

Department of Vermont Health Access Blueprint for Health

Women's Health Initiative Implementation Guide and Toolkit

Update 04/21/2021

Women's Health Providers, Practice Staff and Blueprint Program Managers,

We created this guide and toolkit in order to further support the efforts toward building a network of support for women's health and increasing the rate of pregnancy intention. Thank you for your daily commitment to improving quality of life for Vermonters.

If you have any feedback on the guide and toolkit, please let us know. We hope you find this information helpful.

Sincerely,

Julie Parker, LCMHC

Assistant Director, Blueprint for Health

Julie.parker@vermont.gov

Table of Contents

Program Overview	5
WHY: Healthier Women, Children, and Families	5
WHAT: Women Experience Enhanced Screening, Connections, Family Planning Options	5
HOW: Multi-Disciplinary Expert Support, Community Implementation	5
Current WHI Practices:.....	5
Anticipated Program Impact.....	6
One Key Question	6
Same-day Long Acting Reversible Contraception (LARC) Placement	6
Formal Co-management and Referral Protocols Between the Participating Practice and Community-based Organizations.....	6
Screening, Brief Intervention, and Navigation to Services	6
Vermont Blueprint for Health Program Managers /QI Facilitators/Central staff.....	7
Becoming a Women’s Health Initiative Practice.....	7
LARC Skills Based Training.....	7
Expectations of Participating Practices.....	8
Expectations of Blueprint Central Staff and Program Managers.....	9
Women’s Health Initiative Payments	9
WHI Requirements: Strategies for Success.....	9
Incorporate the Local Community Health Team (CHT) into the Practice	10
Connect EMR to the Vermont HIE and the Vermont Clinical Registry.....	11
Implement Continuous Quality Improvement.....	11
Provide Family Planning Counseling	12
Stock LARC	14
Offer Same Day LARC Insertion.....	15
Screening for Mental Health, Substance Abuse, Inter-Partner Violence, and other Social Determinants of Health	15
Develop Referral Networks for Women’s Health Services and Primary Care	16
Women’s Health Services	16
Primary Care.....	17
Attachment A Sample Job Descriptions.....	18
Attachment B Sample Referral Agreements.....	21
Community Organizations	21
Primary Care	22

Attachment C Screening Tool for Mental Health, Substance Abuse, Inter-Partner Violence, and other Social Determinants of Health 23

Attachment D Sample Screening Workflow 29

Attachment E Links to Resources..... 32

Program Overview

The Women's Health Initiative helps ensure that women's health providers, primary care practices, and community partners have the resources they need to help women be well by supporting healthy pregnancies, avoiding unintended pregnancies, and building thriving families through enhanced screenings, brief in-office interventions, comprehensive family planning counseling and referrals to services for mental health and substance use disorders, interpersonal violence, food insecurity, housing instability and trauma once identified.

WHY: Healthier Women, Children, and Families

Currently in Vermont, an estimated 50% of all pregnancies are unintended. Unintended pregnancies are associated with an increased risk of poor health outcomes for mothers and babies and long-term negative consequences for the health and wellbeing of the children and adults those babies become. By helping to ensure that more pregnancies are intentional, health care providers and community partners can support women and their families to have healthier lives.

WHAT: Women Experience Enhanced Screening, Connections, Family Planning Options

The Women's Health Initiative is focused on strengthening relationships between medical practices and community organizations to provide seamless care. Women who visit participating medical providers – OB- GYN offices, midwifery practices, family planning clinics, and primary care practices – engage in comprehensive family planning counseling and psychosocial screening to assess mental health, substance use, interpersonal safety, and access to food and housing. Women identified by screening at participating providers are immediately connected to an initiative-funded social worker and/or are referred for more intensive treatment or services in the community as needed. Participating community organizations, essential for ensuring seamless care, also provide screening and comprehensive family planning counseling and connect identified women to primary care and women's health providers. Women who wish to become pregnant receive pre- conception counseling and services. Those who tell their providers they do not want to have a baby in the coming year have access to all contraception options, including immediate access to LARC. Newly developed referral relationships, protocols, and workflows support more timely access to care.

HOW: Multi-Disciplinary Expert Support, Community Implementation

Support technical assistance for providers and staff from practices and community organizations in the screening model, referral processes, LARC insertion, and more. Each participating community builds a network to include the participating medical practices and community organizations; local networks develop formal referral relationships that allow access to necessary services in order to improve health outcomes for women in their community.

Current WHI Practices:

[Link to online source.](#) Hasn't been developed yet

Anticipated Program Impact

One Key Question

Unintended pregnancy is a decades-old community health problem that has negative consequences for the health and well-being of the mother and infant. Introducing One Key Question® into a health center or practice helps to achieve the ‘triple aim’ of health care transformation: improved patient experience, improved health, and lower cost. This non-judgmental question brings pregnancy intention screening directly into primary care and opens the door to providing preconception and/or contraceptive care in a patient-centric way. It goes beyond simply asking if a patient is using contraception and starts a conversation that allows women to answer honestly about their reproductive goals.

Health care providers are busier than ever today, and many are initially concerned about asking a question that might take too much time and resources to address. What clinicians do find, however, is that One Key Question® actually helps them to effectively identify women who really need preventive reproductive health care. For example: among women who are undecided about pregnancy, intention screening can identify urgent health needs that may otherwise go undetected, such as depression, violence in the home or substance abuse, which may be underlying factors to the indecision and can lead to negative pregnancy outcomes.¹

Same-day Long Acting Reversible Contraception (LARC) Placement

Research in the state of Indiana published in 2019 showed that Same-day LARC placement was associated with lower overall costs (\$2016 per patient over 1 year) compared with LARC placement at a subsequent visit (\$4133 per patient over 1 year). Compared with the return-visit strategy, same-day LARC was associated with an unintended pregnancy rate of 14% vs 48% and an abortion rate of 4% vs 14%.²

Formal Co-management and Referral Protocols Between the Participating Practice and Community-based Organizations

By establishing referral relationships, making formal connections, supporting patients in getting needed care and information, and being accountable via staff roles, workflows, and information systems, practices help patients get the services they need when they need them. They also ensure that providers get the information they need when they need it—at the lowest cost to the patient and the health system. These changes are important steps toward improving patient outcomes while the work becomes more efficient and less stressful.³

Screening, Brief Intervention, and Navigation to Services

With support from the Blueprint for Health, WHI practices agree to implement enhanced psychosocial screenings and provide brief in-office interventions and initiate referrals to services and supports for mental health and substance use disorders, interpersonal violence, housing instability, food insecurity and trauma. This ensures that women who are identified with mental health or substance use disorder or health-related social needs are connected immediately with a clinician for treatment or services as

¹ <http://www.pccci.org/blog/achieving-triple-aim-through-integration-preventive-reproductive-health-care>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6739899/#:~:text=Results,LARC%20on%20the%20day%20requested.>

³ <http://www.improvingprimarycare.org/work/referral-management>

needed.

The goal is not to provide long-term therapeutic treatment, rather brief intervention and referral to services as needed.

Vermont Blueprint for Health Program Managers /QI Facilitators/Central staff

The state-level Blueprint team is a unit within the Department of Vermont Health Access and collaborates with the Department's payment reform, quality, and clinical units. As part of the Agency of Human Services' leadership group, the Blueprint is positioned to contribute to both health and human services reforms.

The Blueprint Transformation Network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators work with ACO and community-based partners to lead the implementation of these innovations in practices and communities across Vermont.

Each Administrative Entity hires a Blueprint Program Manager to oversee the Blueprint activities in an HSA. The Program Manager will be the primary local contact responsible for management of all programmatic and administrative components of the agreement, including the Women's Health Initiative (WHI). They will be in contact with all WHI practices on an at least quarterly basis to coordinate hiring and deployment of WHI staff and to support quality improvement projects to improve care and patient outcomes. The Program Manager will also collaborate with local leadership to encourage the recruitment of additional practices to join the WHI.

<https://blueprintforhealth.vermont.gov/contact-us>

Becoming a Women's Health Initiative Practice

Women's Health Initiative (WHI) practices attest to implementing and maintaining the WHI strategies and receive WHI payments. Eligible medical practices or clinics include:

- gynecology, maternal-fetal medicine, obstetric, reproductive health, or family planning medical practices, specializing in providing women's health preventive services as defined by the American Congress of Obstetricians and Gynecologists (ACOG);
- mixed practices or clinics that employ at least one board-certified obstetric or gynecology provider whose primary scope of practice is women's preventive services as defined by ACOG; and
- existing Blueprint for Health Patient-centered Medical Homes

Becoming a WHI practice is relatively simple. To begin the process, contact the regional HSA Program Manager or QI Facilitator <https://blueprintforhealth.vermont.gov/contact-us>

LARC Skills Based Training

Participating WHI providers are offered a free CME/CEU-accredited LARC insertion training. A typical training agenda includes:

- IUD Clinical Recommendations, Contraindications, Insertions, and Removals (didactic) (IUDs: Mirena, Kyleena, Liletta, Skyla, Paragard)
- IUD Insertion and Removal Practice with VirtaMed GynoS™ Simulation Model

- MERCK FDA – Approved Nexplanon Training

Expectations of Participating Practices

Participating practices sign and submit a [Women’s Health Initiative attestation form](#). The attestation form clearly describes the expectations for participating practices and the expected time frames for adoption and implementation. A participating practice agrees to:

- **Incorporate Community Health Team (CHT) member into the practice.**
 - **Blueprint PCMH practices** will incorporate their Community Health Team member in support of WHI goals and strategies.
 - **Specialty clinics** will work with their Blueprint Program Manager to hire a behavioral health specialist who will be incorporated into the practice in support of WHI goals and strategies.
- When available through the State-appropriated vendor, **connect the practice’s electronic medical record to the Vermont Health Information Exchange and the clinical data warehouse at Vermont Information Technology Leaders (VITL)** to allow clinical data to be collected, analyzed, and utilized in performance measurement and performance payment calculations.
- **Implement continuous quality improvement** into the practice, including tracking WHI practice data and conducting regular analysis to identify opportunities for interventions and improved outcomes.
- **Submit Staffing and Practice Demographics Reports** each quarter, prior to the fifteenth (15th) day of the first month of each calendar quarter (January, April, July, and October), the BP Project Manager or designee shall enter and update WHI staffing and practice demographics information.
- **Execute and maintain the following services** within the designated timeframes as laid out by the State. At any time, the practice may be audited by the State and will provide proof as defined by the Blueprint for Health Implementation Manual that the services are consistently implemented.
 - **Provide Family Planning Counseling:** The WHI practice will update and/or implement a policy and procedure for evidence-based, comprehensive family planning counseling including implementing “One Key Question.”
 - **Stock LARC:** The WHI practice will stock the full spectrum of LARC devices at a level adequate for the practice size to ensure the availability of same-day insertions for women who choose LARC as their preferred birth control method.
WHI practices that receive payment for more than two IUDs of each type and the one implant have the flexibility to choose among the available options to fulfill the needs of their patients after stocking the minimum requirement.
 - **Offer Same Day LARC Insertion:** The WHI practice will develop and implement a policy and procedures to provide same-day insertion for those women who choose LARC as their preferred birth control method.
 - **Screening for Mental Health, Substance Abuse, Inter-Partner Violence, and other Social Determinants of Health:** The WHI practice will develop and implement policies and procedures for screening, brief intervention (as appropriate), and referral for One Key Question, depression, intimate partner violence, substance abuse, food insecurity, housing insecurity and access to primary care provider/PCMH. Screenings should be conducted minimally at the initial visit, annually, and post-partum.
 - **Develop Referral Networks for Women’s Health Services:** The WHI practice will develop referral protocols and written agreements with at least three (3) community-based organizations to see

patients within one (1) week of being referred for family planning services. At that visit, the WHI practice will provide same-day availability for the full spectrum of birth control options, including LARC devices.

- **Develop Referral Networks for Primary Care:** The WHI practice will develop a referral protocol and written agreement with at least one (1) patient-centered medical home (PCMH) primary care practice to accept patients identified as not having a primary care provider.

Expectations of Blueprint Central Staff and Program Managers

All Blueprint Central Staff and Program Managers support WHI practices with the following:

- Organization and delivery of training and learning events.
- Flow of Medicaid funding consistent with active caseloads for WHI staffing.
- Data and analytics. The latest WHI profiles can be found [here](#).
- Assistance in hiring and organizing WHI staff in each participating practice.
- Support with technical assistance needs of the practices.
- Quality Improvement (QI) facilitation to implement new workflows.
- Participation in monthly Program Manager conference calls
- Facilitation of regular WHI CHT technical assistance / peer-to-peer learning calls

Women's Health Initiative Payments

WHI practices shall receive three (3) Blueprint-specific forms of payment from WHI participating insurers or payers, to support the provision of high-quality women's health primary care and well-coordinated preventive women's health services for women ages 15 – 44. Payments include:

1. Recurring per member per month (PMPM) payments to WHI practices
2. Recurring payments to support WHI Community Health Team (CHT) staff to the CHT administrative entities (*This payment applies to WHI Specialty Clinics Only. BP PCMH practices have existing CHT staff*)
3. A one-time per member payment (PMP) to support stocking of Long Acting Reversible Contraceptive (LARC) devices to WHI practices.

Payment details can be found in the Blueprint for Health Manual
<https://blueprintforhealth.vermont.gov/implementation-materials>

WHI Requirements: Strategies for Success

The following guidelines, strategies, resources and measures of success are compiled to help WHI practices comply with attestation expectations and more importantly successfully meet the shared goals of the WHI. This section of the Guide is intended to evolve over time as new ideas and resources are surfaced.

Incorporate the Local Community Health Team (CHT) into the Practice



| **Documentation:** 1. Job Description 2. Workflows |

Each of Vermont’s Health Service Areas designs a Community Health Team to meet the needs of the local population. The Community Health Team services may include:

- Patient-centered medical home patient population / panel management and outreach
- Individual care coordination
- Brief counseling and referral to more intensive mental health care as needed.
- Substance use disorder treatment support
- Condition-specific wellness education

WHI practices incorporate the newly hired or existing local CHT into their practice by developing workflows that include referral / warm hand off protocols from providers to CHT staff members. The CHT staff member supplements the services otherwise available in the practice and links patients with social and economic services.

Blueprint for Health PCMH practices that are part of the WHI will already be receiving funds to support CHT staff in the practice.

Depending on the number of attributed patients, WHI women’s specialty practices will have a minimum of one .5 FTE CHT licensed, Master’s prepared mental health professional designated to support the practice. CHT payments for that position will be made to the local Blueprint Administrative Entity. See [the Blueprint for Health Manual](#) for more details.

Best Practices in Behavioral Health (BH) Integration

While not all BH needs can be provided within the practice, having a BH specialist on site at least part time is a key aspect of the WHI. The National Committee for Quality Assurance (NCQA) outlines overarching elements for best practice in behavioral health integration, with the intent to enhance the care provided in a primary care setting to improve access, clinical outcomes and patient experience.

1. **Behavioral Health Workforce.** The practice incorporates behavioral health providers at the site, utilizes behavioral health providers outside the practice and trains the care team to address patients’ mental health and substance use concerns.
2. **Information Sharing.** The practice shares patient information within and outside of the practice to support an integrated/coordinated patient treatment plan.
3. **Evidence-Based Care.** The practice uses evidence-based protocols to identify and address patients’ behavioral health needs.

4. **Measuring and Monitoring.** The practice utilizes quality measures to monitor the care of patients with behavioral health needs.

<https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/distinction-in-behavioral-health-integration/>

[Attachment A Sample Job Description](#)

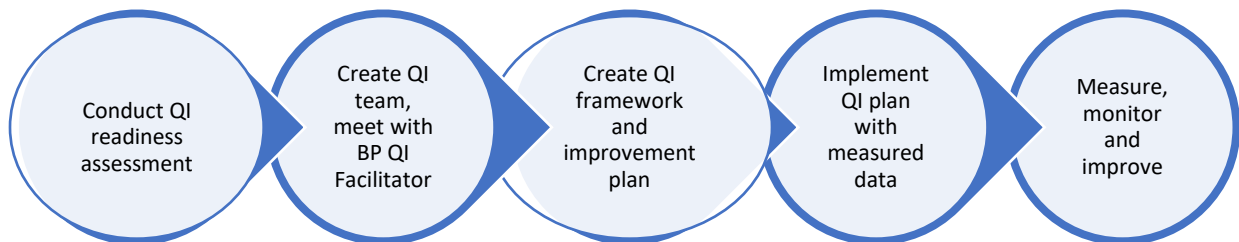
Connect EMR to the Vermont HIE and the Vermont Clinical Registry

| **Documentation:** Email confirmation from VITL that the practice EMR has been connected |

The participating practice, when available through the State-appropriated vendor, shall connect the practice’s electronic medical record to the Vermont Health Information Exchange and the Vermont Clinical Registry to allow clinical data to be collected, analyzed, and utilized in performance measurement and performance payment calculations.

Practices that are not yet connected are encouraged to reach out to Vermont Information Technology Leaders (vitl.net) or join Electronic Medical Records user groups in the state to explore opportunities for improved data sharing that will contribute to statewide quality improvement activities.

Implement Continuous Quality Improvement



| **Documentation:** 1. Written Quality Improvement policy/workflow 2. QI Reports to include issue(s) identified, intervention, and outcomes |

Blueprint Central and Regional Quality Improvement Facilitators can help with the design and structure of the practices’ QI efforts. The QI process is grounded in the following basic concepts:

Establish a culture of quality in your practice. This looks different for every practice, but may include establishing dedicated QI teams, holding regular QI meetings, or creating policies around your QI goals.

Determine and prioritize potential areas for improvement. Identify and understand the ways in which your practice could improve.

Collect and analyze data. Your data will help you understand how well your systems work, identify potential areas for improvement, set measurable goals, and monitor the effectiveness of change.

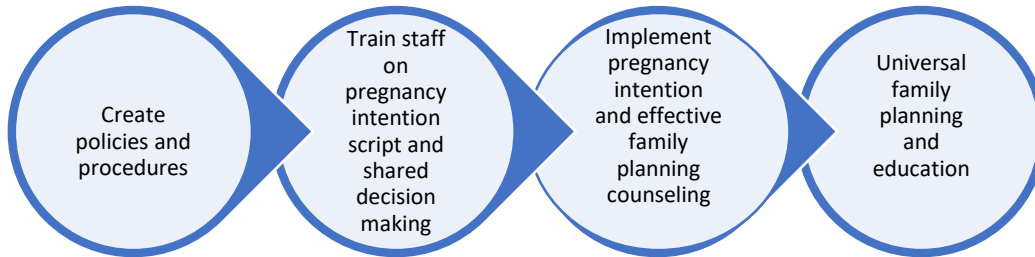
Communicate your results. Include the entire practice team and patients when planning and implementing QI projects, and communicate your project needs, priorities, actions, and results to everyone (patients included).

Commit to ongoing evaluation. A high-functioning practice will strive to continually improve performance, revisit the effectiveness of interventions, and regularly solicit patient and staff feedback.

Spread your successes. Share lessons learned with others

<https://www.aafp.org/practice-management/improvement/basics.html>

Provide Family Planning Counseling



| **Documentation:** Written policy/workflows |

One Key Question®

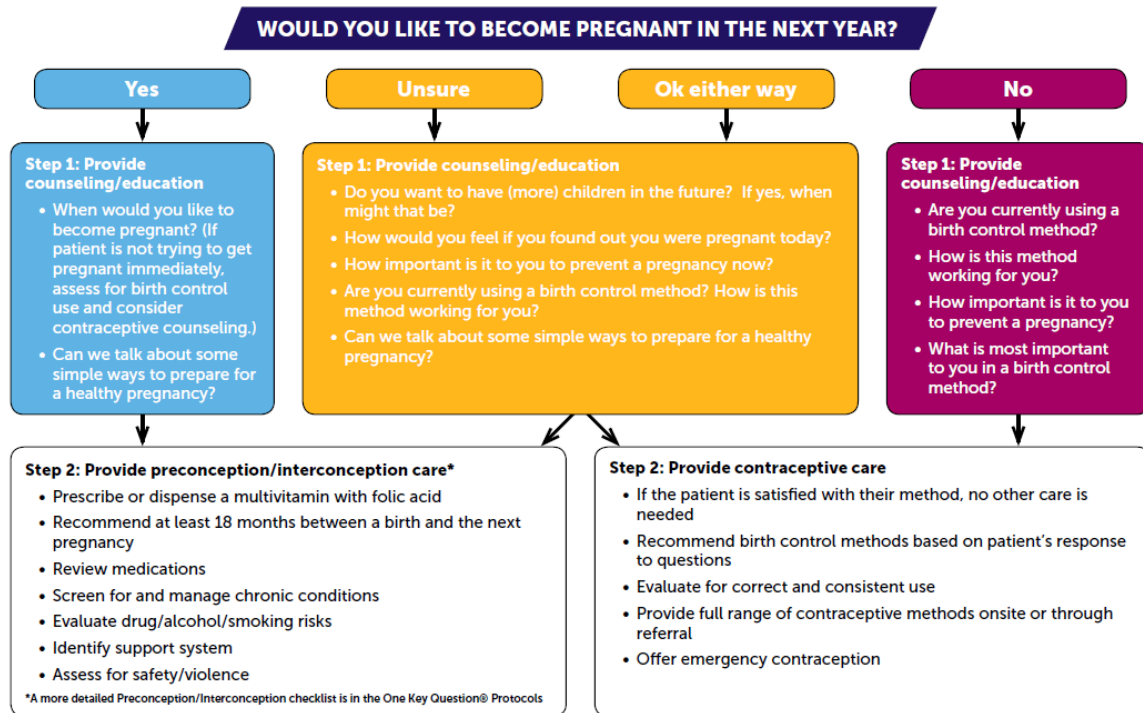
One Key Question® is a transformative tool that starts the conversation about if, when, and under what circumstances women want to get pregnant and have a child. The notion behind One Key Question® is simple: it provides a framework for health providers, social service providers, and champions to routinely ask, "Would you like to become pregnant in the next year?"

While it's a simple question, the answers are more complex. One Key Question® meets women where they are by offering four responses: yes, no, ok either way, and unsure. Follow up counseling is patient-centered and tailored appropriately based on a women's desire for or ambivalence about pregnancy.

One Key Question® is used by thousands of health care and social service providers in approximately 30 states. One Key Question® providers include clinicians, community health workers, and home visiting nurses among others. Large health systems, state and local public health departments, and others have all adopted One Key Question® to address a myriad of health equity efforts, including perinatal equity and maternal child health. <https://powertodecide.org/one-key-question>

CLINICAL ALGORITHM

This algorithm is for providers in a clinical setting who provide counseling and clinical services related to preconception, interconception, and/or contraception care. When you are unable to provide all clinical services onsite, refer patients for care.



Copyright © 2019 Power to Decide All Rights Reserved

ONE KEY QUESTION® TRAILBLAZER POWER TO DECIDE

10 Best Practices in Contraceptive Counseling

#1 Demonstrate the “key three” attributes of an effective counselor –trustworthiness, expertise, and accessibility (TEA)

#2 Use active as opposed to passive learning strategies to engage the patient in learning and remembering important points

#3 Ask about pregnancy plans and offer resources

#4 Simplify choice process

#5 Make a plan for accurate use

#6 Make a plan for side effects

#7 Address lifestyle and broader context (POISE)

#8 Make a plan for method switching

#9 Talk about condoms for STI protection

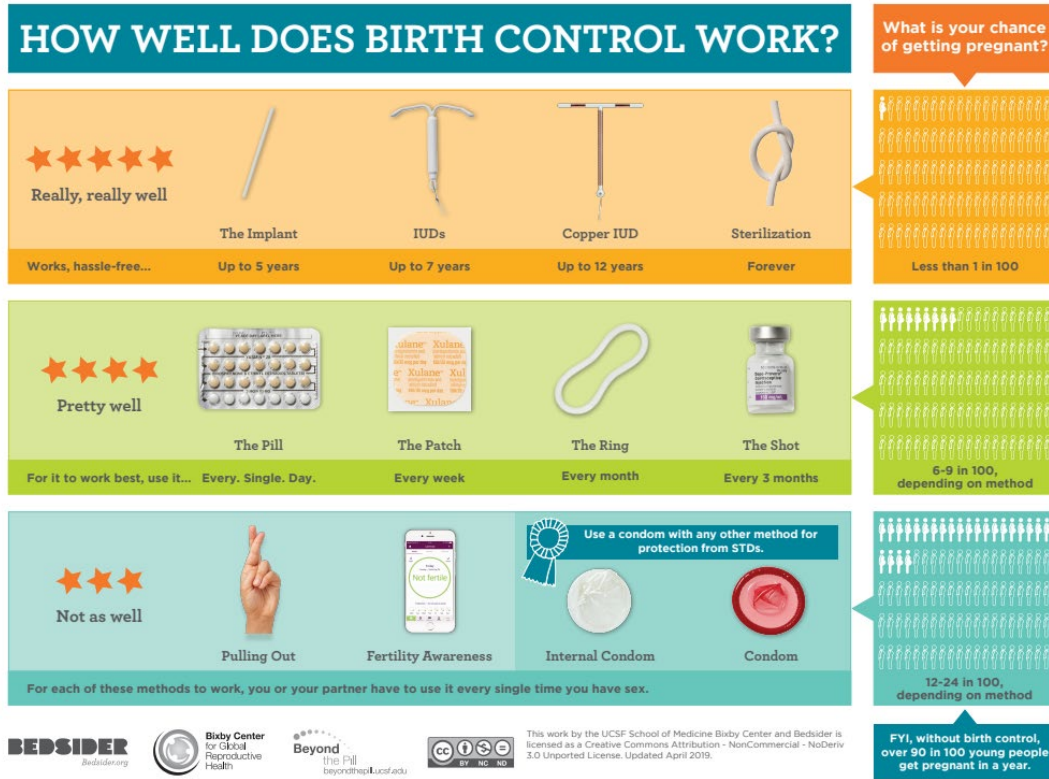
#10 Mention use of quick start

<http://www.nnepqin.org/wp-content/uploads/2018/08/14a.-NNEPQIN-Chapter-10-Best-Practices-in-Contraceptive-Counseling-6.1.18-1.pdf>

Bedsider

Free tools and materials reduce no-show rates and increase the overall quality of a patient’s visit. “From the staff at Power to Decide who work on Bedsider to the medical advisors and partners

who help us, we believe that family planning can improve the lives and future prospects of children and families.” <https://providers.bedsider.org/>



Stock LARC

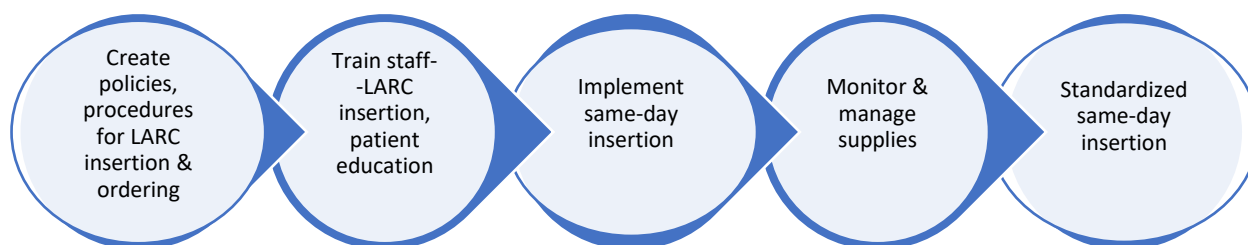
| **Documentation:** Practice attestation of adequate stock of LARC. Blueprint staff may conduct an audit |

The minimum number of stocked LARC devices shall be proportional to the number of patients served by the practice, as outlined in the table below:

Number of WHI Patients	Minimum Number of Devices
up to 300	at least 5 devices, including 2 of hormonal IUD, 2 non-hormonal IUD, and 1 implant
300-499	at least 6 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
500-699	at least 9 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
700-799	at least 12 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
800-999	at least 15 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1000-1199	at least 18 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant

Number of WHI Patients	Minimum Number of Devices
1200-1299	at least 21 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant
1300 or greater	at least 24 devices, including 2 hormonal IUD, 2 non-hormonal IUD, and 1 implant

Offer Same Day LARC Insertion



| **Documentation:** Written policy/workflows |

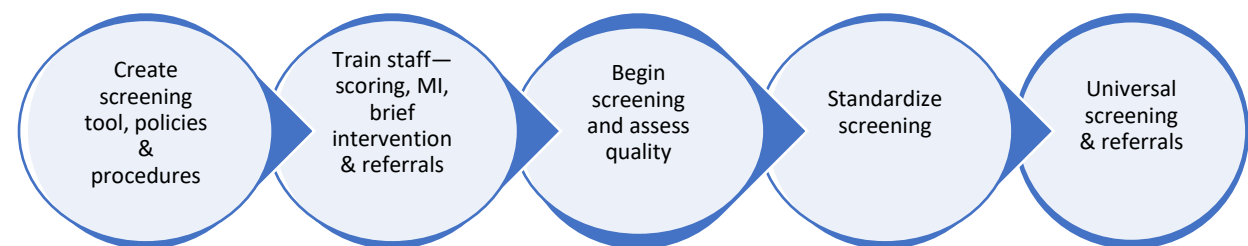
“Many providers already prescribe short-acting methods—like the pill, patch, and ring—when requested by the client. Provider-dependent methods have not always been stocked in the clinic, thus requiring clients to return for a second visit. However, when clients are required to return for a second visit for the insertion of a long-acting reversible contraception (LARC) method, the likelihood they receive their method of choice decreases. Up to 50% of clients will not return for a LARC insertion visit (Bergin 2012). Moreover, a two-visit insertion protocol disproportionately impacts low-income clients (Higgins 2016).”

“Use a standard length for all appointment types, including LARC insertions. Some appointments will take more (or less) time but will balance out over the course of the day and should not cause delays for clients.” <https://www.fpntc.org/resources/same-visit-contraception-toolkit-family-planning-providers>

Same-Visit Contraceptive Services Coding Examples:

https://www.fpntc.org/sites/default/files/resources/fpntc_smvst_contra_coding_ex_2018-07.pdf

Screening for Mental Health, Substance Abuse, Inter-Partner Violence, and other Social Determinants of Health



| **Documentation:** Written policy/workflows |

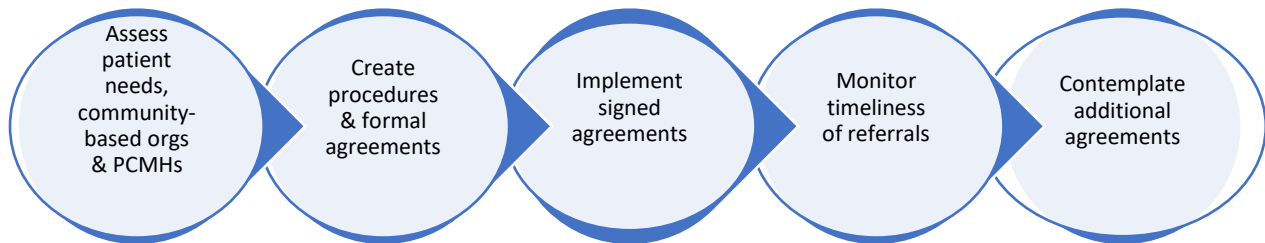
Screening for mental health, substance abuse, and inter-partner violence is a valuable tool for practitioners to help understand their patients' complex care needs and provide a better-rounded picture of a patient's status. Similarly, the impacts of unmet health-related social needs, such as homelessness, inconsistent access to food, and lack of reliable transportation on health care outcomes and utilization are well-established. Growing evidence indicates that addressing these and other needs can help reverse their damaging health effects, but screening for social needs is not yet standard clinical practice.

WHI practices are asked to develop comprehensive screening tools that are deployed on a regular basis. Additionally, WHI practices follow workflows to address positive screens that include making referrals to services or providing interventions directly to mitigate risks. A preferred screening tool is provided in attachment C, but practices are welcome to use their own tool as long as all elements are incorporated. Minimally, patients should be screened at first visit, annually, and post-partum.

[Attachment C Screening Tool](#)

[Attachment D Sample Workflow](#)

Develop Referral Networks for Women's Health Services and Primary Care



| **Documentations:** 1. Written policy/workflows 2. Signed referral agreements |

Women's Health Services

While most referrals between medical care providers and community organizations that address health-related social needs originate with the medical provider, the WHI seeks to make referrals a two-way street. Community-based service providers, such as designated agencies, food pantries, WIC programs, homeless shelters, schools and organizations serving at-risk youth, are in key positions to identify women in need of family planning and other health services. WHI practices are asked to reach out to their local sources of potential referrals to make those personal connections and develop agreements, creating a network of local service organizations that can refer women for needed and timely family planning as well as accept referrals from the WHI practice. Referral agreements should be reviewed and updated on an annual basis, or more often as needed.

Ideally, no shows for referred in patients are reported to the referring organization, and outgoing referrals are tracked in patient records with a date for the practice to follow up to ensure the connection was made and patient needs were met.

[Attachment B Sample Referral Agreements](#)

Primary Care

WHI specialty practices are asked to reach out to local primary care providers in their region to establish referral agreements in order to refer patients who are in need of primary health care, as well as to receive referrals for family planning and other WHI services. Referral agreements should be reviewed and updated on an annual basis, or more often as needed.

[Attachment B Sample Referral Agreements](#)

Attachment A Sample Job Descriptions

Position Description and Employee Evaluation Tool

Organization CVMC	Position Title Behavioral Health Clinician	Department MGP/ Women's Health	Date 09/2018	Exempt Yes	Employee Evaluation Name: _____ Date: _____
-----------------------------	--	---	------------------------	----------------------	--

(See end of form for definitions of Essential Function codes and Evaluation codes used on right hand side)

POSITION SUMMARY

Behavioral Health Clinician is position for a licensed behavioral health clinician who provides integrated behavioral health services in ambulatory care settings. This role functions as a core member of a collaborative care team that involves the patient's care provider and other health professionals working in ambulatory and primary care clinics. This position is integrated embedded in ambulatory and primary care practices, although some outreach education and consultation with community-based organizations and other CVMC departments may be required. The position will report to the Primary Care Behavioral Health Supervisor and will work as part of a collaborative team of behavioral health professionals within the CVMC UVM Health Network.

A. To work closely with practice clinicians and staff to provide screening, brief treatment, and referral for substance abuse and mental health conditions. The clinician will be part of a team who conducts initial SBIRT screening for adults who are seen at the CVMC Medical Group Practices.	_____
B.	_____
C. To provide case consultation to practice staff on a regular basis.	_____
D. To make referrals for assessments, individual, group and family therapies, and medication-assisted treatment when need is demonstrated for longer term services.	_____
E. Administer or refer to inter-agency resources for specialized screening and assessments for substance abuse, mental health, and trauma, as well as specialty care needs associated with woman's health	_____
F. To complete all relevant documentation, including clinical notes, treatment plans and administrative forms. Clinician will also need to collect and enter data according to the program requirements.	_____
G. Collaborate and consult with client's primary care and other care providers such as case manager, clinicians, community partners and others involved with the treatment team on an on-going basis.	_____
H. Attend staff meetings at CVMC as required. Attend required trainings, including individual and/or group supervision.	_____
I. Employees will perform his/her job in a safe manner as defined in any and all applicable CVMC policies specific to the job including but not limited to policies	_____

addressing: Universal precautions, Use of PPE, Safe lifting/ergonomics, Handling of hazardous materials. EF=4,5,6	
J. “Notifies direct supervisor of infractions of policy, procedure, laws and regulations as they are identified. Notifies supervisor’s manager of same issue if supervisor does not correct or receive issue within a reasonable time frame. Notifies Corporate Compliance Officer of any issues that continue to be unresolved.”	_____
K. All other duties as assigned or requested. **	_____

This position is responsible for providing behavioral health and social determinant screenings, acute risk assessments, integrated mental health and substance use diagnostic evaluations, brief and ongoing behavioral health counseling, referrals, and care navigation of patients in need of additional supports. As part of the Woman’s Health Initiative, the position will be working with woman engaged in seeking services specifically related to woman’s health. The position assists practices with helping to address pertinent patient issues associated with behavioral health and social needs. In addition to a having a case load of scheduled patients and percentage of time will be dedicated to seeing patients who had a positive screening result during routine medical visits. The candidate for this position must have strong diagnostic and assessment skills as well as working knowledge of motivational interviewing, cognitive behavioral therapies modality of treatment for counseling services. Experience working in health care settings with multidisciplinary teams is preferred. This position will maintain absolute confidentiality of all patients’ records, medical treatment and diagnosis and abide with all policies and procedures of CVMC. This position is funded by a grant from the Department of Vermont Health Access, Vermont Blueprint for Health, Woman’s Health Initiative.

CODE OR DUTIES **PERFORMANCE**
CODE LETTER **COMPETENCY**

****Marginal Function**
BASIC KNOWLEDGE

Master’s Degree in behavioral health field with full licensure is required. Dually licensed behavioral health and Licensed Alcohol and Drug Abuse Counselor (LADC) preferred. **Tobacco Treatment Specialist Training (TTS) certification preferred**

EXPERIENCE

Minimum of three years of clinical experience post master’s degree necessary. Experience utilizing Motivational Interviewing, Relapse Prevention and Cognitive Behavioral Therapy modalities required. Experience with writing diagnostic biopsychosocial assessments. Ability to maintain cohesive professional relationships with medical professionals and community resource advocates.

INDEPENDENT ACTION

Excellent communications skills. Demonstrated ability to collaborate effectively in a health care multidisciplinary team setting. Proven critical thinking and problem-solving skills. Ability to establish a therapeutic relationship with patients and their support resources. Sensitivity to the unique needs of clients with a history of chronic conditions such as addiction, chronic pain, and PTSD expected. Ability to manage priorities, multiple tasks simultaneously, and organize work effectively with great attention to detail while managing multiple complex cases. Versatility, flexibility, and willingness to work within constantly changing priorities with enthusiasm. Commitment to quality improvement working in a team-oriented collaborative model. Passion, enthusiasm, focus, creativity, and a positive working attitude that supports the goals of the MGP Practices and Community Health Team. Flexibility and the ability to adapt to the changing healthcare environment and legislation.

SUPERVISORY RESPONSIBILITIES

None

JOB SPECIFICATIONS

Physical Demand: () Light (X) Moderate () Heavy

% of Time: Standing 15% Sitting 70% Bending 10% Lifting 5% Max. lbs. to be lifted 30 lbs.

Performance Ratings:

M. Meets Expectations

N. Does Not Meet Expectations

Initial Competency and Completion of Orientation

Codes

A. No experience with this skill.

B. Intermittent experience with this skill.

C. One year consistent experience with this skill.

D. Two years or more consistent experience with this skill.

E. Able to teach and supervise this skill.

F. Have determined competency in this skill by self- assessment

G. Demonstrated competency in this skill.

Essential/Non-essential Duties

Essential accountabilities are key accountabilities that must be performed with or without accommodation.

For accountabilities to be considered essential they must meet one or more of the following requirements:

- The performance of this function is the reason that the job exists.
- There are limited employees among whom the performance of this function can be distributed.
- This function is highly specialized. Employees are hired for the skill/ability to perform this function.
- Failure to perform this function may have serious consequences.

Non-essential accountabilities, while important, do not meet the requirements listed above and can be reassigned to another individual. Those accountabilities that are considered to be NON-ESSENTIAL are marked with two asterisks (**) following each description of accountability.

Competency Requirements

A. By the end of the orientation period, the new staff member must demonstrate:

1. Familiarity with CVMC mission and vision;
2. Knowledge and skill in the essential duties outline in this description;
3. Familiarity and compliance with the department standards of productivity, pro-activity, and professionalism.

B. On an annual basis, staff members must:

1. Complete the annual in-service self-study materials and achieve a score of 80 or better on the annual test;
2. Obtain a focal review rating of acceptable or better.

C. On a continuing basis, the staff member must maintain competence by means of one or more of the following:

1. Participation in CVMC or Departmental committee or staff meetings;
2. Participation in Departmental projects (e.g. TQM);
3. Attendance at in-house or outside workshops/seminars related to field of expertise or other common body subjects;
4. Self-Study;
5. Teaching of Department- based in-service training.

The purpose of this evaluation is:

- _____ Documentation of initial competency.
_____ Demonstration of progress throughout orientation.
_____ Annual Evaluation.

With completion of this assessment, this employee is competent to perform all required duties.

YES NO

Employee: _____

Immediate Supervisor: _____

Date: _____

Attachment B Sample Referral Agreements

Community Organizations

Women’s Health Initiative Referral Agreement with Community Organization

The (*community organization*) and (*Women’s Health Services Provider*) have developed the following Referral Agreement, based upon the guidelines outlined below.

Background and Purpose: The Women’s Health Initiative (WHI) helps ensure that women’s health providers, primary care practices, and community partners have the resources they need to help women be well by supporting healthy pregnancies, avoiding unintended pregnancies, and building thriving families through enhanced screenings, brief in-office interventions, comprehensive family planning counseling and referrals to services for mental health and substance use disorders, interpersonal violence, food insecurity, housing instability and trauma once identified.

The Healthy Vermonters 2020 goal for pregnancy intention is 65%.

A few key supports can help WHI practices to be even more effective in providing preventive care, identifying health and social risks, connecting women to community supports, and helping ensure more pregnancies are intentional. We accomplish this in part by strengthening relationships and building a network of care for our community.

To that end, this agreement outlines what each partner promises to do when a referral takes place. They are not legal documents and can be amended with mutual agreement at any time.

Referral to Care Expectations	
Mutual Agreement	
<ul style="list-style-type: none"> • Accept patient referrals from the other party, with priority access to care • Identify a specific referral contact person • Referring organization: <ul style="list-style-type: none"> ○ Indicate urgency of referral ○ With written permission from the patient, provide needed patient information: <i>Name, DOB, insurance, reason for referral</i> ○ Inform patient of need, purpose, expectations & goals of referral ○ Provide patient with contact information & expected time frame for appointment • Receiving organization: <ul style="list-style-type: none"> ○ Communicate with referring contact person regarding no-shows or canceled appointments 	
Women’s Health Provider (name) Agreement	
<ul style="list-style-type: none"> • Provide family planning consultation, including asking One Key Question® • Offer same-day access to long-acting reversible contraception (LARC) • Offer referral for free consultation with Community Health Team staff to address psycho-social barriers to well-being (including primary care access, behavioral and mental health, substance abuse, food and housing insecurity, and intimate-partner violence) • Maintain accurate and up-to-date clinical record • Determine &/or confirm insurance eligibility 	

Signed Organization Date	Signed Organization Date
--	--

Primary Care

Women's Health Initiative Referral Agreement with Primary Care Practice

The (*primary care practice*) and (*Women's Health Services Provider*) have developed the following Referral Agreement, based upon the guidelines outlined below.

Background and Purpose: The Women's Health Initiative (WHI) helps ensure that women's health providers, primary care practices, and community partners have the resources they need to help women be well by supporting healthy pregnancies, avoiding unintended pregnancies, and building thriving families through enhanced screenings, brief in-office interventions, comprehensive family planning counseling and referrals to services for mental health and substance use disorders, interpersonal violence, food insecurity, housing instability and trauma once identified.

The Healthy Vermonters 2020 goal for pregnancy intention is 65%.

A few key supports can help WHI practices to be even more effective in providing preventive care, identifying health and social risks, connecting women to community supports, and helping ensure more pregnancies are intentional. We accomplish this in part by strengthening relationships and building a network of care for our community.

To that end, this agreement outlines what each partner promises to do when a referral takes place. They are not legal documents and can be amended with mutual agreement at any time.

Referral to Care Expectations	
Mutual Agreement	
<ul style="list-style-type: none">• Accept patient referrals from the other party, with priority access to care• Identify a specific referral contact person• Referring practice:<ul style="list-style-type: none">○ Indicate urgency of referral○ With written permission from the patient, provide appropriate and complete information with the referral. This includes, but may not be limited to, pertinent demographic information, clinical findings and relevant clinical data such as lab/test results or procedures, the current treatment plan, the required timing, and the referral purpose.○ Inform patient of need, purpose, expectations & goals of referral○ Provide patient with contact information & expected time frame for appointment○ Determine &/or confirm insurance eligibility• Receiving practice:<ul style="list-style-type: none">○ Communicate with referring contact person regarding no-shows or canceled appointments○ Maintain accurate and up-to-date clinical record	
Women's Health Provider (name) Agreement	
<ul style="list-style-type: none">• Provide family planning consultation, including asking One Key Question®• Offer same-day access to long-acting reversible contraception (LARC)• Offer referral for free consultation with Community Health Team staff to address psycho-social barriers to well-being (including primary care access, behavioral and mental health, substance abuse, food and housing insecurity, and intimate-partner violence).	

Signed	Signed
Practice	Practice
Date	Date

Attachment C Screening Tool for Mental Health, Substance Abuse, Inter-Partner Violence, and other Social Determinants of Health



Thank you for taking the time to answer all of the questions below. All our patients are asked to complete these questions which are only shared with your medical team. Please help us provide you with the best medical care by answering the questions as completely as possible.

Pregnancy Intention

One Key Question®				
Would you like to become pregnant in the next year?	No	I'm okay either way	Yes	I don't know

Mood and wellbeing

Over the past two (2) weeks, how often have you been bothered by any of the following problems?				
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several days	More than half the days	Nearly every day

Relationships

How often does anyone, including your family...					
physically hurt you?	Never	Rarely	Sometimes	Fairly often	Frequently
insult or talk down to you?	Never	Rarely	Sometimes	Fairly often	Frequently
threaten you with harm?	Never	Rarely	Sometimes	Fairly often	Frequently
scream or curse at you?	Never	Rarely	Sometimes	Fairly often	Frequently

Food security

Within the past 12 months, you worried that your food would run out before you got money to buy more...			
	Never true	Sometimes true	Often true
Within the past 12 months, the food you bought just didn't last and you didn't have the money to get more...			
	Never True	Sometimes true	Often true

Housing security

What is your housing situation today? Please check one box.

I have housing <input type="checkbox"/>	I have housing today, but am worried about losing housing in the future. <input type="checkbox"/>	I do not have housing I do not have housing (I am 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) <input type="checkbox"/>
---	---	---





Substance use

Do you use tobacco products?	No	Sometimes	Yes
------------------------------	----	-----------	-----

Have you used marijuana/ cannabis in the last year?						
Never	Monthly or less	Several days per month	Weekly	2-3 times a week	4-6 times a week	daily
How often have you used prescription medications that were not prescribed to you?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
Have you used other drugs in the past year (for example opiates, amphetamines, ecstasy, etc.)?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week

1 standard drink* is equivalent to:



6. In the last year, how often do you have a drink containing alcohol?							
	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
7. In the last year, when you drink alcohol, how many drinks do you typically have on any given day?							
	1 drink	2 drinks	3 drinks	4 drinks	5 – 6 drinks	7 – 8 drinks	10 or more
8. In the last year, how often have you had 4 or more drinks on one occasion?							
	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily



PHQ-3: a score of 3 or higher is positive

Over the past 2 weeks how often have you been bothered by any of the following problems:

0	1	2	3
Little interest or pleasure in doing things?			
Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed or hopeless?			
Not at all	Several days	More than half the days	Nearly every day
Thoughts that you would be better off dead, or hurting yourself in some way?			
Not at all	Several days	More than half the days	Nearly every day
Positive screen = 3+		Score:	

1 standard drink* is equivalent to:



1 bottle of beer (ale, lager) 12oz @ 5% alcohol = 1 shot of spirits (Whisky, Gin, Vodka) 1.5oz @ 40% alcohol = 1 glass of wine (red, white, Rosé) 5oz @ 12% alcohol = 1 glass of liqueur (Irish Cream, Schnapps) 2.5oz @ 25% alcohol

AUDIT-C: Any woman scoring 7, or men scoring 8 or more is positive

0	1	2	3	4	5	6
6. In the last year, how often do you have a drink containing alcohol?						
Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
7. In the last year, when you drink alcohol, how many drinks do you typically have on any given day?						
1 drink	2 drinks	3 drinks	4 drinks	5 – 6 drinks	7 – 8 drinks	10 or more
8. In the last year, how often do you have X (5 for men; 4 for women & men 66+) or more drinks on one occasion?						
Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
Positive screen = 7+ for women, 8+ for men					Score:	

	<i>In a single day...</i>	<i>Per week...</i>
Women 	 No more than drinks per day 3	 No more than drinks per week 7
Men 	 No more than drinks per day 4	 No more than drinks per week 14

* For patients aged 65+ drinking limit is 7 drinks/week for both men and women

Drug Screening

0	0	0	1	1	1	1
9. Have you used marijuana/ cannabis in the last year?						
Never, <i>OR</i> I have a medical marijuana card	1 day a month or less	2-3 days per month	Weekly	Several days per week (2-4 days per wk)	Daily or almost daily (5 to 7 days per wk)	
10. How often have you used prescription medications that were not prescribed to you?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
11. How often have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
11. Have you used other drugs in the past year (for example street heroin, salvia, inhalants, etc.)?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
Positive Screen = 1+. Score:						

Interpersonal Safety Screening

How often does anyone, including family...	1	2	3	4	5
Physically hurt you?	Never	Rarely	Sometimes	Fairly often	Frequently
Insult or talk down to you?					
Threaten you with harm?					
Scream or curse at you?					
A Score of 10+ is positive				Total Score =	

Food & Housing Screening

Within the past 12 months, you worried that food would run out before you got money to buy more	Often true	Sometimes true	Never true
Within the past 12 months the food you bought just didn't last and you didn't have money to buy more	Often true	Sometimes true	Never true

What is your housing situation today?

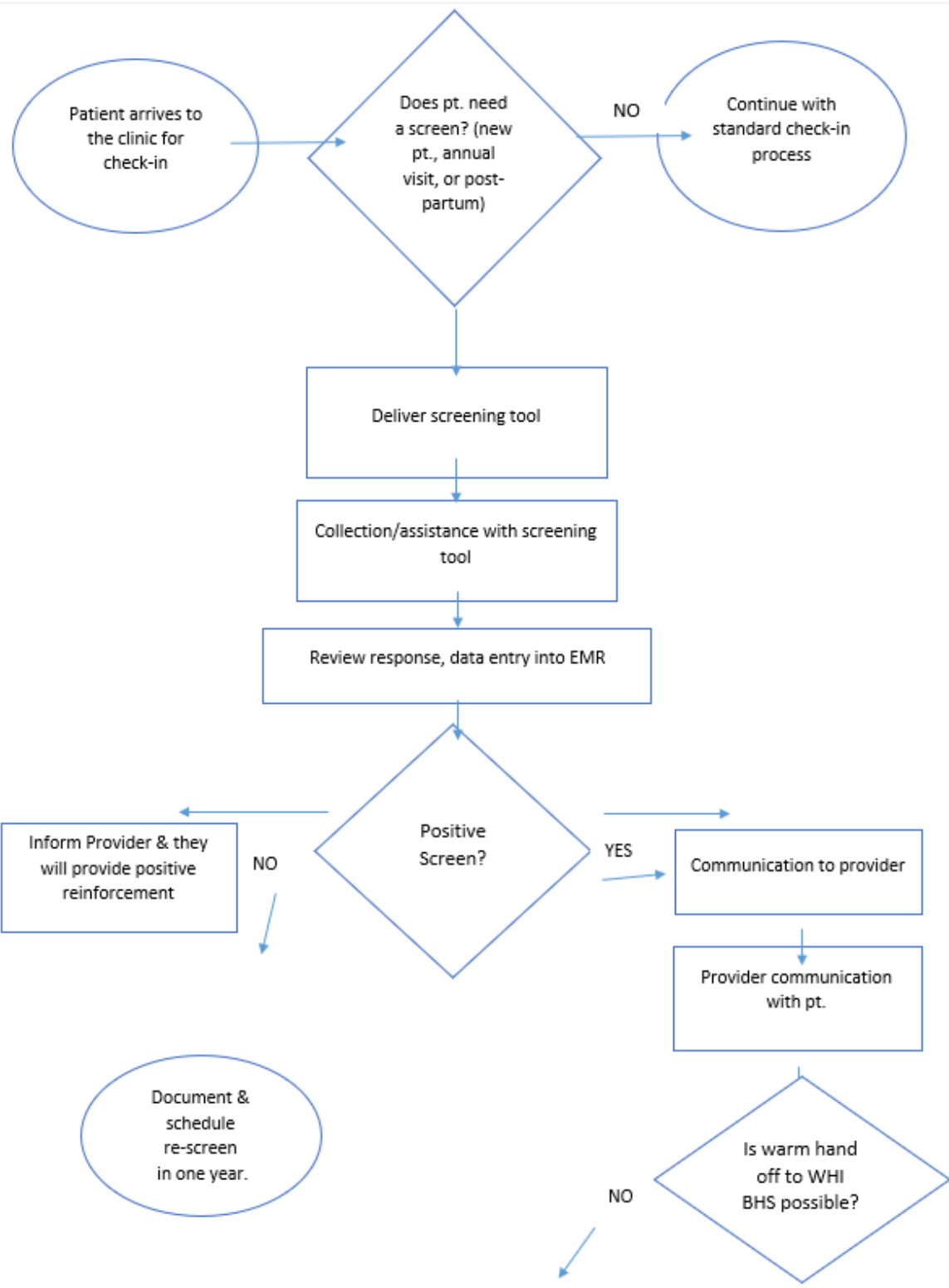
<input type="checkbox"/>	I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).
<input type="checkbox"/>	I have housing today, but I am worried about losing housing in the future.
<input type="checkbox"/>	I have housing.

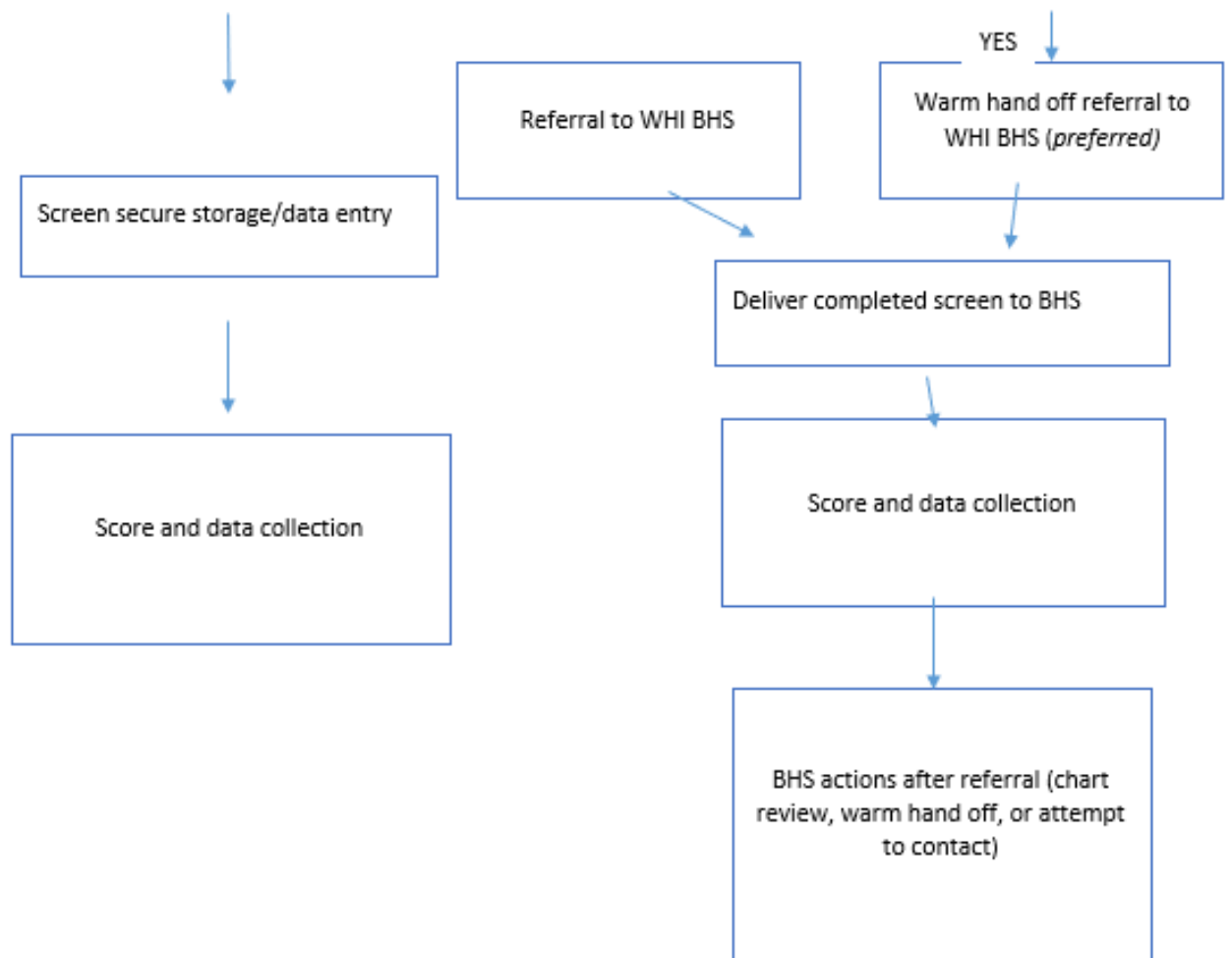
Circled answers are considered positive and would trigger an intervention

Attachment D Sample Screening Workflow

Process elements to include and define, based on practice patterns:

- Who gets screened? How to assess for need for screen? *new pt., annual visit, or post-partum*
- Process for delivering screening. *Location, staff involved, paper/electronic*
- Process for assessing screen *negative v positive*
- Process for storing paper screens, tracking screening data, and noting when next screen is due
- Process for responding to negative screen
- Process for responding to positive screen. *Nurse, providers, WHI BHS, other staff*
- Process for referrals to WHI BHS. *warm hand offs when possible*





Attachment E Links to Resources

Blueprint for Health Contact Information

<https://blueprintforhealth.vermont.gov/contact-us>

Blueprint for Health Implementation Manual

<https://blueprintforhealth.vermont.gov/implementation-materials>

Women's Health Initiative Attestation Document

https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/WHIPracticeAttestation9.24.20.pdf

Behavioral Health Integration

<https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/distinction-in-behavioral-health-integration/>

One Key Question

<https://powertodecide.org/one-key-question>

Family Planning Counseling

<http://www.nnepqin.org/wp-content/uploads/2018/08/14a.-NNEPQIN-Chapter-10-Best-Practices-in-Contraceptive-Counseling-6.1.18-1.pdf>

<https://providers.bedsider.org/>

Same-day LARC Insertion

<https://www.fpntc.org/resources/same-visit-contraception-toolkit-family-planning-providers>

Same-day Billing Codes

https://www.fpntc.org/sites/default/files/resources/fpntc_smvst_contra_coding_ex_2018-07.pdf

Marijuana Resources

<https://www.drugabuse.gov/sites/default/files/drugfacts-marijuana.pdf>

<https://www.cdc.gov/marijuana/factsheets/pregnancy.htm>

Quality Improvement

<https://www.aafp.org/practice-management/improvement/basics.html>