish In Your Office

Pediatric

Who Can Apply Fluoride Varnish in MA	▪ MD ▪ PA ▪ NP ▪ RN ▪ LPN ▪ MA
Create a portable Fluoride Varnish Basket	▪ Patient Handouts ▪ Fluoride Varnish ▪ Progress Notes ▪ Gloves ▪ Gauze
Divide the Process	▪ Example: – MA reviews risk assessment and gets materials ready – MA or nurse applies varnish – Provider or RN reviews handouts with patient and provides prevention advice
Test Cases	▪ Do a few test cases to assess – Flow – Billing – Patient Satisfaction – Staff Satisfaction
Advertise	▪ Advertise in your waiting room, office newsletters, and website about fluoride varnish service
Recommendations	▪ American Academy of Pediatric Dentistry recommends that physicians refer patients to the dentist six months after the first tooth erupts and no later than 12 months of age ▪ Create a list of local dentists that accept MassHealth (Call 1-800-207-5019 or visit www.masshealth-dental.net for a list)

*Source: From the First Tooth, https://www.fromthefirsttooth.org/by-state/massachusetts/reimbursement-information/

Implementation Strategy: Fluoride Varnish Application

Pediatric

Implementation Strategy

In-Office

- Supplies: Varnish, gauze, gloves routinely stocked in exam rooms
- Designated team member (MA, LPN, RN, MD, PA, NP) provides varnish at visit close
- Positioning for varnish application:
  - Lap-to-lap for children <5
  - Facing child for older patients
- Educational handout available for caregivers with aftercare instructions
- Patient has option to refuse

Operational Considerations

- Integration of oral health screening
- Technician comfort with fluoride varnish application (in-office screening)
- Standardized EHR template/note to ensure documentation and billing and recurrence.

Resources & Supports*

- MassHealth: Dental Provider Finder
- MassHealth patient education one-pager (can be found on Box or MoveIt)
- DentaQuest

*These are available in appendix

Fluoride Varnish Progress Notes (Template 1)

Pediatric

- The Fluoride Varnish Progress Notes should contain the following information:
  - Oral Health Examination
  - Documentation of findings and application of fluoride varnish
- Sample of patient stamp:

Dental visit in last 6 months	Yes/No
Fluoride Rx given	Yes/No
Fluoride varnish applied	Yes/No
Oral Hygiene instruction	Yes/No
Dental referral done	Yes/No

Name of patient _____ DOB _____ MRN _____

Procedure Documentation

□ Child was positioned for varnish application. Teeth were dried. Varnish was applied.

Post-Procedure Documentation

□ Fluoride varnish handout provided

□ Caries prevention handout reviewed/provided or risk prevention discussed

_____ _____

Name, Title, and Signature of Varnish Provider Date/Time

_____ _____

Name and Signature of Supervising Physician Date/Time

□ I have reviewed risk assessment and have overseen application of fluoride varnish.

Fluoride Varnish Progress Notes (Template 2)

Pediatric

- The Fluoride Varnish Progress Notes should contain the following information:
  - Oral Health Examination
  - Documentation of findings and application of fluoride varnish
- Sample of patient stamp:

Caries or defects	Yes/No
Dental visit in last 6 months	Yes/No
Systemic Fluoride assessed	Yes/No
Fluoride Rx given	Yes/No
Fluoride varnish applied	Yes/No
Oral Hygiene instruction	Yes/No
Dental referral done	Yes/No

Name of patient _____ DOB _____ MRN _____

Oral Examination

□ Caries (including white or brown spots) or enamel defects present

□ Plaque present on teeth

Procedure Documentation

□ Child was positioned for varnish application. Teeth were dried. Varnish was applied.

Post-Procedure Documentation

□ Fluoride varnish handout provided

□ Caries prevention handout reviewed/provided or risk prevention discussed

_____ _____

Name, Title, and Signature of Varnish Provider Date/Time

_____ _____

Name and Signature of Supervising Physician Date/Time

□ I have reviewed risk assessment and have overseen application of fluoride varnish.