DRAFT – April 18, 2023	
Target Population	**Required Activities**
0-6 Months	- Screening for familial social needs (food, housing, finances/employment, Utilities, Interpersonal Violence, and maternal depression) per periodicity schedule - Same visit intervention for positive screens - Warm hand off to additional services
6-12 Months	- Screening for familial MH and SDOH needs, frequency TBD - CHT Follow up for positive screens - Referral to additional services
1 year – 3 years	- Screening for familial SDOH needs, frequency TBD - CHT follow up for positive screens - Referral to additional services
4 years – 11 years	SCREENING REQUIREMENTS - Familial SDOH Screening, frequency TBD - 4 years – AAP recommends general screening tool (e.g. Pediatric Symptom Checklist-17 or Strengths and Difficulties Questionnaire) - Child mental health screening (anxiety screening recommended starting at age 8, depression at age 12) - SU screen at age 11 - Suicide screen when clinically indicated for 8-11 INTERVENTION REQUIREMENTS - CHT follow up for positive screens - Ensure follow up within 30 days after discharge from ED and hospital for Mental Health (measure includes ages 6 -17, Vermont Medicaid and CHIP populations have highest rate in nation at 88.1% in 2020) REFERRAL REQUIREMENTS – Practice will have protocols and/or agreements in place for pediatric MH consultation, co-management, higher level of care access
12-17 years	SCREENING REQUIREMENTS – Frequency TBD (Adolescent Well Care Visit and Pre-participation Physical Evaluation) - Adolescent MH Screening - Universal Suicide Screening - Adolescent SUD Screening - Adolescent SDOH Screening INTERVENTION REQUIREMENTS - CHT follow up for positive screens - Spoke staffing for further assessment of Treatment Needs - Ensure follow up after ED and Hospitalization for MH and SUD within 30 days - Initiation and Engagement of treatment 1. Opioid, 2. Alcohol, 3. Other substance.

	REFERRAL REQUIREMENTS – Practice will have protocols and/or agreements in place for adolescent MH/SUD consultation, co-management, higher level of care access
18 years +	SCREENING REQUIREMENTS SUD Screening at annual well visits – Alcohol, Opioids, Tobacco, Other Substances Mental Health Screening for Depression and Suicide at Every ~~Visit~~ Suicide Screening – frequency TBD Screening for Anxiety – Frequency TBD SDOH Screening for SDOH – frequency TBD ASSESSMENT Further assessment of Mental Health Treatment and SUD Treatment Needs INTERVENTION REQUIREMENTS – Stepped care protocols in place for practice to ensure: **When MH needs exist, CHT supports the following Interventions.** ◦ Teaching Self management skills ◦ Providing time limited Low Intensity Services (address social supports and situational stressors) ◦ Providing time limited Moderate Intensity Services (peer supports and lifestyle interventions) ◦ Referral for High Intensity Services (Psychosocial support and community supports such as peer support, social participation or lifestyle interventions) ◦ Referral to Acute/Specialist Community Level Services (Intensive team-based specialist assessment and intervention) **Patients discharged from hospital will be followed up in 30 days -** ◦ Provide treatment plan continuity ◦ Address new or changed physical health, mental health (anxiety, depression, PTSD), substance use, and physical function needs resulting from hospitalization ◦ Set up preventative/chronic care appointments **Stepped Care (post discharge from residential or intensive outpatient treatment)** ◦ Provide treatment plan continuity ◦ Support social adjustment (finances/employment, housing, food security, safety, general health status, relationships, recreational and social activities) **When SUD needs exist, CHT will support the following:**

	◦ Create individualized care plans/provide and coordinate care. ◦ Motivational Interviewing ◦ Brief behavioral change counseling ◦ Behavioral therapy ◦ Referral management/follow up/support ◦ Ref to spoke CHT for further assessment **Post Acute Episode Follow Up (post hospitalization follow up)** ◦ Provide treatment plan continuity ◦ Address new or changed physical health, mental health (anxiety, depression, PTSD), and physical function needs resulting from hospitalization ◦ Set up preventative/chronic care appointments **Stepped Care (post discharge from residential or intensive outpatient treatment)** ◦ Provide treatment plan continuity ◦ Support social adjustment (finances/employment, housing, food security, safety, general health status, relationships, recreational and social activities) **Continuous Care (long term relationship with PCMH)** ◦ Addressing Relapse Risks ◦ Providing support for co-occurring issues and needs ◦ Medication Adherence ◦ Harm Reduction ◦ Self-management REFERRAL REQUIREMENTS – Practice will have protocols and/or agreements in place for MH/SUD consultation, co-management, higher level of care access

AND/OR, based on NCQA Standards for Behavioral Health Integration:

Practice must demonstrate that they have:

- At least one care manager, clinical social worker, or MH/SUD clinician qualified to identify and coordinate mental health and substance use needs (may conduct duties via telehealth)
- Plan for providing resources and training for the care team to enhance its capacity to address mental health needs of patients using: skill development and support systems for care team members, clinical protocols to determine when to contact a consulting specialist to advice on cases, training to conduct screening and brief interventions for alcohol (ages 12+)
- Training to conduct screening and brief interventions for depression (12+)
- Training on when to access a clinician for medication assisted treatment (adult practices)
- Demonstrate use of validated screening tools (such as the AUDIT, DAST, BAGE, CRAFFT, PHQ-2 or 9, etc)

- Have at least one clinician located in the practice who can directly provide brief interventions on an urgent basis for patients identified with a mental health condition (can be CHT or other clinician)
- Have at least one clinician located in the practice who can support Medicated Assisted Treatment and provide therapy directly, or via referral, for substance use disorders
- Works with MH and SUD providers to whom the practice frequently refers, to set expectations for info sharing and patient care
- *Has a formal agreement/consultative relationship with a licensed MH or SUD provider or practice group that acts as a resource for patient treatment, referral guidance, and medication management*
- Tracks referrals to CHT and external MH/SUD providers and has a process to monitor the timeliness of referral response

References:

AAP Recommendations for Preventive Pediatric Health Care /Bright Futures

periodicity_schedule.pdf (aap.org)

US Preventive Services Task Force Recommendations for Pediatric Mental Health and Suicide Screening

https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/screening-anxiety-depression-suicide-risk-final-rec-bulletin.pdf

AAP Screening for Suicide Risk

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/

Integrating Mental Health Treatment into the Patient Centered Medical Home

https://medschool.lsuhsc.edu/pediatrics/docs/Integrating%20Mental%20Health%20Treatment%20into%20the%20Patient%20Centered%20Medical%20Home.pdf

Substance Use Disorders and the Patient Centered Healthcare Home

https://www.thenationalcouncil.org/wp-content/uploads/2020/01/National_Council_SU_Report.pdf?daf=375ateTbd56

Mental Health, Substance Abuse, and Health Behavior Services in Patient-Centered Medical Homes

https://www.aafp.org/dam/AAFP/documents/patient_care/nrn/kessler-mental-health-pcmh.pdf

NCQA Distinction in Behavioral Health Integration

06. PCMH Recognition_Appendix 4_Distinction in Behavioral Health Integration_9.30.pdf (tnpcaeducation.org)