Commonwealth of Massachusetts
Executive Office of Health and Human Services www.mass.gov/masshealth

MassHealth ACO Tiering Initiative

2023

TABLE OF CONTENTS

Requirement 1

- **Traditional Primary Care**

Practice meets this requirement.

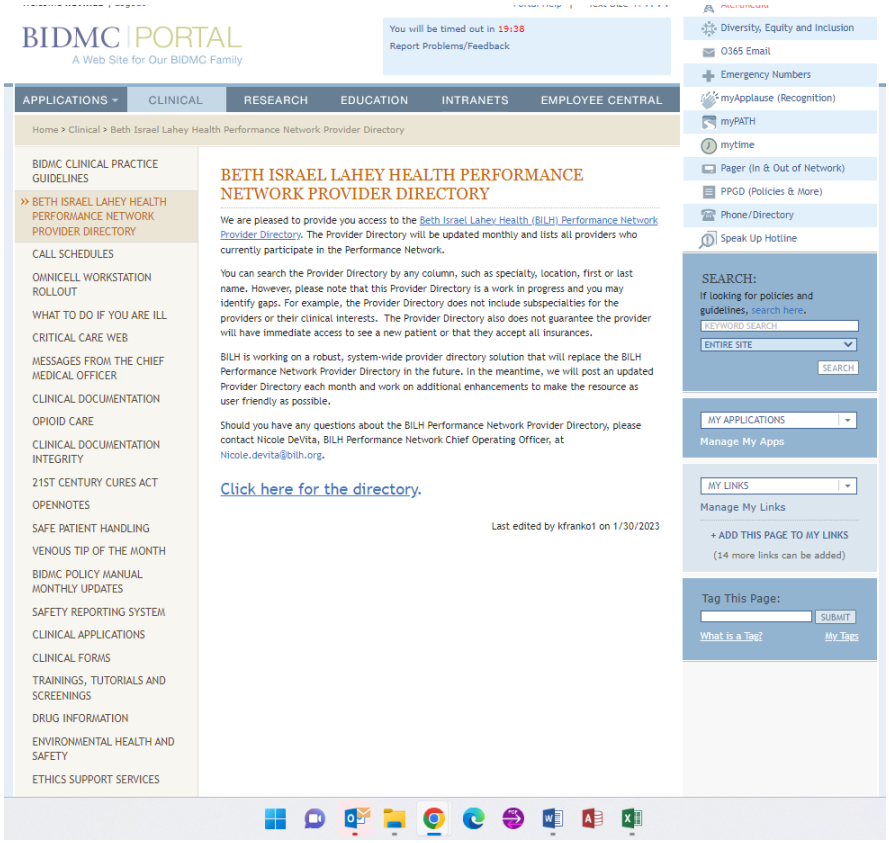
We provide both in person and virtual telehealth visits.

Requirement 2

- **Referral to Specialty Care**

Practice meets this requirement.
The practice utilizes the Referral Directory via BILHPN website (login with individual BILH email account to access link)
https://portal.bidmc.org/Clinical/BILH-Performance-Network-Provider-Directory.aspx
You will need to log in to the BILH portal with your login and password

Practice also refers patients BH/SUD to WellSense – insurance number found on patient cards



Requirement 3

- **Oral Health Screening and Referral**

Practice meets this requirement.
Practice conducts an annual oral health screening on-site for patients. Refer to MassHealth dentists. (Oral health/flourides are recorded in doctor note after the visit)
https://provider.masshealth-dental.net/MH_Find_a_Provider#/home

https://bethisraellaheyhealth.us.newsweaver.com/1xi7592y5k/1lbehx0g87gvigjlnyjb5e?a=5&p=11945143&t=2322822

Oral Health Screening Questions

Offering the MassHealth Find a Dentist Referral and Resource OnePager when a patient has a positive oral health screening checks the box for a referral as long as this is documented in the visit note.

- English
- Spanish
- Portuguese
- Vietnamese

MassHealth Dentist and Clinic Finder

MassHealth Dental Website - **this is same link as the QR code on the OnePager**
All three dental schools in Massachusetts:
Boston University School of Dental Medicine, 635 Albany Street, (617) 358-8300
Harvard School of Dental Medicine, 188 Longwood Avenue, (617) 432-1434
Tufts School of Dental Medicine, 1 Kneeland Street, (617) 636-6828

Other Clinics:

Boston Medical Center, Yawkey Ambulatory Care Center, 850 Harrison Avenue, 6th Floor, Boston, MA 02118, (617) 414-2243 - This clinic is for pulling teeth. They do not make appointments - you must call the same day to have a visit.

Requirement 3, cont.

- **Oral Health Screening and Referral**

PCP Oral Health Screening Recommended Questions (from Wellsense) for annual screening:

Adult Oral Health 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 Oral Health Questions:

MassHealth ACO 2023
Oral Health Screening & Fluoride Varnish Implementation

Beth Israel Lahey Health
Performance Network

Contents


Tier Requirement Review
Oral Health Screening Implementation
Fluoride Varnish Implementation
Documenting on EMR platforms
Workflows
Additional Resources

Review of Tier 1 Requirements:

Annual Oral Health Screening:

Population: All members

- An annual oral health screening for MH enrollees should assess if the enrollee has access to a reliable dentist. If the patient does not have access to a dentist then the PCP should provide a referral resource to a MassHealth dentist.
- Screening has to be documented appropriately to be counted as completed. It can be a template included in a visit note, a separate questionnaire, or a scanned paper.
- The screening must be available on-site but a virtual option me be implemented for patient and provider ease.

Biannual Pedi Fluoride Varnish:

Population: Pediatric (6 mo. – 6 years)

- Starting at 6 months and when the first tooth errupts, MH pediatric providers should apply fluoride varnish every 6 months to this population or until the patient has a regular MH dentist. If the patient does not have a regualr dentist the PCP should provide a referral resource to a MassHealth dentist
- The application of Fluoride Varnish should be documented somewhere in visit note.
- This application must be provided on-site.

Implementation:
Annual Oral Health Screening
Population: All Members

Beth Israel Lahey Health
Performance Network

Oral Health Screening Questions

Adult

- Do you have a dentist you see annually?
- In the last 6 months did you have a dental concern that was not addressed?

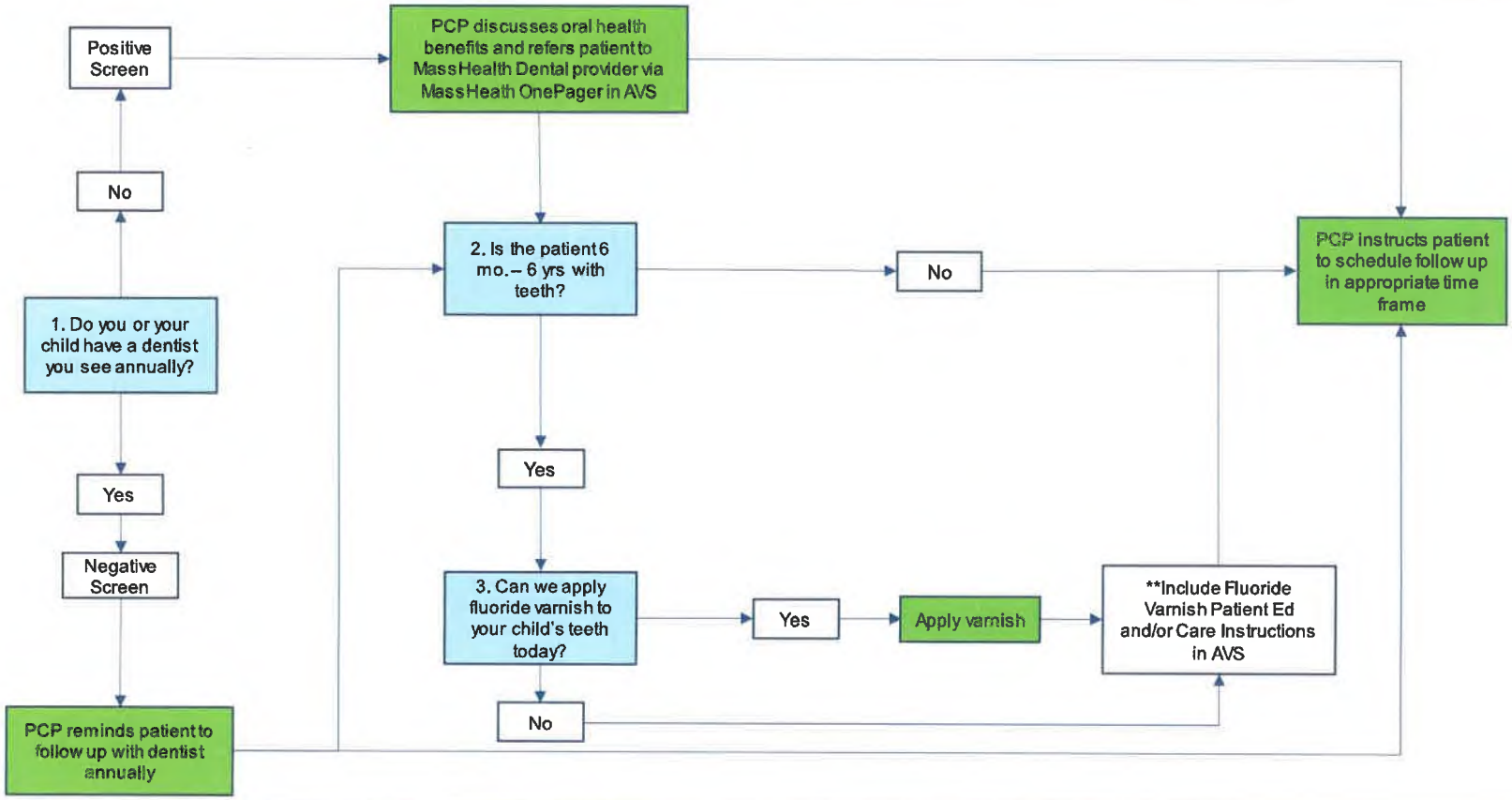
Pediatric

- Does your child have a dentist that provides oral care twice a year?
- Has your child received oral care in the last 6 months?
- Can we apply Fluoride Varnish to your child's teeth today as a preventative care measure?

Combined (Recommended)

- Do you or your child have a dentist you see regularly?
- Have you or your child received oral healthcare in the past 6 mo?
- Can we apply Fluoride Varnish to your child today as a preventative care measure?

Combined Oral Health Screening + Fluoride Varnish Workflow



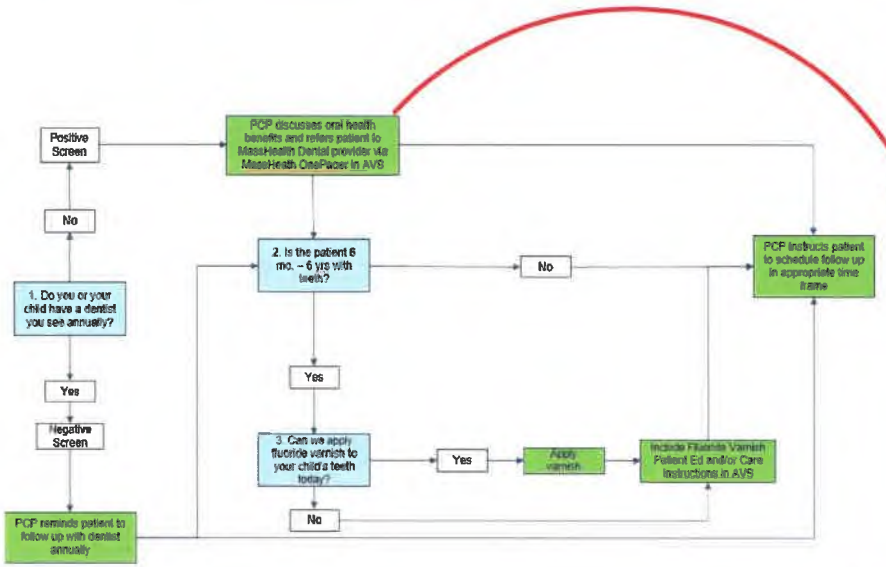
Oral Health Screening Progress Note Template:

Recommended Combined Adult/ Pedi Screening

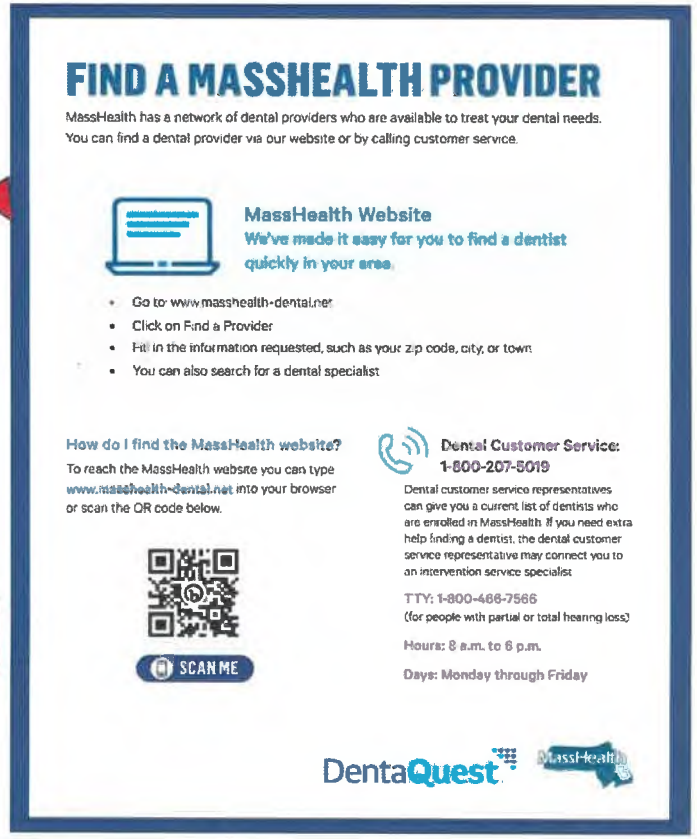
Question	Check Box		Additional Comments
Do you or your child have a dentist you see regularly?	Yes	No	
Have you or your child received oral healthcare in the past 6 mo.?	Yes	No	
Can we apply Fluoride Varnish to your child today as a preventative care measure?	Yes	No	
Was a MassHealth Dental referral given?	Yes	No	

Key:
Question 1: No = Positive Screen --> Refer to MH Dental OnePager (Download from Oral Health Screening Resource slide)
Question 2: No = Positive Screen --> Refer patient to MH Dentist or to follow up with their regular dentist
Question 3: Yes = Continue to Fluoride Varnish Application Workflow

When to Refer to the MassHealth Dental OnePager



Providing a patient who has a positive oral health screening with the MassHealth OnePager or equivalent and documenting the screening and referral in the visit note is sufficient for the Oral Health Screening and Referral Tier 1 Requirement.



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

Implementation

Paediatric Fluoride Varnish

Population: (6 mo. – 6 years)

Beth Israel Lahey Health
Performance Network

Implementing Fluoride Varnish Workflow in Practice

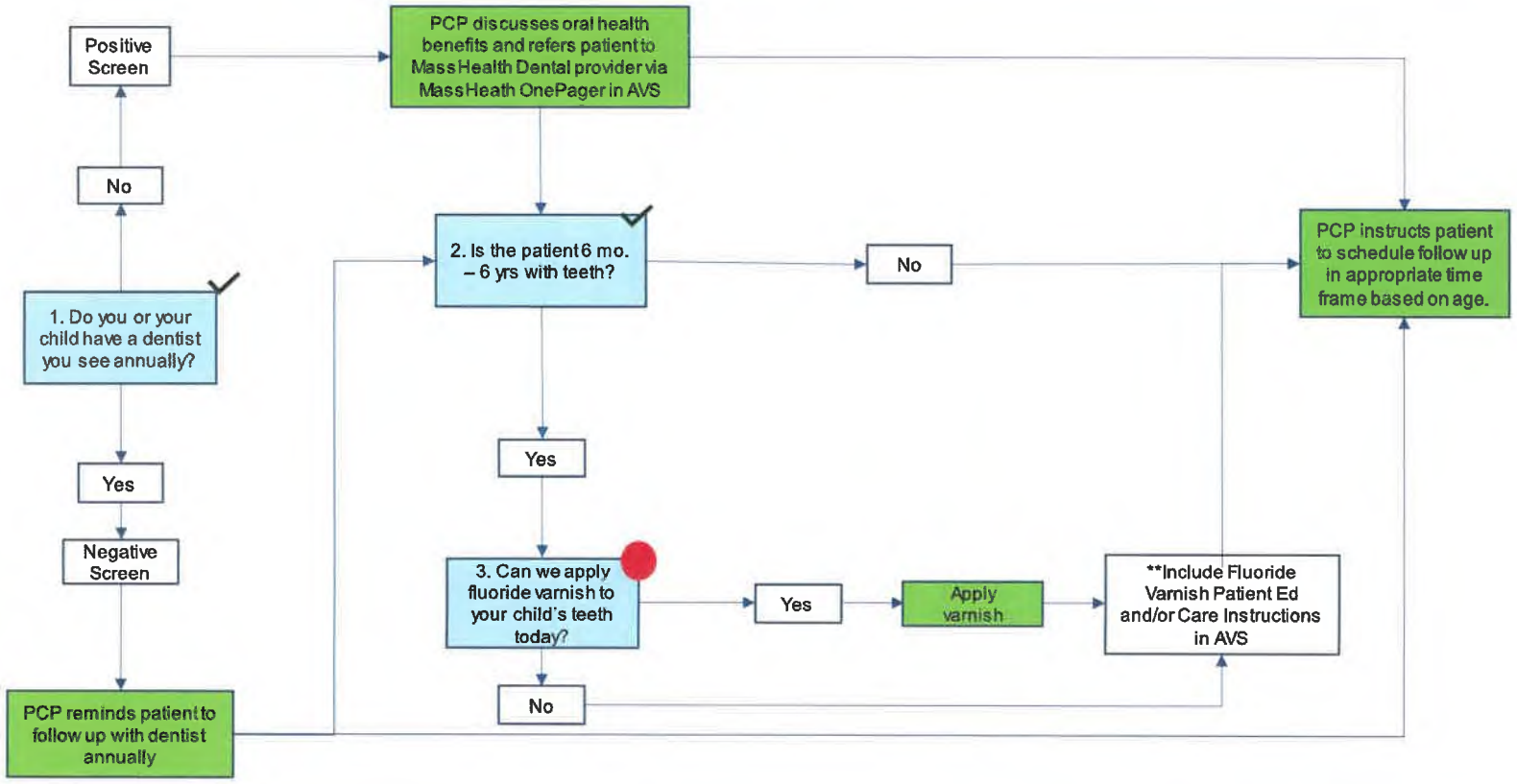
Communicate with Staff

1. Communicate the July 1, 2023, start date.
2. Include operational updates through newsletters.
3. Share optional training resources with staff.

Employ a Task Force & Responsabilities

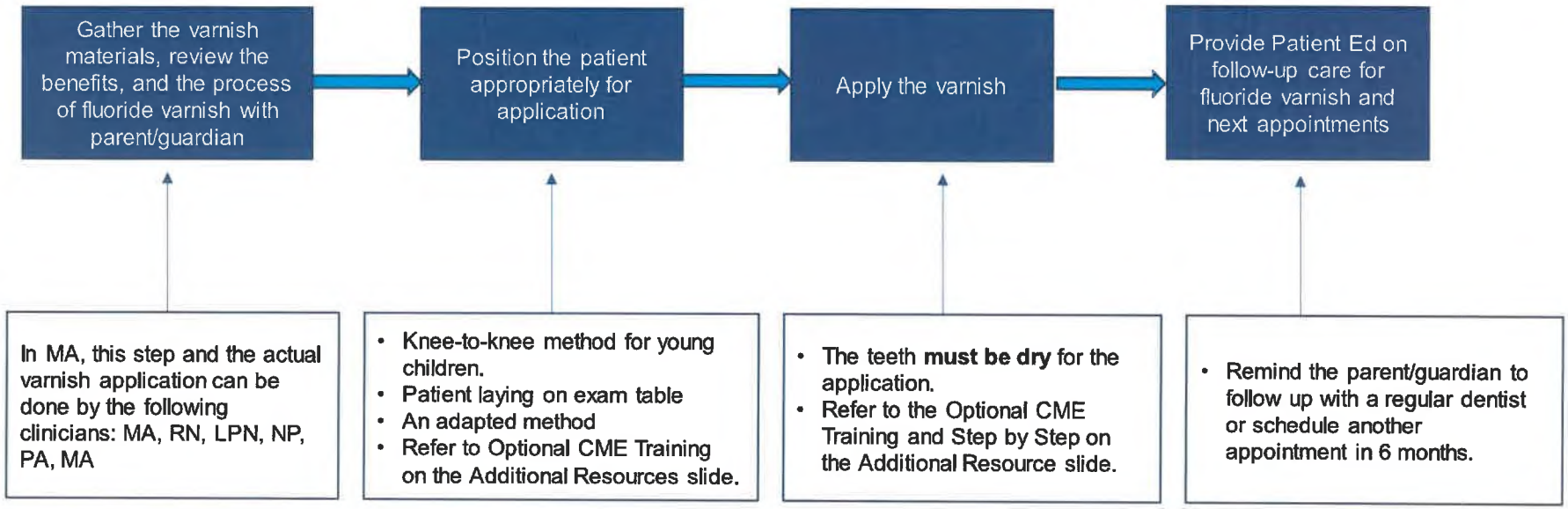
1. Download the "MassHealth Fluoride Varnish Training Manual" and make the manual accessible to all staff.
2. Add a Fluoride Varnish Progress Note Template, Patient Ed. and Billing Codes to your practice and EHR.
3. Order and stock fluoride varnish. See Vendor Resources
4. In Mass., Fluoride Varnish can be applied by an MD, DO, PA, NP, RN, LPN, or MA. Practices should decide where in a visit flow the fluoride application fits best. (Rooming, PCP visit, at visit close by MA/RN)
5. Add Fluoride Varnish supplies to inventory and exam rooms
    1. Patient Education, Fluoride Varnish, Progress Notes (if no EHR), Gloves, Gauze (See the Provider Application Review Sheet on the Fluoride Varnish Resource slide)
6. Stand up workflows and implement trial runs before July 1.
7. Advertise the Fluoride Varnish through Patient Education materials through the practice and website. See Fluoride Varnish Resources slide

Oral Health Screening + Fluoride Varnish Workflow



Fluoride Varnish Application Workflow

1. For patients 6 mo. – 6 years, the fluoride varnish application should be administered following the oral health screening. If there is a question whether the patient already received fluoride varnish in the past 6 months, continue with the workflow. There is no harm in an additional fluoride application.
2. Practices should decide where the application of the varnish fits best into their Wellness visit:
    1. We recommend at the end of the appointment when other procedures like vaccinations are administered.



Oral Screening + Fluoride Varnish Progress Note Examples

Oral Health Screening and Fluoride Varnish Template

Combined Screening Questions:

Question	Check Box			Additional Comments
Do you or your child have a dentist you see regularly?	Yes	No		
Have you or your child received oral healthcare in the past 6 –12 months?	Yes	No		
Can we apply Fluoride Varnish to your child today as a preventative care measure?	Yes	No	N/A	
Referral to MassHealth Dentist was given?	Yes	No		

Pediatric Fluoride Varnish Application **(6 mo. – 6 years)**

Event	Documentation	
Fl. Varnish Order Given	Yes	No
Patient was positioned appropriately	Yes	No
Teeth were dried with gauze	Yes	No
Fl. Varnish Applied	Yes	No
Review of Oral Hygiene	Yes	No

Fluoride Varnish Claim Submission:

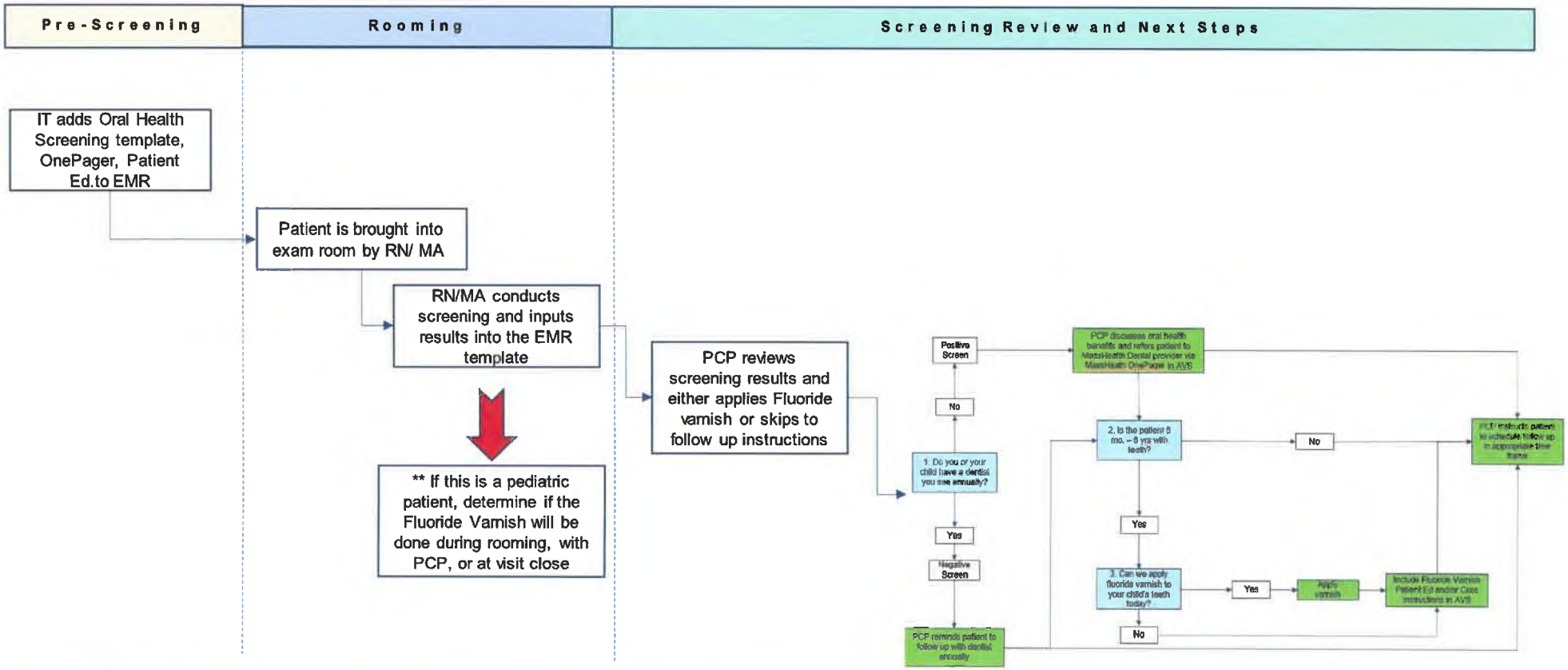
Encounter	Service	Billing Code	Reimbursement
Well-Child Visit	Topical application of fluoride varnish; therapeutic application for moderate to high caries risk patients	CPT: 99188 **AND** ICD-10: Z00.129 " "Routine Child Health Check"	$28.00 per application, includes all materials and supplies needed for the application. **Can be billed up to 4 times a year.**
All other visit types	Fluoride varnish Application	CPT: 99188 **AND** ICD-10: Z41.8 "Need for Prophylactic Fluoride Administration"	

- **Reminders**:
  - Although claims will be "zero paid" under the sub cap, it is important that all providers continue to submit claims for services that fall under the primary care sub-capitation program. If claims are not submitted, future rate development and payments will be impacted
  - FFS medical providers can bill for an office visit and the application of fluoride varnish when the procedure is provided during a well-child visit. When the sole purpose of the visit is for the application of fluoride varnish, the medical provider may bill only for the fluoride varnish.
  - The fluoride varnish metric is reimbursable for patients 21 and under but the fluoride varnish application is only required for ages 6 mo. – 6 years to meet the tier 1 requirement.

Workflows:
Oral Health Screening & Paediatric Fluoride Varnish

Beth Israel Lahey Health
Performance Network

Workflow:
In-Person Oral Health Screening by RN/MA during Rooming



Task Force Responsibility Matrix: Clinical Fluoride Varnish Implementation

	Procedure	Operations Team	IT	Admin Support	Clinical Staff	APP
Implementation Stages	Download Masshealth Fluoride Varnish Training Manual to clinic shared drive for easy access	✓		✓		
	Upload Oral Health Screening Template, MassHealth Referral OnePager, Patient Ed. and billing code to EMR.		✓			
	Select a vendor and order Fluoride Varnish supplies – See Vendor Resources Slide	✓				
	Add fluoride varnish supplies to inventory and distribute fluoride varnish to clinic exam rooms	✓			✓	
	Distribute Patient Ed. about fluoride varnish and oral health in lobby and throughout practice.			✓		
	Following Pedi Oral Health Screen at Visit:					
Clinical Application Process	Gather FV materials and explain the application process				✓	✓
	Apply Fluoride Varnish using best practice techniques				✓	✓
	Provide Patient/ Parent Ed. about Fluoride Varnish care and follow up instructions				✓	✓

Additional Resources

Beth Israel Lahey Health
Performance Network

Oral Health Screening Referral Resources

MassHealth OnePager Dental Referral

- Add the OnePager for MassHealth Dental Referral to EMR or practice shared drive
  - English
  - Spanish
  - Vietnamese
  - Portuguese

MassHealth-Accepting Dental Schools + Clinics

Benefits: May provide lower OOP prices for services that an insurer won't cover.

- Boston University School of Dental Medicine, 635 Albany Street, (617) 358-8300
- Harvard School of Dental Medicine, 188 Longwood Avenue, (617) 432-1434
- Tufts School of Dental Medicine, 1 Kneeland Street, (617) 636-6828

Boston Medical Center, Yawkey Ambulatory Care Center, 850 Harrison Avenue, 6th Floor, Boston, MA 02118, (617) 414-2243 - This clinic is for pulling teeth. They do not make appointments - you must call the same day to have a visit.

MassHealth Patient Education

These are direct links that can also be accessed via the QR code on the OnePager

- Find a MassHealth Dentist
- MassHealth Dental Program Website
- MassHealth Dental / DentaQuest Program Manual

Fluoride Varnish Application Resources

Optional CME Training	Implementation Resources	Patient Ed. and Marketing Tools	Vendor Resources

• Online Training: Carries Risk Assessment, Fluoride Varnish and Counseling
  • Select '**Register for Courses**'
  • This course provides information on Early Childhood Carries (ECC) and the oral hygiene benefits of applying fluoride varnish at WellChild visits. This gives a demonstration of how to appropriately apply fluoride varnish to a pediatric patient.
  • Course slides can be accessed here
• In-Person Training: Contact Jenna Blanchette, DentaQuest Outreach Coordinator/MassHealth Jenna.Blanchette@dentaquest.com or 617-886-1797
	• 2022 MassHealth Fluoride Varnish Training Manual
	• NCDHHS Fluoride Varnish Clinic Implementation Video
	  • Varnish Application (5:55)
	• Why Should we apply Fluoride Varnish
	• Provider Fluoride Varnish Application Review Sheet
		Add the following to EMR or shared drive to include in AVS
		• Fluoride Varnish Patient Ed Handout
		
		Marketing Tool:
		• What is Child Fluonde Varnish – MassHealth
			• 0.25 ml is the recommended dose of fluoride varnish for children under 6 and 0.4 ml for children 6 and up.
			• List of Fluoride Varnish Vendors and the doses they offer

Contacts:

Katerina Koch: Katerina.Koch@lahey.org
Christine Ouellette: Christine.E.Ouellette@Lahey.org
Emily Chin: Emily.chin@lahey.org

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DentaQuest

MassHealth

PCP Oral Health Screening Recommended Questions (from Wellsense) for annual screening:

Adult Oral Health 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 Oral Health 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

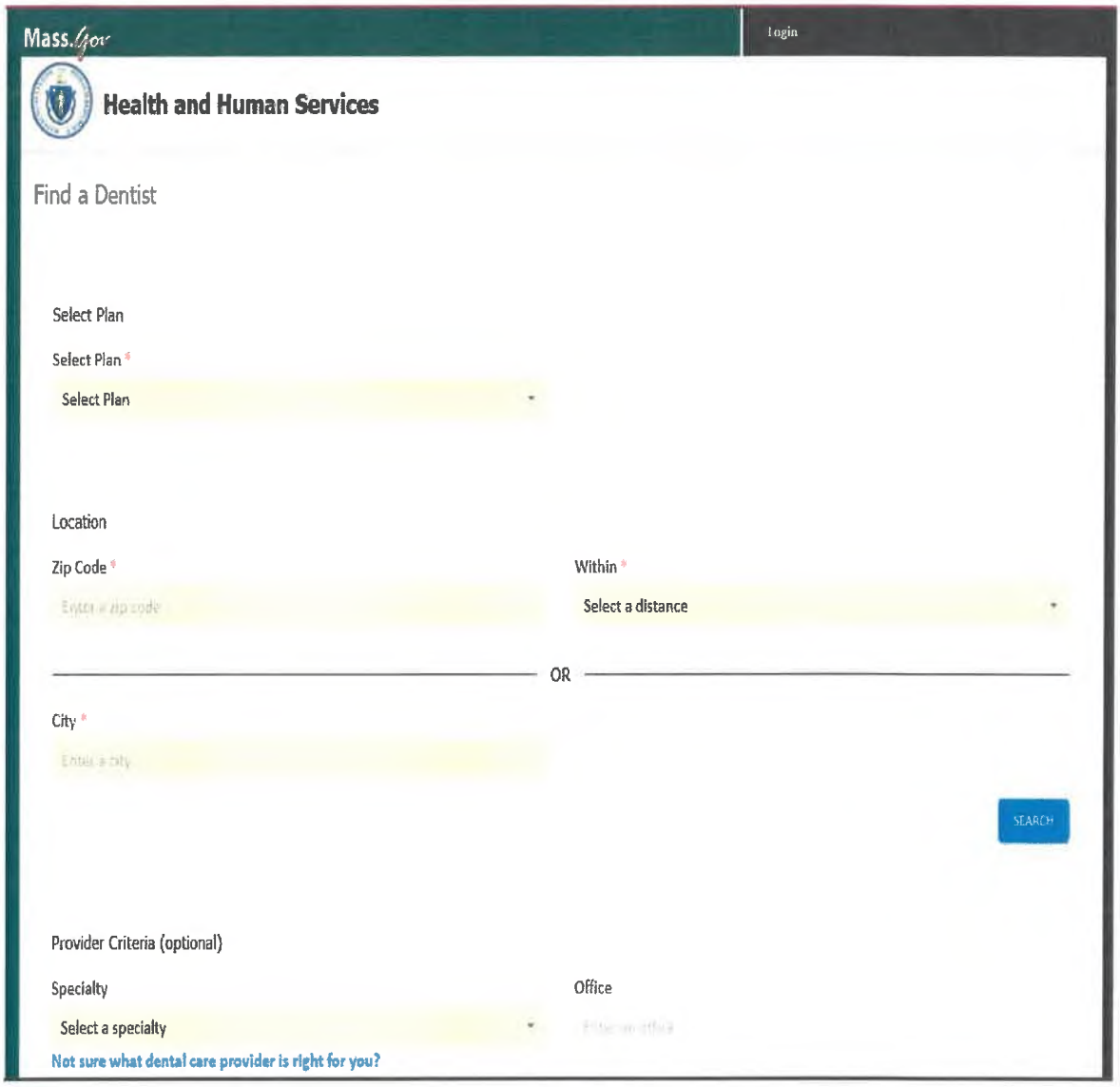
- No will indicate a positive screen

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

MassHealth Dental Providers

Practice	Address	City	Telephone Number
Amesbury Orthodontics LLC	194 Main St Apt 1R	Amesbury	(978) 834-6695
Dental Elements	100 Macy Street Ste 2B	Amesbury	(978) 893-3988
Leonard Orthodontics LLC	43 Sparkhawk Street	Amesbury	(978) 388-4411
Riverside Pediatric Dentistry LLC	194 Main St Ste 2R	Amesbury	(978) 378-0408
River's Edge Family Dental	241 Lincoln Ave	Haverhill	(978) 469-9200
JAMES T QUINN DDS PC	253 Low Street	Newburyport	(978) 462-5050


Mass.gov
Login
Health and Human Services
Find a Dentist
Select Plan
Select Plan *
Select Plan
Location
Zip Code *
Within *
Select a distance
OR
City *
SEARCH
Provider Criteria (optional)
Specialty
Office
Select a specialty
Not sure what dental care provider is right for you?

Mass.gov | State Offices & Courts | State A-Z Topics | State Forms

Health and Human Services

Find a Dentist

Home | Dentists | Members | Partners | Trading Partners | ER Services

Welcome to the MassHealth Dental Program!

The MassHealth Dental Program serves over 1.8 million residents of the Commonwealth. The team at MassHealth / DentaQuest works with several partners to ensure access to care, great customer service and implementation of programs to educate and inform members and stakeholders.

Above, we have created tabs to allow our partners to access needed information and resources. The tabs included are for:

- **Dentists**- Access the provider web portal, information as to how to become a provider, our online application / re-credentialing system App Central, important documents and contact information.
- **Members**- Access dental benefit information, oral health brochures, the member web portal, important forms, the Find a Provider tool and contact information.
- **Partners**- Access important documents, contact information and the client web portal for those who have been granted access by MassHealth.
- **Trading Partners**- Access the trading partner portal to submit 837 files.
- **ER Services**- Physicians and their teams working in urgent care or emergency room settings can access important information about our ER Diversion program, contact information and the online entry page to submit information regarding MassHealth members treated for oral health related conditions.

Requirement 4

- **Behavioral and Substance Abuse Screening**

Practice meets this requirement as follows

- **Use of the PHQ-2 Assessment Tool**
- **Use of the PHQ-9 Assessment Tool**

https://www.hiv.uw.edu/page/mental-health-screening/phq-2
https://www.hiv.uw.edu/page/mental-health-screening/phq-9

Utilize Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP) as needed

1-822-PAIN-SUD

https://www.mcstap.com

Massachusetts Consultation Service

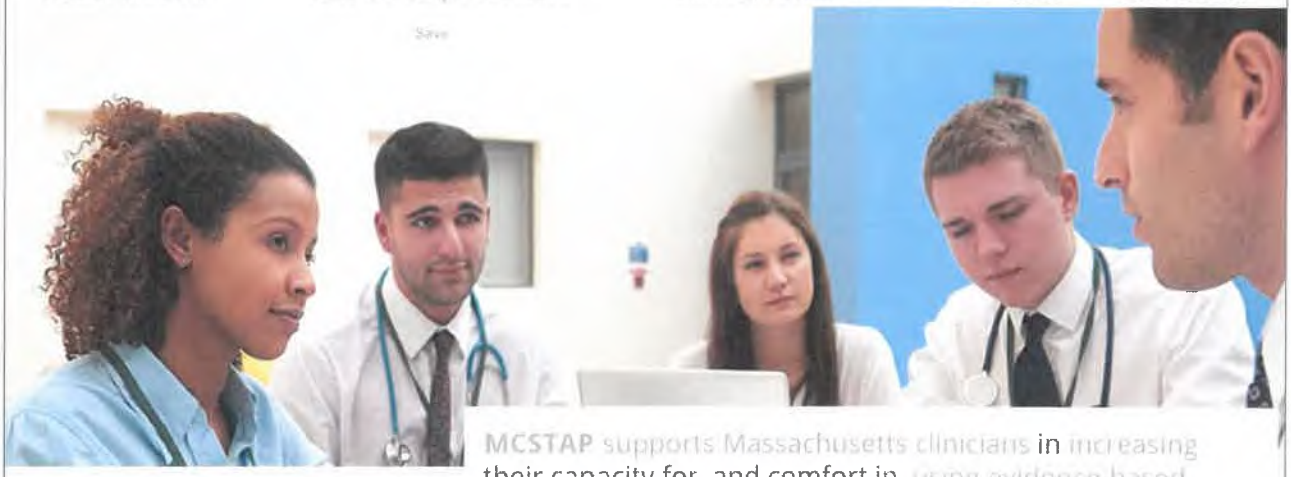
MCSTAP

for Treatment of Addiction and Pain

Call for a Consult, Care with Confidence

Contact number: 1-833-PAIN-SUD (1-833-724-6783)

MCSTAP Custom Search



MCSTAP supports Massachusetts clinicians in increasing their capacity for, and comfort in, using evidence-based practices to screen, diagnose, treat, and manage the care of all patients with chronic pain, substance use disorders, or both

Testimonial from a primary care physician in Boston...

"I had a lovely and productive conversation with a physician consultant at MCSTAP. He was so amazingly helpful, practical, and flexible. The situation was that my colleague had scheduled a new patient with me, whose opioid dependence from a prior prescription had escalated into addiction and she was asking for help. MCSTAP was completely essential. With the physician consultant's expert assistance, we came up with an individualized plan and follow-up. This is an amazing service, a real game-changer."

In the News »

For Providers Only
Enroll in MCSTAP

Request Consultation | COVID-19 Resources

New and Noteworthy

Recently the U.S. Department of Health and Human Services issued guidance, exempting previous training requirements for eligible practitioners to treat up to 30 patients with buprenorphine at any one time. MCSTAP can help you learn to prescribe buprenorphine safely and effectively. Click here for resources on prescribing buprenorphine. Call MCSTAP for a consultation if you plan to begin or increase prescribing buprenorphine to your patients with OUD and would like support.

Provider Resources

Tools for providers and their staff on evidence-based guidelines for: screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options

Real-time physician consultation for clinicians on safe prescribing and managing care for adult patients with chronic pain, substance use disorders, or both

Resource and referral information about community-based providers, programs, and services to support patients with either chronic pain or substance use disorders

Mental Health Screening

Anxiety: GAD-2

Anxiety: GAD-7

Dementia: IHDS

Depression: PHQ-2

Depression: PHQ-9

PTSD: PC-PTSD-5

Substance Use Screening

Alcohol: AUDIT-C

Alcohol: CAGE

CAGE-AID

Drug Use: TICS

Opioid: Risk Tool

Clinical Calculators

APRI Calculator

BMI Calculator

CrCl Calculator

CTP Calculator

FIB-4 Calculator

FEPO4 Calculator

GFR Calculator

Patient Health Questionnaire-2 (PHQ-2)

Share

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

○ 0 ○ +1 ○ +2 ○ +3

2. Feeling down, depressed or hopeless

○ 0 ○ +1 ○ +2 ○ +3

PHQ-2 score obtained by adding score for each question (total points)

Interpretation:

- A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cutpoint when using the PHQ-2 to screen for depression.
- If the score is 3 or greater, major depressive disorder is likely.
- Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.

Operating Characteristics of PHQ-2 as a Screener for Depressive Disorders in 580 Patients Who Had an Independent Mental Health Professional Interview

PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4
2	92.7	73.7	21.1
3	82.9	90.0	38.4
4	73.2	93.3	45.4
5	53.7	96.8	56.4
6	26.8	99.4	78.6

(18%

PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	90.6	65.4	36.9
2	82.1	80.4	48.3
3	62.3	95.4	75.0
4	50.9	97.9	81.2
5	31.1	98.7	84.6
6	12.3	99.8	92.9

Notes:

- *Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of

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Health Resources and Services Administration (HRSA)

Created at

An AETC Program

Part of

CME provided by

CNE provided by

The National HIV Curriculum is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $1,021,448 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov

Patient Health Questionnaire-9 (PHQ-9)

Share

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

○ 0 ○ +1 ○ +2 ○ +3

2. Feeling down, depressed or hopeless

○ 0 ○ +1 ○ +2 ○ +3

3. Trouble falling asleep, staying asleep, or sleeping too much

○ 0 ○ +1 ○ +2 ○ +3

4. Feeling tired or having little energy

○ 0 ○ +1 ○ +2 ○ +3

5. Poor appetite or overeating

○ 0 ○ +1 ○ +2 ○ +3

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down

○ 0 ○ +1 ○ +2 ○ +3

7. Trouble concentrating on things, such as reading the newspaper or watching television

○ 0 ○ +1 ○ +2 ○ +3

8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual

○ 0 ○ +1 ○ +2 ○ +3

9. Thoughts that you would be better off dead or of hurting yourself in some way

○ 0 ○ +1 ○ +2 ○ +3

PHQ-9 score obtained by adding score for each question (total points)

Interpretation:

- Total scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe

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An AETC Program

Part of

CME provided by

CNE provided by

Antiretroviral Medications

Single-Tablet Regimens
Long-Acting Injectable Regimens
Capsid Inhibitors
Entry Inhibitors
Integrase Inhibitors
Nucleoside Reverse Transcriptase Inhibitors
Non-Nucleoside Reverse Transcriptase Inhibitors
Protease Inhibitors
Pharmacokinetic Enhancers

Course Modules

Screening and Diagnosis
Basic HIV Primary Care
Antiretroviral Therapy
Co-Occurring Conditions
Prevention of HIV
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Find a Provider

Need Help

As the public health emergency related to COVID-19 continues to spread, we are recommending that our providers use telehealth services (where allowed) to ensure patients have access to care while adhering to social distancing. Please call your provider to understand his/her current telehealth capabilities.

To find an in-network provider, select your Insurance Carrier or Employer below

Select Your Insurance Carrier

"More than 4,500 employees nationally, serving more than 40 million people."

MASSHEALTH PLAN CONTACT INFORMATION

Health Plan Name	Customer Service Phone	Behavioral Health Phone	Website
Be Healthy Partnership	(800) 786-9999	(800) 495-0086	www.behealthypartnership.org
Berkshire Fallon Health Collaborative	(855) 203-4660	(888) 877-7184	www.fallonhealth.org/Berkshires
BMC HealthNet Plan	(888) 566-0010	(888) 217-3501	www.bmchp.org
BMC HealthNet Plan Community Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/community
BMC HealthNet Plan Mercy Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/mercy
BMC HealthNet Plan Signature Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/signature
BMC HealthNet Plan Southcoast Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/southcoast
Community Care Cooperative (C3)	(866) 676-9226	(800) 495-0086	www.c3aco.org
Fallon 365 Care	(855) 508-3390	(888) 877-7182	www.fallonhealth.org/365care
My Care Family	(800) 462-5449	(844) 451-3519	www.mycarefamily.org
Partners HealthCare Choice	(800) 231-2722	(800) 495-0086	www.partners.org/MassHealthACO
Primary Care Clinician (PCC) Plan	(800) 841-2900	(800) 495-0086	www.mass.gov/service-details/primary-care-clinician-pcc-plan-for-masshealth-members
Steward Health Choice	(855) 860-4949	(800) 495-0086	www.stewardhealthchoice.org/massachusetts
Tufts Health Together	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/together
Tufts Health Together with Atrius Health	(888) 257-1985	(888) 257-1985	www.tuftshealthplan.com/public-plan/atrius-health
Tufts Health Together with BIDCO	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/BIDCO
Tufts Health Together with Boston Children's ACO	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/BCACO
Tufts Health Together with CHA	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/CHA
Wellforce Care Plan	(855) 508-4715	(888) 877-7183	www.fallonhealth.org/wellforce

CBHI-MB (Rev. 3/19)

MASSHEALTH SERVICES FOR CHILDREN & YOUTH

Did you know that MassHealth offers many services for children and youth up to age 21?

Most of the services in this brochure are home and community-based. All of them can help families support their children in difficult times. Read on to learn more about these services and how you can find providers.

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.

[redacted]

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.

How can I find providers?

For Home- and Community-Based services, you can search for providers and get their contact information at www.mabhaccess.com. You can see if a provider is accepting new clients. If they are, make sure to call for an appointment.

For Youth Substance-Use Services, you can find a provider by

- going to www.mabhaccess.com
- accessing https://helplinema.org, or
- calling **(800) 327-5050**.

For Outpatient Therapy and Applied Behavioral Analysis, call the Behavioral Health Customer Service line of your MassHealth Plan. See back page for phone numbers.

If you have questions or need help finding any of the services in this brochure, call the Behavioral Health Customer Service line of your MassHealth Plan.

For more information, go to www.mass.gov/masshealth/CBHI, where you can find guides and tip sheets and watch videos about some of the services described in this brochure.

What if my child doesn't have MassHealth?

If your child is under 21 and doesn't have health insurance, call MassHealth Customer Service at **(800) 841-2900** and find out if they can get MassHealth. You can learn more about applying to MassHealth by visiting www.mass.gov/masshealth

*Youth under 21 on MassHealth Family Assistance who are enrolled in managed care may be able to get this service if it is medically necessary. Youth on MassHealth Standard or CommonHealth can get ANY service that is medically necessary. Youth with a mental or physical disability can apply to get CommonHealth. Contact MassHealth Customer Service at (800) 841-2900 for more information.

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

[redacted]

ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: [redacted] **Gender:** [redacted] **Date:** [redacted]

Did you have a drink containing alcohol in the past year?

- [x] Yes
- [ ] No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- [ ] Never (0 points)
- [x] Monthly or less (1 point)
- [ ] Two to four times a month (2 points)
- [ ] Two to three times a month (3 points)
- [ ] Four or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- [x] 1 or 2 (0 points)
- [ ] 3 or 4 (1 point)
- [ ] 5 or 6 (2 points)
- [ ] 7 to 9 (3 points)
- [ ] 10 or more (4 points)

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

- [x] Never (0 points)
- [ ] Less than monthly (1 point)
- [ ] Monthly (2 points)
- [ ] Weekly (3 points)
- [ ] Daily or almost daily (4 points)

Points 1

Interpretation

- [ ] Positive
- [x] Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

Source: Adapted from materials prepared by: Bush K, Kihlavan DR, McConell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Intern Med 1998:158(16):1789-1795.

NIDA Clinical Trials Network

Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Segment: _ _

Visit Number: _ _

Date of Assessment: (mm/dd/yyyy) _ _/_ _/_ _ _ _

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. **Have you used drugs other than those required for medical reasons?**
   ☐No ☐Yes

2. **Do you use more than one drug at a time?**
   ☐No ☐Yes

3. **Are you always able to stop using drugs when you want to?**
   ☐No ☐Yes

4. **Have you had "blackouts" or "flashbacks" as a result of drug use?**
   ☐No ☐Yes

5. **Do you ever feel bad or guilty about your drug use?**
   ☐No ☐Yes

6. **Does your spouse (or parents) ever complain about your involvement with drugs?**
   ☐No ☐Yes

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.
Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.

NIDA Clinical Trials Network

Drug Abuse Screening Test (DAST-10)

7. **Have you neglected your family because of your use of drugs?**

☐No ☐Yes

8. **Have you engaged in illegal activities in order to obtain drugs?**

☐No ☐Yes

9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

☐No ☐Yes

10. **Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?**

☐No ☐Yes

Comments:

Scoring

Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.

DAST Score: _ _

Interpretation of Score:

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

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.
Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.

Massachusetts Consultation Service

MCSTAP

for Treatment of Addiction and Pain

Call for a Consult, Care with Confidence

Contact number: 1-833-PAIN-SUD (1-833-724-6783)

MCSTAP Custom Search

About MCSTAP | How We Help **Providers** | Clinical Resources | Our Team | For Patients

MCSTAP supports Massachusetts clinicians in increasing their capacity for, and comfort in, using evidence-based practices to screen, diagnose, treat, and manage the care of all patients with chronic pain, substance use disorders, or both.

Testimonial from a primary care physician in Boston...

"I had a lovely and productive conversation with a physician consultant at MCSTAP. He was so amazingly helpful, practical, and flexible. The situation was that my colleague had scheduled a new patient with me, whose opioid dependence from a prior prescription had escalated into addiction and she was asking for help. MCSTAP was completely essential. With the physician consultant's expert assistance, we came up with an individualized plan and follow-up. This is an amazing service, a real game-changer."

In the News »

For Providers Only
Enroll in MCSTAP

Request **Consultation** | **COVID-19 Resources**

New and Noteworthy

Important news! The Federal Drug Enforcement Agency has ended the requirement of a DEA-X Waiver to prescribe buprenorphine as a medication for MOUD. Any prescriber with a DEA license can now prescribe buprenorphine. MCSTAP can help you learn to prescribe buprenorphine safely and effectively. Click here for a guide of prescribing. Call MCSTAP for a consultation on any questions on prescribing buprenorphine to your patients with OUD.

Provider Resources

Tools for providers and their staff on evidence-based guidelines for: screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options

Real-time physician consultation for clinicians on safe prescribing and managing care for adult patients with chronic pain, substance use disorders, or both

Resource and referral information about community-based providers, programs, and services to support patients with either chronic pain or substance use disorders

Contact MCSTAP at 1-833-PAIN-SUD (1-833-724-6783)

1000 Washington St. Suite 310, Boston, MA 02118

MCSTAP@beaconhealthoptions.com

Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP)

https://www.mcstap.com/

Basics: Offers real-time phone consultation to PCPs on safe prescribing and managing care for adults with chronic pain and/or SUD

Mission: MCSTAP's mission is to support Massachusetts clinicians in increasing their capacity for, and comfort in, using evidence-based practices in screening for, diagnosing, treating, and managing the care of all patients with chronic pain, substance use disorders, or both. MCSTAP does this by providing real-time, telephonic consultation on safe prescribing and managing care for these patients.

Services

Physician consultation: After being notified by the resource and referral specialist about a request for consultation, the physician consultant will call the provider within 30 minutes, or at a time specified by the provider. The physician consultant will ask the provider about the presenting issue and a summary of the patient's history. The consultation may involve diagnostic support, guidance related to prescribing new medications or adjusting current medications, treatment planning, and community support needs. The physician consultant will collaborate with the provider to identify next steps and will ask if the provider would like a follow-up call in the future.

Resource and Referral Specialist: If a provider would like information about community-based resources, the physician consultant will pass the request back to the resource and referral specialist. The resource and referral specialist will identify outpatient community resources for patients with chronic pain or substance use disorders. These can include individual therapy, group therapy, and other services that are geographically convenient for the patient and accept the patient's insurance.

MCSTAP Clinical Mentoring Program: MCSTAP offers short-term mentoring support, enabling a clinician to work with a designated MCSTAP physician consultant on an ongoing basis. A clinician who participates in this free service receives expert input on challenging cases and on clinical management topics for which they feel they would benefit from additional support. Click here for more information.

Requirement 5

- **Behavioral Health Medication Management**

Practice meets this requirement.

Utilizing Massachusetts Child Psychiatry Access Program (MCPAP) – links provided

WellSense BH Requirements Overview

Educational/CME opportunities on MDD/GAD/ADD: https://www.mycme.com/pages/mental-health-courses

Massachusetts Child Psychiatry Access Program (MCPAP) Summary

MCPAP summary (1).pdf

myCME

PROFESSIONS SPECIALTIES FEATURED PREMIUM CONTENT LIVE EVENTS CATALOGS Create A Free Account Cart (0)

These online mental health continuing medical education (CME) and continuing education (CE) courses provide education for physicians, physician assistants, nurses, nurse practitioners, pharmacists, and other clinicians. Courses on mental health include information on diagnosis, management, and treatment of mental health issues such as depression, schizophrenia, and eating disorders as well as related topics such as protocols, updates, special considerations when treating patients, and more.

What Mental Health CME/CE content is on myCME?

Below you will find a complete listing of courses applicable to those searching for education on mental health. The list includes free mental health CME/CE courses as well as those that require a fee, which are clearly marked as "Premium content."

Courses



Boston Medical Center
HEALTH SYSTEM

MassHealth Primary Care Sub-Capitation Provider Collaboration Series

Behavioral Health & Administrative Requirements

November 10, 2022

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**
- Tier Requirements
- Provider Resources
- Next steps and Q&A
- Appendix

Primary Care Sub-Capitation Provider Collaboration Series Reminders

- The **intent of the series** is to allow BMCHS/WS 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/WS is advocating to MassHealth regarding use of the PID/SL and offering recommendations for alternate methodologies.

Primary Care Sub-Capitation Program Provider Collaboration Series

We will host a network-wide provider collaboration series focused on helping our ACO partners understand the requirements for the primary care sub-capitation program, how to meet those requirements, and share best practices and barriers. Notes and materials from prior sessions are available on Box/MoveIt.

Registration for these meetings is required.

Today's Focus

Session Date Weekly Thursdays 3pm – 4pm	Topic	Description	Registration Link
November 10th	Behavioral Health Part 2	Consult on IBH approaches and partnership/administrative requirements (continued)	Zoom Registration
November 17th	E Consults	Exploring vendor systems for practices without access to broader network with integrated EMR	Zoom Registration
November 24th	CANCELED FOR THANKSGIVING	N/A	
December 1st	Oral Health	Identify oral health screening, develop local practice resources, share staffing, workflows, best practices for fluoride application in pediatrics	Zoom Registration
December 8th	WellSense Payment & Operations	Overview of MassHealth's payment methodology for the primary care sub-capitation program, how it impacts WellSense operations, and payment for primary care providers. *Suggested Attendees: Operations, Billing, Finance, Credentialing, Enrollment*	Zoom Registration
December 15th	Hours-Associated Requirements + SNAP/WIC Assistance	Discuss requirements associated with hours, inclusive of telehealth parameters; also offer guidance on SNAP/WIC assistance requirement	Zoom Registration

Schedule is subject to change. Any changes will be communicated ASAP.
If you have any comments, questions, or feedback please review with your ACO Operations Lead.

Agenda

- Overview
- **Tier Requirements**
- Provider Resources
- Next steps and Q&A
- Appendix

Today's webinar focuses on strategies to meet the following 4 requirements pertaining to BH and care coordination and FAQs

Sub-cap Tier	Population	Requirement
2	Adult + Pedi	Consulting Independent BH Clinician
2	Adult + Pedi	**One (1)** Team-based Staff Role
3	Adult + Pedi	Consulting BH Clinician with Prescribing Capability
3	Adult + Pedi	**Three (3)** Team-based Staff Roles

- **Note:** recent MassHealth Sub-cap Tier Requirement changes made team-based staffing requirements more flexible

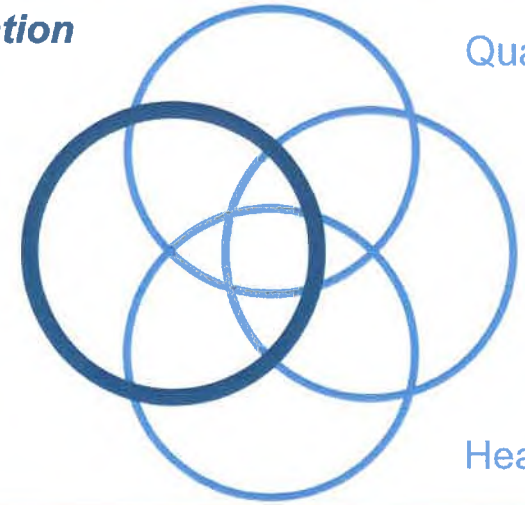
- **Pedi** applies to practices *primarily* serving Enrollees 21 years of age or younger
- **Adult** applies to practices *primarily* serving Enrollees ages 21-65

Note that many of the sub-capitation requirements have overlap with other MassHealth programs

Note that these BH requirements for the Primary Care sub-capitation program can help achieve…

- **Quality metrics**:
  - Depression Screening & Follow-up (DSF)
  - Initiation of Alcohol, or Other Drug Abuse or Dependence Treatment (IET)
  - Follow-up after Hospitalization for Mental illness (FUH)
- **Care management staffing**: Complex Care Managers (CCM) may also count toward the **Team-based Staff Roles** (Tier 2 and Tier 3 requirements)
- **Follow-up on screening requirements**: Including Adult BH and SUD screening, postpartum depression screening, and EPDST screening

*Meeting **primary care sub-capitation** requirements can help meet other requirements and targets*



BMCHS primary care sub-capitation FAQ guide: Coming soon

The BMCHS PHS team is cataloguing all FAQs that have come up for the primary care sub-capitation requirements, both during and outside of the Thursday Provider Collaboration Series.

We will disseminate a copy of our FAQ document, including both questions and guidances, once an initial version as been prepared. We will continually update the document (with notification of updates) as new questions arise and new guidances emerge.

Recap of requirements: Consulting Behavioral Health Clinician

Tier	Population	Requirement	Description
2	Adult + Pedi	Consulting Independent BH Clinician	Maintain a consulting independent BH clinician: maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above. • This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care. • This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two (2) business days.
3	Adult + Pedi	Consulting BH Clinician with Prescribing Capability	Maintain a consulting BH clinician with prescribing capability: maintain a dedicated and accessible consulting BH clinician on-site or virtually with prescribing capability available to assist the practice with cases of moderate and rising complexity. Such BH clinician shall: • Have familiarity with titration of BH medications (e.g., psychiatrist or psychiatric clinical nurse practitioner). • Be regularly available for activities including but not limited to making appointments on behalf of the practice in the same week, participating in case management activities, answering practice queries within two (2) business days, and assisting with co-management of referred cases

Implementation Strategy: Consulting Behavioral Health Clinician

	Implementation Recommendations	
	Option 1: For site with BH Clinicians	**Option 2: For Sites without BH Clinicians**
Tier 2	▪ **Consulting BH clinician**: Independently licensed BH clinician with or without prescribing capability for patient visits ▪ Note: This individual can also meet the "Team-based staff roles" requirements (Tier 2 and Tier 3)	▪ **CoCM Vendor**: Behavioral Health vendors that provide Collaborative Care Model (CoCM) services will meet Tier 2 Consulting BH clinician requirements.
Tier 3	▪ **Consulting BH prescriber**: BH clinician **<u>with</u>** prescribing capability available for patient visits, including same-week appointments ▪ Note: A Consulting BH prescriber will also meet the Tier 2 Consulting BH clinician requirement	▪ Note: Vendors that provide Collaborative Care Model (CoCM) services will likely not meet Tier 3 Consulting BH prescriber requirements, as most CoCM prescribers do not provide direct patient care

Operational Considerations

- **Fully virtual is acceptable**: On-site or hybrid is not required
- **BH clinician/prescriber availability**: To meet the two business day response requirement, the BH clinician/prescriber will need to be available for response on at least 3 days within a typical 5-day work week
- **Tier 3 prescriber same week availability**: Recommend "holding" subset of prescriber appointments until 1 week prior to date to create capacity for urgent appointments
- **Areas of flexibility**:
  - Tier 2: Team-based huddles and warm handoffs "where feasible"
  - Tier 3: Sites have discretion how often/for which cases to offer same-week appointments

Resources & Supports

- Please contact BMCHS PHS team if you are concerned that one of your Tier 2 or Tier 3 sites will not be able to meet this requirement

Backup: BH provider operationalization

Intentional clinic scheduling can meet MassHealth's requirements

0.3 FTE spread across 3 separate days can ensure BH provider **response within 2 business days**…

Example only

Mon	Tue	Wed	Thu	Fri
X				X*
		X		

X = *clinic session*
X* = *same-week session (for prescriber only)*

…and leaving a subset of slots (e.g., 1 session) as unscheduled until 1 week before can ensure **same-week availability**

For limited provider capacity or demand, consider fewer "sessions"

<0.3 FTE may be sufficient to meet BH provider **response within 2 business days**

Example only

Mon	Tue	Wed	Thu	Fri
T				X*
		(R)		

X = *clinic session*
X* = *same-week session (for prescriber only)*
T = *Team meeting / in-basket review*
(R) = *In-basket review only*

Recap of requirements: Team-based Staff Roles

Tier	Population	Requirement	Description
2	Adult + Pedi	**One (1)** Team-based Staff Role	Team-based staff role: maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles: • Community health worker (CHW) • Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator) • Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW) • Nurse case manager Such team-based role shall: • Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., >0.3 FTE) per week, • Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities. • Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

Implementation Strategy: Team-based Staff Roles (Tier 2)

Implementation Recommendations

Option 1: In-Person Staff Rotations

- Ensure staff role is available on-site to a specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 1 team-based staff role could meet staffing requirement for up to 3 separate PIDSL sites (see back-up slide for example)
- Note: A BH clinician can be used to meet both team-based staff requirement and Tier 2 "Consulting Independent BH Clinician" requirement

Option 2: Dedicated Virtual Availability

- Ensure staff role is available virtually to each specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 1 remote team-based role could meet staffing requirement for up to 3 separate PIDSL sites (see next slide for example)
- Remote staff must be available on-site at each PIDSL site they cover **at least once per month**
  - Staffing at least one shift per week in-person at a unique PIDSL would meet this requirement

Operational Considerations

- For all implementation options: shift staffing for these roles should align with regular team huddles/care planning meetings at each PIDSL site
- We recommend scheduled shifts remain at consistent days/times as much as possible for reliable patient access and schedule management for team-based personnel
- We encourage sites to use existing roles/staff to meet these requirements where possible
- Sites should consider how meeting these team-based roles can best support their organizational priorities, including: care management, Flexible Services program referrals, HRSN screenings, quality performance, etc.

Backup: Team-based role operationalization (Tier 2)

Intentional staffing can meet MassHealth requirements

0.3 FTE spread across 3 separate PIDSLs (sites "A," "B," and "C") can meet the team-based role availability requirement for each:

Example only

	Mon	Tue	Wed	Thu	Fri
Shift 1 (*4 hrs*)	*Site A*	*Site B*	*Site A**	*Site C*	*Site C*
Shift 2 (*4 hrs*)	*Site A*	*Site B*	*Site B*	*Site C*	**

** = illustrative; same-day travel between two PIDSL sites for sessions may not be feasible. Consider tele-work as a solution for these "split coverage" days in particular*

*** = open availability; work conducted on behalf of any PIDSL site, or held for non-site-specific work*

- This example staffing model can apply to both in-person and virtual availability sessions.
- For operationalizing a virtual team-based role, ensure the FTE works in-person from each clinic site they are supporting **at least once per month.**

Recap of requirements: Team-based Staff Roles

Tier	Population	Requirement	Description

3	Adult + Pedi	Three (3) Team-based Staff Roles	Three team-based staff roles: maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following:
			• At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW)
			• At least one (1) staff role shall be a peer, family navigator, CHW, or similar.
			• The other staff role(s) may be one of the following, or similar:
			  • Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
			  • Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
			  • Nurse case manager
			Such team-based roles shall:
			• Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE) individually, and at minimum collectively 1.0 FTE per the practice.
			• Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
			• Collectively, ensure at least one (1) FTE meeting these staff roles is available and dedicated to the practice at each of the 10 usual business hour sessions (Monday through Friday, mornings and afternoons) to respond in real-time to practice needs.
			• All participate in regular team activities such as team huddles (i.e., standing team meetings for the purpose of pre-visit planning), population health management, and/or process improvement

Implementation Strategy: Team-based Staff Roles (Tier 3)

Implementation Recommendations

Option 1: In-Person Staff Rotations

- Ensure staff roles are available on-site to each specific PIDSL for a minimum of 3, 4-hour sessions per week individually
  - Ex: 3 team-based staff roles could meet staffing requirement for up to 3 separate PIDSL sites (see next slide example)
- Note: A BH clinician can count towards both team-based staff requirement and Tier 2 "Consulting Independent BH Clinician" requirement

Option 2: Dedicated Virtual Availability

- Ensure staff role is available virtually to each specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 3 remote team-based roles could meet staffing requirement for up to 3 separate PIDSL sites (see next slide example)
- Remote staff must be available on-site at each PIDSL site they cover **at least once per month**
  - Staffing each role for at least one shift per week in-person at one of the PIDSL sites they cover would meet this requirement

Operational Considerations

- Aligning with tier 2 strategy: shift staffing for these roles should align with regular team huddles/care planning meetings at each PIDSL site
- We recommend scheduled shifts remain at consistent days/times as much as possible for reliable patient access and schedule management for team-based personnel
- Team-based roles must also provide a **combined** support capacity of 1 FTE per week to each PIDSL site – unlike the tier 2 strategy, minimum staffing may not allow capacity for non-site-specific shifts
- Sites should consider how meeting these team-based roles can best support their organizational priorities, including: care management, Flexible Services program referrals, HRSN screenings, quality performance, etc.

Backup: Team-based role operationalization (Tier 3)

Intentional staffing can meet MassHealth requirements

3 FTEs staffed across 3 separate PIDSLs (sites "A," "B," and "C") can meet the team-based role availability requirement for each:

Example only

		Mon	Tue	Wed	Thu	Fri
Role #1	Shift 1 (*4 hrs*)	*Site A*	*Site A*	*Site B*	*Site C*	*Site C*
	Shift 2 (*4 hrs*)	*Site A*	*Site B**	*Site B*	*Site C*	*Site C*
Role #2	Shift 1 (*4 hrs*)	*Site B*	*Site B**	*Site C*	*Site A*	*Site A*
	Shift 2 (*4 hrs*)	*Site B*	*Site C*	*Site C*	*Site B**	*Site A*
Role #3	Shift 1 (*4 hrs*)	*Site C*	*Site C**	*Site A*	*Site B**	*Site B*
	Shift 2 (*4 hrs*)	*Site C*	*Site A*	*Site A*	*Site A*	*Site B*

* = *same-day travel between two PIDSL sites for sessions may not be feasible. Consider tele-work as a solution for these "split coverage" days in particular*

- Each role works 1 or 2 days "split" between sites per week
- This example staffing model can apply to both in-person and virtual availability sessions.
- For operationalizing virtual team-based roles, ensure the FTE works in-person from each clinic site they are supporting **at least once per month.**

Agenda

- Overview
- Tier Requirements
- Provider Resources
- **Next steps and Q&A**
- Appendix

Next steps

- ACO Operations leads will continue to work with ACOs to support implementation strategies for these requirements

- Please reach out to our BH Subcap Team if you have questions or ideas:
  - Chris Lim, Christopher.Lim@bmc.org
  - Fili Heider, Felicia.Heider@bmc.org
  - Ben Delikat, Benjamin.Delikat@bmc.org

Questions & Discussion

- Do you have any clarifying questions about the requirements?
- What ideas and best practices pertaining to these requirements do you have that you would like to share?
- What are other ideas for additional supports or resources that BMCHS could provide?

Primary Care Sub-Capitation Program Provider Collaboration Series

We will host a network-wide provider collaboration series focused on helping our ACO partners understand the requirements for the primary care sub-capitation program, how to meet those requirements, and share best practices and barriers. Notes and materials from prior sessions are available on Box/MoveIt.

Registration for these meetings is required.

Next Session

Session Date Weekly Thursdays 3pm – 4pm	Topic	Description	Registration Link
November 10th	Behavioral Health Part 2	Consult on IBH approaches and partnership/administrative requirements (continued)	Zoom Registration
November 17th	E Consults	Exploring vendor systems for practices without access to broader network with integrated EMR	Zoom Registration
November 24th	CANCELED FOR THANKSGIVING	N/A	
December 1st	Oral Health	Identify oral health screening, develop local practice resources, share staffing, workflows, best practices for fluoride application in pediatrics	Zoom Registration
December 8th	WellSense Payment & Operations	Overview of MassHealth's payment methodology for the primary care sub-capitation program, how it impacts WellSense operations, and payment for primary care providers. *Suggested Attendees: Operations, Billing, Finance, Credentialing, Enrollment*	Zoom Registration
December 15th	Hours-Associated Requirements + SNAP/WIC Assistance	Discuss requirements associated with hours, inclusive of telehealth parameters; also offer guidance on SNAP/WIC assistance requirement	Zoom Registration

Schedule is subject to change. Any changes will be communicated ASAP.
If you have any comments, questions, or feedback please review with your ACO Operations Lead.

Agenda

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- **Appendix**
  - **General Sub-Cap Resources**

Acronyms

ABMS	American Board of Medical Specialties
AUD	Alcohol Use Disorder
BH	Behavioral Health
CBHI	Children's Behavioral Health Initiative
CBT	Cognitive Behavioral Therapy
CHW	Community Health Worker
DCF	Massachusetts Department of Children and Families
DDS	Massachusetts Department of Developmental Services
DMH	Massachusetts Department of Mental Health
DPH	Massachusetts Department of Public Health
DTA	Massachusetts Department of Transitional Assistance
DYS	Massachusetts Department of Youth Services
EHR	Electronic Health Record
EPDS	Edinburgh Postnatal Depression Scale
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FRC	Family Resource Centers

HRSN	Health-Related Social Needs
LARC	Long-Acting Reversible Contraception
LCSW	Licensed Clinical Social Worker
LICSW	Licensed Independent Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
M4M	Massachusetts Child Psychiatry Access Program for Moms
Mass PAT	Massachusetts Prescription Awareness Tool
MCPAP	Massachusetts Child Psychiatry Access Program
MOUD	Medication for Opioid Use Disorder
MSW	Master of Social Work
NOI	Notice of intent
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SNAP	Supplemental Nutrition Assistance Program
WIC	Special Supplemental Nutrition Assistance Program for Women, Infants, and Children

Terms

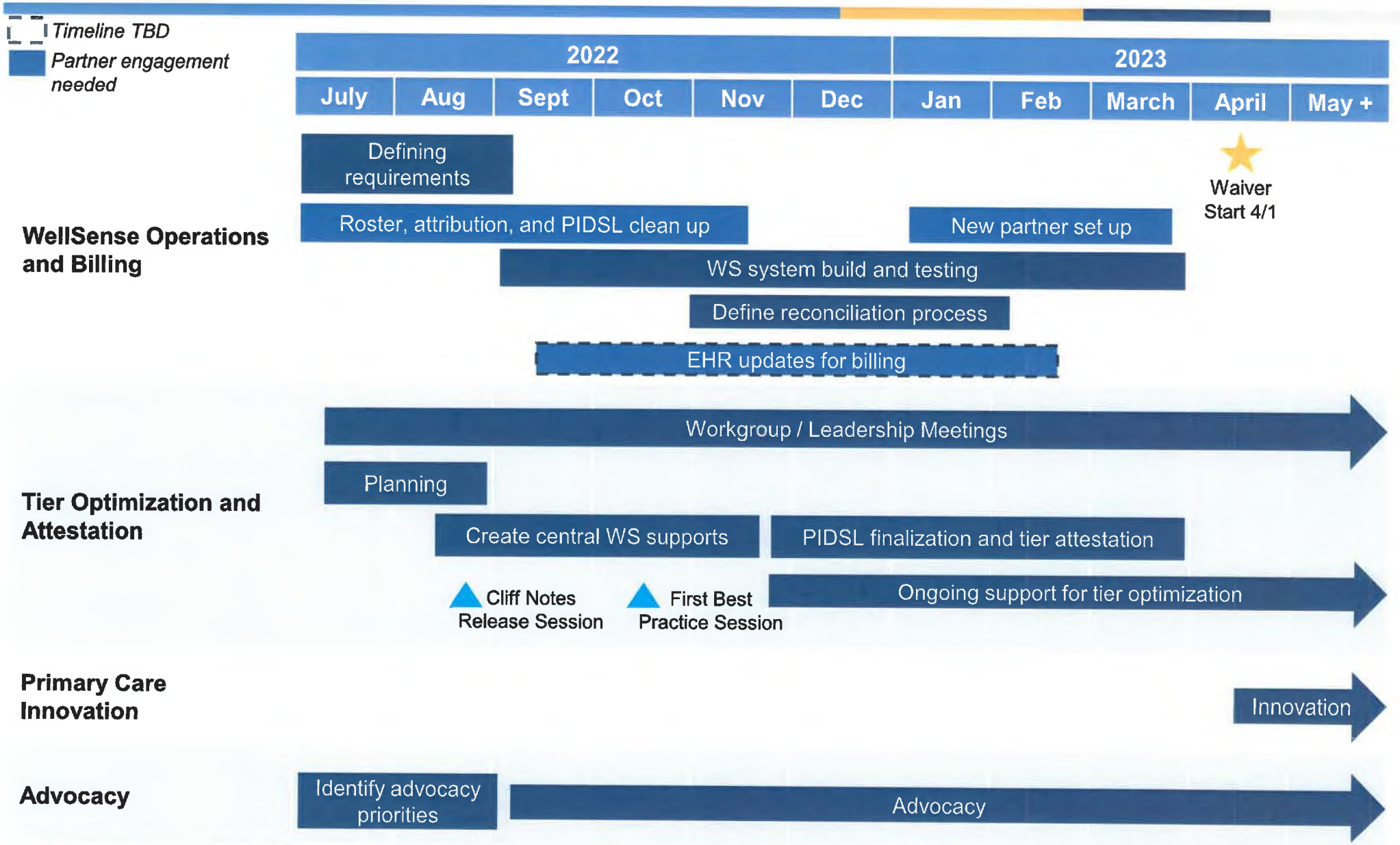
Adult practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to adults and those >21 years of age. An adult practice shall fulfill requirements specific to adult populations. Pediatric practices that serve a small number of adult patients are not adult practices, and do not need to meet the requirements specific to adult populations Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
E-Consult	Asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.
Family Medicine practice	Any primary care practice, either standalone or within a larger building, that provides care to patients across the lifespan. A family medicine practice shall fulfill requirements specific to both pediatric and adult populations. Each Family Medicine practice shall have a single Tier Designation
Pediatric practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to children and adolescent patients 21 years of age or younger. A pediatric practice shall fulfill requirements specific to pediatric populations. Adult practices that serve a small number of patients under age 21 are not pediatric practices, and do not need to meet the requirements specific to adult populations. Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
Session	≥4 consecutive hours of clinical work time, usually defined as a continuous morning or afternoon block of time in which providers see patients.

Requirements by Tier

TIER 1	TIER 2	TIER 3
Requirement	Requirement	Requirement
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
Oral health screening and referral	E-consults available in at least three (3) specialties	After-hours or weekend sessions (3+ sessions)
BH and substance use disorder screening	After-hours or weekend session (1+ sessions)	Three team-based staff roles
BH referral with bi-directional communication, tracking, and monitoring	Team-based staff role	Maintain consulting BH clinician with prescribing capability
BH medication management	Maintain consulting independent BH clinician	On-site staff with children, youth, family-specific expertise (FT) P
Health-Related Social Needs screening	On-site staff with children, youth, and family-specific expertise (part or full time) P	LARC provision, at least 1 option P
Care coordination	Provide SNAP and WIC assistance P	Active Buprenorphine Availability P
Clinical Advice and Support Line	Buprenorphine Waivered Practitioner (1) P	LARC provision, multiple options A
Postpartum depression screening	LARC provision, at least one option A	Next-business-day MOUD induction and F/U A
Use of Prescription Monitoring Program	Active Buprenorphine Availability A	
LARC provision, referral option	Active AUD Treatment Availability A	
Same-day urgent care capacity		
Video telehealth capability		
No reduction in hours		
Translation and Interpreter Services		
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		
Buprenorphine Waivered Practitioners (all) A		

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

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.

MCPAP (Massachusetts Child Psychiatry Access Program)

https://www.mcpap.com/Provider/McPAPservice.aspx

Basics: system of regional children's behavioral health consultation teams designed to help primary care providers and their practices to promote and manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness

Mission: MCPAP provides collaborative support to pediatric primary care providers (PCPs) and their patient-care teams to enhance their ability to promote and manage their patients' behavioral health as a fundamental component of overall health and wellness. Through consultation and education, MCPAP improves the pediatric team's competencies in screening, identification, and assessment; treating mild to moderate cases of behavioral health disorders; and in making effective referrals and coordinating the care for patients who need community-based specialty services.

Services:

MCPAP's core services include:

- Telephone consultation with either a Child and Adolescent Psychiatrist or independently licensed Behavioral Health Clinician
- Face-to-face consultation with either a Child and Adolescent Psychiatrist or independently licensed Behavioral Health Clinician when indicated
- Resource and Referral
- Practice-focused training and education

Consultation
Practices use MCPAP most frequently for consultation. Phone inquiries are usually patient-specific, but can also be about any general question related to child psychiatry, behavioral health, or community resources. Telephone consultation can be with the Regional Team's psychiatric consultant, the behavioral health clinician or resource & referral specialist.
MCPAP team members respond to a request for consultation within 30 minutes and often immediately.

Resource and Referral
The behavioral health system is complex and difficult to navigate. There are often lengthy waits for services, especially for child psychiatry services. MCPAP resource and referral specialists are experts at identifying and maintaining up-to-date behavioral health resources in the community.

Education & Practice-Focused Consultation Services
Over time, PCPs increase their knowledge and comfort level from the telephone consultations around specific patients. MCPAP team members are also available for education and training relative to psychiatric disorders and medications, as well as practice transformation processes to improve integration of behavioral health with primary care. At times MCPAP is involved with implementing a new or updated screening or treatment protocol and the regional teams will proactively contact enrolled practices to provide training for providers.

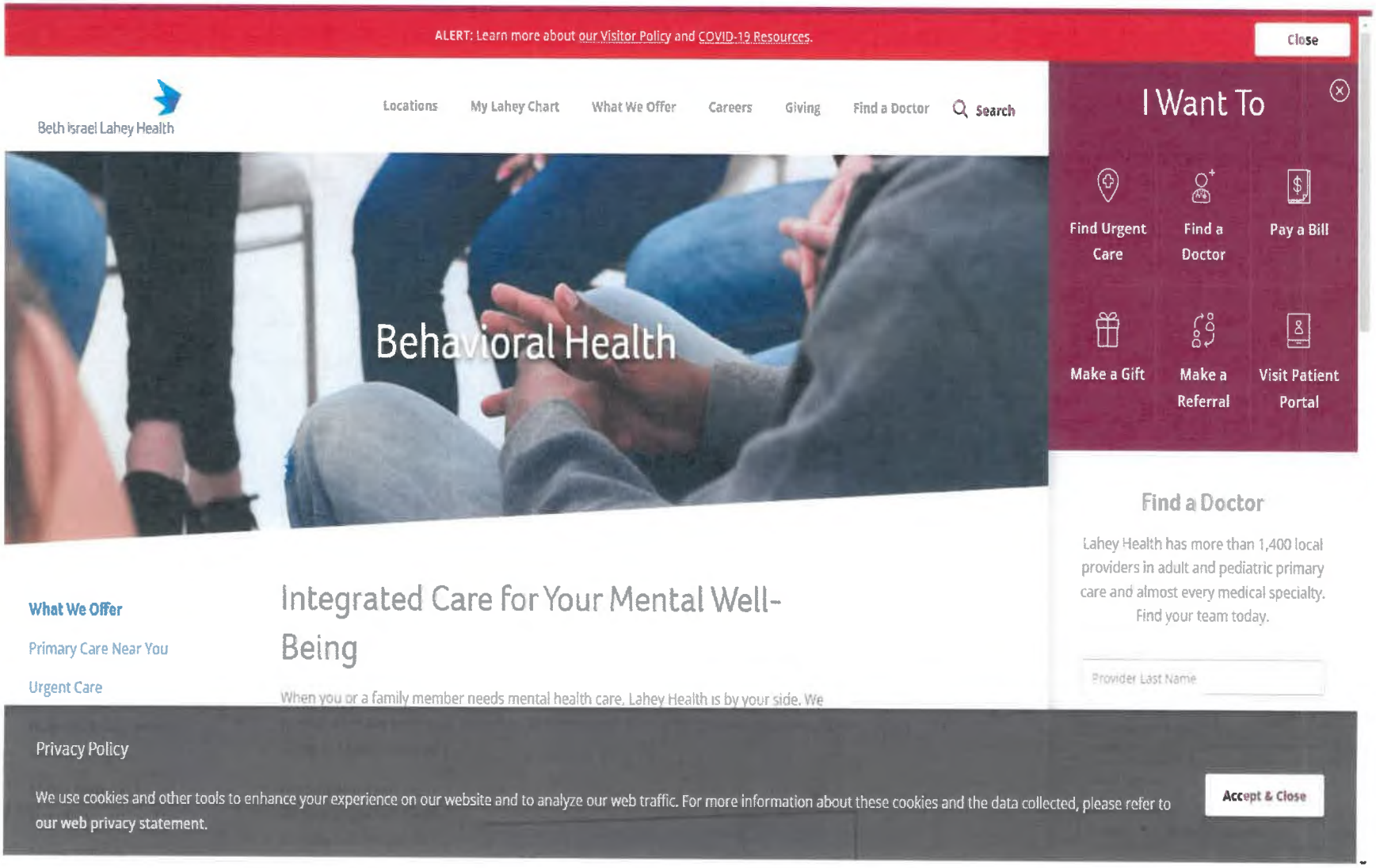
Requirement 6

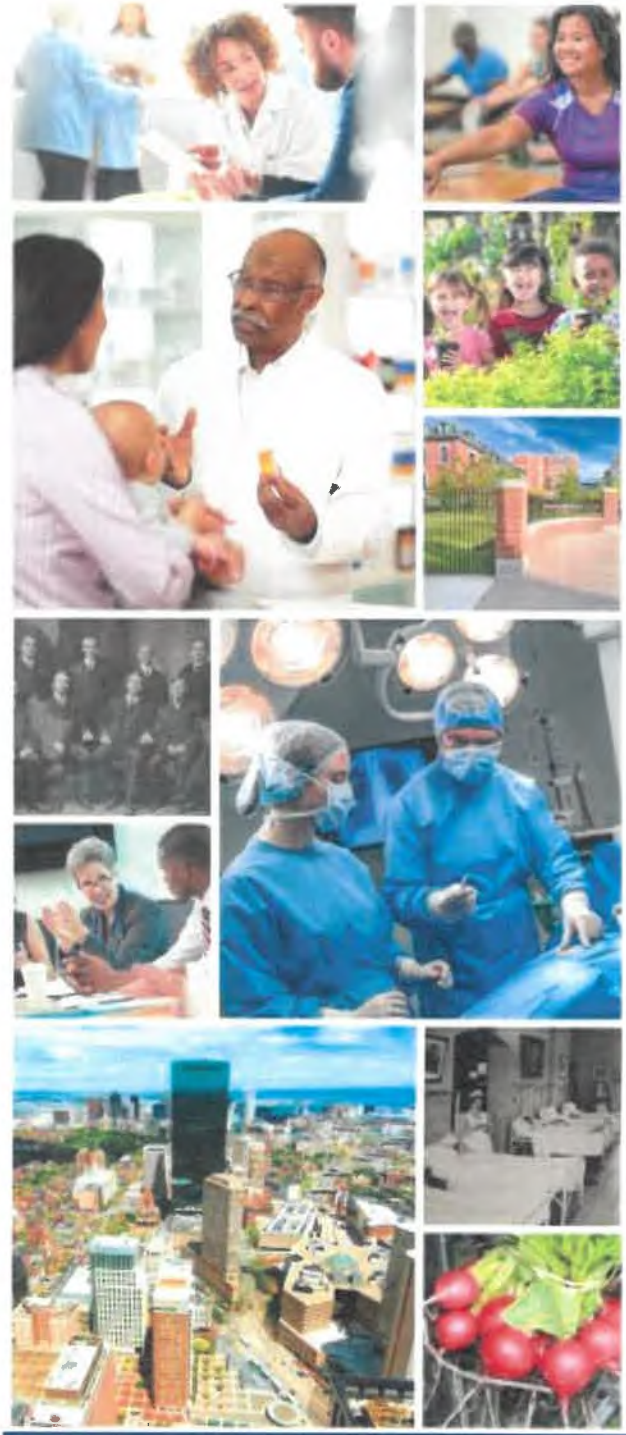
- **Behavioral Health Referral with Bidirectional Communication**

Practice meets this requirement.

Practice utilizes the Lahey Behavioral Health Services and WellSense network list of local and reasonably accessible BH providers within the MassHealth network. Links provided below.

https://www.lahey.org/what-we-offer/behavioral-health/
https://www.beaconhealthoptions.com/find-a-provider/


ALERT: Learn more about our Visitor Policy and COVID-19 Resources.
Close
Beth Israel Lahey Health
Locations
My Lahey Chart
What We Offer
Careers
Giving
Find a Doctor
Search
Behavioral Health
I Want To
Find Urgent Care
Find a Doctor
Pay a Bill
Make a Gift
Make a Referral
Visit Patient Portal
What We Offer
Primary Care Near You
Urgent Care
Integrated Care for Your Mental Well-Being
When you or a family member needs mental health care, Lahey Health is by your side. We
Find a Doctor
Lahey Health has more than 1,400 local providers in adult and pediatric primary care and almost every medical specialty. Find your team today.
Provider Last Name
Privacy Policy
We use cookies and other tools to enhance your experience on our website and to analyze our web traffic. For more information about these cookies and the data collected, please refer to our web privacy statement.
Accept & Close



Boston Medical Center
HEALTH SYSTEM

MassHealth Primary Care Sub-Capitation Provider Collaboration Series

Behavioral Health & Administrative Requirements

November 10, 2022

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**
- Tier Requirements
- Provider Resources
- Next steps and Q&A
- Appendix

Primary Care Sub-Capitation Provider Collaboration Series Reminders

- The **intent of the series** is to allow BMCHS/WS 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/WS is advocating to MassHealth regarding use of the PID/SL and offering recommendations for alternate methodologies.

Primary Care Sub-Capitation Program Provider Collaboration Series

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Today's Focus

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Today's webinar focuses on strategies to meet the following 4 requirements pertaining to BH and care coordination and FAQs

Sub-cap Tier	Population	Requirement
2	Adult + Pedi	Consulting Independent BH Clinician
2	Adult + Pedi	**One (1)** Team-based Staff Role
3	Adult + Pedi	Consulting BH Clinician with Prescribing Capability
3	Adult + Pedi	**Three (3)** Team-based Staff Roles

- **Note:** recent MassHealth Sub-cap Tier Requirement changes made team-based staffing requirements more flexible

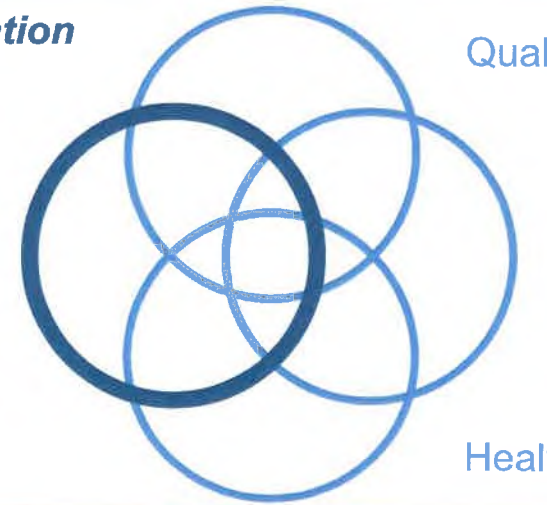
- **Pedi** applies to practices *primarily* serving Enrollees 21 years of age or younger
- **Adult** applies to practices *primarily* serving Enrollees ages 21-65

Note that many of the sub-capitation requirements have overlap with other MassHealth programs

Note that these BH requirements for the Primary Care sub-capitation program can help achieve…

- **Quality metrics**:
  - Depression Screening & Follow-up (DSF)
  - Initiation of Alcohol, or Other Drug Abuse or Dependence Treatment (IET)
  - Follow-up after Hospitalization for Mental illness (FUH)
- **Care management staffing**: Complex Care Managers (CCM) may also count toward the **Team-based Staff Roles** (Tier 2 and Tier 3 requirements)
- **Follow-up on screening requirements**: Including Adult BH and SUD screening, postpartum depression screening, and EPDST screening

*Meeting **primary care sub-capitation** requirements can help meet other requirements and targets*



BMCHS primary care sub-capitation FAQ guide: Coming soon

The BMCHS PHS team is cataloguing all FAQs that have come up for the primary care sub-capitation requirements, both during and outside of the Thursday Provider Collaboration Series.

We will disseminate a copy of our FAQ document, including both questions and guidances, once an initial version as been prepared. We will continually update the document (with notification of updates) as new questions arise and new guidances emerge.

Recap of requirements: Consulting Behavioral Health Clinician

Tier	Population	Requirement	Description
2	Adult + Pedi	Consulting Independent BH Clinician	Maintain a consulting independent BH clinician: maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above. • This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care. • This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two (2) business days.
3	Adult + Pedi	Consulting BH Clinician with Prescribing Capability	Maintain a consulting BH clinician with prescribing capability: maintain a dedicated and accessible consulting BH clinician on-site or virtually with prescribing capability available to assist the practice with cases of moderate and rising complexity. Such BH clinician shall: • Have familiarity with titration of BH medications (e.g., psychiatrist or psychiatric clinical nurse practitioner). • Be regularly available for activities including but not limited to making appointments on behalf of the practice in the same week, participating in case management activities, answering practice queries within two (2) business days, and assisting with co-management of referred cases

Implementation Strategy: Consulting Behavioral Health Clinician

	Implementation Recommendations	
	Option 1: For site with BH Clinicians	**Option 2: For Sites without BH Clinicians**
Tier 2	▪ **Consulting BH clinician**: Independently licensed BH clinician with or without prescribing capability for patient visits ▪ Note: This individual can also meet the "Team-based staff roles" requirements (Tier 2 and Tier 3)	▪ **CoCM Vendor**: Behavioral Health vendors that provide Collaborative Care Model (CoCM) services will meet Tier 2 Consulting BH clinician requirements.
Tier 3	▪ **Consulting BH prescriber**: BH clinician **<u>with</u>** prescribing capability available for patient visits, including same-week appointments ▪ Note: A Consulting BH prescriber will also meet the Tier 2 Consulting BH clinician requirement	▪ Note: Vendors that provide Collaborative Care Model (CoCM) services will likely not meet Tier 3 Consulting BH prescriber requirements, as most CoCM prescribers do not provide direct patient care

Operational Considerations

- **Fully virtual is acceptable**: On-site or hybrid is not required
- **BH clinician/prescriber availability**: To meet the two business day response requirement, the BH clinician/prescriber will need to be available for response on at least 3 days within a typical 5-day work week
- **Tier 3 prescriber same week availability**: Recommend "holding" subset of prescriber appointments until 1 week prior to date to create capacity for urgent appointments
- **Areas of flexibility**:
  - Tier 2: Team-based huddles and warm handoffs "where feasible"
  - Tier 3: Sites have discretion how often/for which cases to offer same-week appointments

Resources & Supports

- Please contact BMCHS PHS team if you are concerned that one of your Tier 2 or Tier 3 sites will not be able to meet this requirement

Backup: BH provider operationalization

Intentional clinic scheduling can meet MassHealth's requirements

0.3 FTE spread across 3 separate days can ensure BH provider **response within 2 business days**…

Example only

Mon	Tue	Wed	Thu	Fri
X				X*
		X		

X = *clinic session*
X* = *same-week session (for prescriber only)*

…and leaving a subset of slots (e.g., 1 session) as unscheduled until 1 week before can ensure **same-week availability**

For limited provider capacity or demand, consider fewer "sessions"

<0.3 FTE may be sufficient to meet BH provider **response within 2 business days**

Example only

Mon	Tue	Wed	Thu	Fri
T				X*
		(R)		

X = *clinic session*
X* = *same-week session (for prescriber only)*
T = *Team meeting / in-basket review*
(R) = *In-basket review only*

Recap of requirements: Team-based Staff Roles

Tier	Population	Requirement	Description
2	Adult + Pedi	**One (1)** Team-based Staff Role	Team-based staff role: maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles: • Community health worker (CHW) • Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator) • Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW) • Nurse case manager Such team-based role shall: • Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., >0.3 FTE) per week, • Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities. • Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

Implementation Strategy: Team-based Staff Roles (Tier 2)

Implementation Recommendations

Option 1: In-Person Staff Rotations

- Ensure staff role is available on-site to a specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 1 team-based staff role could meet staffing requirement for up to 3 separate PIDSL sites (see back-up slide for example)
- Note: A BH clinician can be used to meet both team-based staff requirement and Tier 2 "Consulting Independent BH Clinician" requirement

Option 2: Dedicated Virtual Availability

- Ensure staff role is available virtually to each specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 1 remote team-based role could meet staffing requirement for up to 3 separate PIDSL sites (see next slide for example)
- Remote staff must be available on-site at each PIDSL site they cover **at least once per month**
  - Staffing at least one shift per week in-person at a unique PIDSL would meet this requirement

Operational Considerations

- For all implementation options: shift staffing for these roles should align with regular team huddles/care planning meetings at each PIDSL site
- We recommend scheduled shifts remain at consistent days/times as much as possible for reliable patient access and schedule management for team-based personnel
- We encourage sites to use existing roles/staff to meet these requirements where possible
- Sites should consider how meeting these team-based roles can best support their organizational priorities, including: care management, Flexible Services program referrals, HRSN screenings, quality performance, etc.

Backup: Team-based role operationalization (Tier 2)

Intentional staffing can meet MassHealth requirements

0.3 FTE spread across 3 separate PIDSLs (sites "A," "B," and "C") can meet the team-based role availability requirement for each:

Example only

	Mon	Tue	Wed	Thu	Fri
Shift 1 (*4 hrs*)	*Site A*	*Site B*	*Site A**	*Site C*	*Site C*
Shift 2 (*4 hrs*)	*Site A*	*Site B*	*Site B*	*Site C*	**

** = illustrative; same-day travel between two PIDSL sites for sessions may not be feasible. Consider tele-work as a solution for these "split coverage" days in particular*

*** = open availability; work conducted on behalf of any PIDSL site, or held for non-site-specific work*

- This example staffing model can apply to both in-person and virtual availability sessions.
- For operationalizing a virtual team-based role, ensure the FTE works in-person from each clinic site they are supporting **at least once per month.**

Recap of requirements: Team-based Staff Roles

Tier	Population	Requirement	Description

3	Adult + Pedi	Three (3) Team-based Staff Roles	Three team-based staff roles: maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following:
			• At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW)
			• At least one (1) staff role shall be a peer, family navigator, CHW, or similar.
			• The other staff role(s) may be one of the following, or similar:
			  • Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
			  • Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
			  • Nurse case manager
			Such team-based roles shall:
			• Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE) individually, and at minimum collectively 1.0 FTE per the practice.
			• Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
			• Collectively, ensure at least one (1) FTE meeting these staff roles is available and dedicated to the practice at each of the 10 usual business hour sessions (Monday through Friday, mornings and afternoons) to respond in real-time to practice needs.
			• All participate in regular team activities such as team huddles (i.e., standing team meetings for the purpose of pre-visit planning), population health management, and/or process improvement

Implementation Strategy: Team-based Staff Roles (Tier 3)

Implementation Recommendations

Option 1: In-Person Staff Rotations

- Ensure staff roles are available on-site to each specific PIDSL for a minimum of 3, 4-hour sessions per week individually
  - Ex: 3 team-based staff roles could meet staffing requirement for up to 3 separate PIDSL sites (see next slide example)
- Note: A BH clinician can count towards both team-based staff requirement and Tier 2 "Consulting Independent BH Clinician" requirement

Option 2: Dedicated Virtual Availability

- Ensure staff role is available virtually to each specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 3 remote team-based roles could meet staffing requirement for up to 3 separate PIDSL sites (see next slide example)
- Remote staff must be available on-site at each PIDSL site they cover **at least once per month**
  - Staffing each role for at least one shift per week in-person at one of the PIDSL sites they cover would meet this requirement

Operational Considerations

- Aligning with tier 2 strategy: shift staffing for these roles should align with regular team huddles/care planning meetings at each PIDSL site
- We recommend scheduled shifts remain at consistent days/times as much as possible for reliable patient access and schedule management for team-based personnel
- Team-based roles must also provide a **combined** support capacity of 1 FTE per week to each PIDSL site – unlike the tier 2 strategy, minimum staffing may not allow capacity for non-site-specific shifts
- Sites should consider how meeting these team-based roles can best support their organizational priorities, including: care management, Flexible Services program referrals, HRSN screenings, quality performance, etc.

Backup: Team-based role operationalization (Tier 3)

Intentional staffing can meet MassHealth requirements

3 FTEs staffed across 3 separate PIDSLs (sites "A," "B," and "C") can meet the team-based role availability requirement for each:

Example only

		Mon	Tue	Wed	Thu	Fri
Role #1	Shift 1 (*4 hrs*)	*Site A*	*Site A*	*Site B*	*Site C*	*Site C*
	Shift 2 (*4 hrs*)	*Site A*	*Site B**	*Site B*	*Site C*	*Site C*
Role #2	Shift 1 (*4 hrs*)	*Site B*	*Site B**	*Site C*	*Site A*	*Site A*
	Shift 2 (*4 hrs*)	*Site B*	*Site C*	*Site C*	*Site B**	*Site A*
Role #3	Shift 1 (*4 hrs*)	*Site C*	*Site C**	*Site A*	*Site B**	*Site B*
	Shift 2 (*4 hrs*)	*Site C*	*Site A*	*Site A*	*Site A*	*Site B*

** = same-day travel between two PIDSL sites for sessions may not be feasible. Consider tele-work as a solution for these "split coverage" days in particular*

- Each role works 1 or 2 days "split" between sites per week
- This example staffing model can apply to both in-person and virtual availability sessions.
- For operationalizing virtual team-based roles, ensure the FTE works in-person from each clinic site they are supporting **at least once per month**.

Agenda

- Overview
- Tier Requirements
- Provider Resources
- **Next steps and Q&A**
- Appendix

Next steps

- ACO Operations leads will continue to work with ACOs to support implementation strategies for these requirements

- Please reach out to our BH Subcap Team if you have questions or ideas:
  - Chris Lim, Christopher.Lim@bmc.org
  - Fili Heider, Felicia.Heider@bmc.org
  - Ben Delikat, Benjamin.Delikat@bmc.org

Questions & Discussion

- Do you have any clarifying questions about the requirements?
- What ideas and best practices pertaining to these requirements do you have that you would like to share?
- What are other ideas for additional supports or resources that BMCHS could provide?

Primary Care Sub-Capitation Program Provider Collaboration Series

We will host a network-wide provider collaboration series focused on helping our ACO partners understand the requirements for the primary care sub-capitation program, how to meet those requirements, and share best practices and barriers. Notes and materials from prior sessions are available on Box/MoveIt.

Registration for these meetings is required.

Next Session

Session Date Weekly Thursdays 3pm – 4pm	Topic	Description	Registration Link
November 10th	Behavioral Health Part 2	Consult on IBH approaches and partnership/administrative requirements (continued)	Zoom Registration
November 17th	**E Consults**	**Exploring vendor systems for practices without access to broader network with integrated EMR**	Zoom Registration
November 24th	CANCELED FOR THANKSGIVING	N/A	
December 1st	Oral Health	Identify oral health screening, develop local practice resources, share staffing, workflows, best practices for fluoride application in pediatrics	Zoom Registration
December 8th	WellSense Payment & Operations	Overview of MassHealth's payment methodology for the primary care sub-capitation program, how it impacts WellSense operations, and payment for primary care providers. *Suggested Attendees: Operations, Billing, Finance, Credentialing, Enrollment*	Zoom Registration
December 15th	Hours-Associated Requirements + SNAP/WIC Assistance	Discuss requirements associated with hours, inclusive of telehealth parameters; also offer guidance on SNAP/WIC assistance requirement	Zoom Registration

Schedule is subject to change. Any changes will be communicated ASAP.
If you have any comments, questions, or feedback please review with your ACO Operations Lead.

Agenda

- Overview
- Tier Requirements
- Provider Resources
- Next steps and Q&A
- **Appendix**
  - **General Sub-Cap Resources**

Acronyms

ABMS	American Board of Medical Specialties
AUD	Alcohol Use Disorder
BH	Behavioral Health
CBHI	Children's Behavioral Health Initiative
CBT	Cognitive Behavioral Therapy
CHW	Community Health Worker
DCF	Massachusetts Department of Children and Families
DDS	Massachusetts Department of Developmental Services
DMH	Massachusetts Department of Mental Health
DPH	Massachusetts Department of Public Health
DTA	Massachusetts Department of Transitional Assistance
DYS	Massachusetts Department of Youth Services
EHR	Electronic Health Record
EPDS	Edinburgh Postnatal Depression Scale
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FRC	Family Resource Centers

HRSN	Health-Related Social Needs
LARC	Long-Acting Reversible Contraception
LCSW	Licensed Clinical Social Worker
LICSW	Licensed Independent Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
M4M	Massachusetts Child Psychiatry Access Program for Moms
Mass PAT	Massachusetts Prescription Awareness Tool
MCPAP	Massachusetts Child Psychiatry Access Program
MOUD	Medication for Opioid Use Disorder
MSW	Master of Social Work
NOI	Notice of intent
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SNAP	Supplemental Nutrition Assistance Program
WIC	Special Supplemental Nutrition Assistance Program for Women, Infants, and Children

Terms

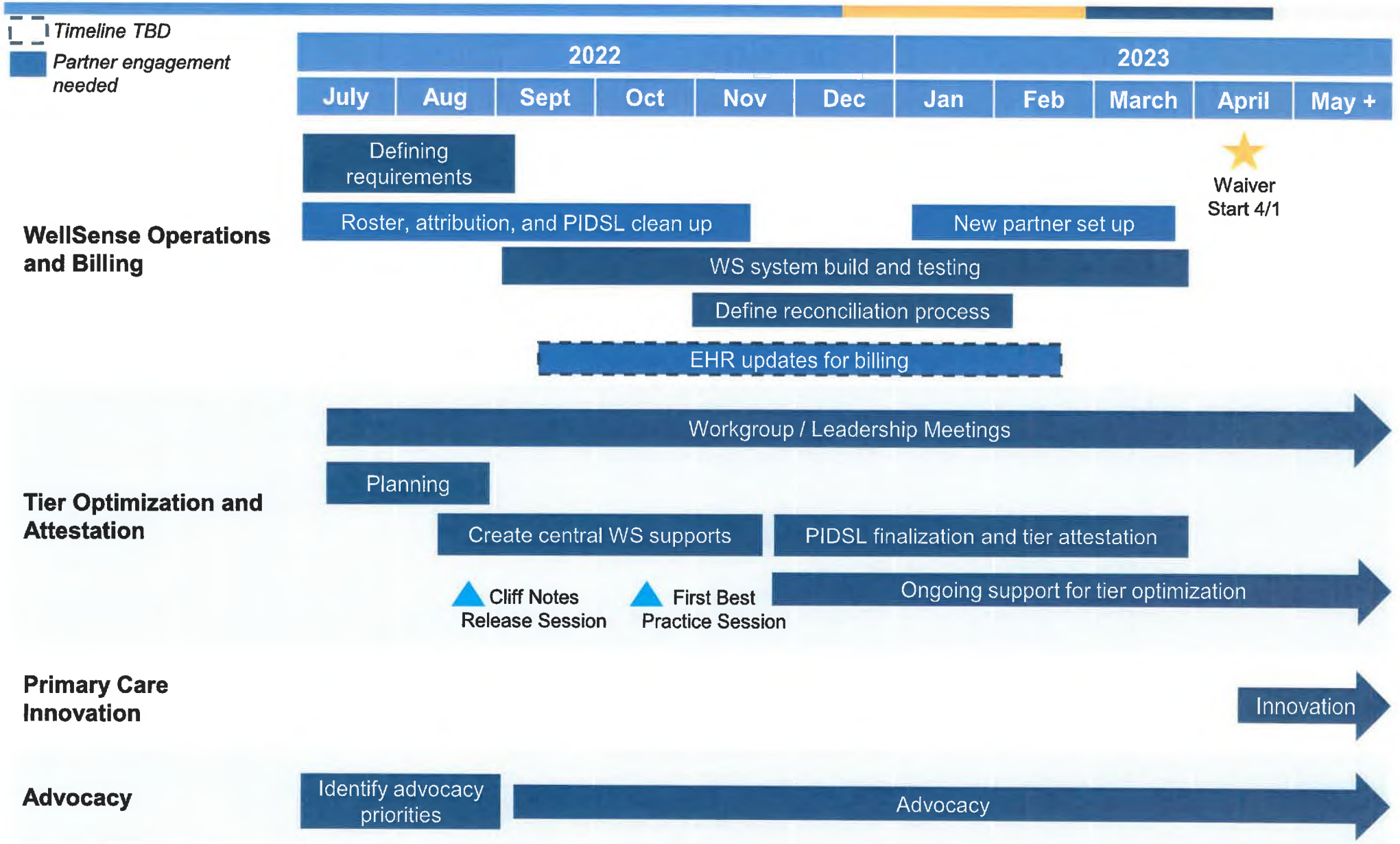
Adult practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to adults and those >21 years of age. An adult practice shall fulfill requirements specific to adult populations. Pediatric practices that serve a small number of adult patients are not adult practices, and do not need to meet the requirements specific to adult populations Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
E-Consult	Asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.
Family Medicine practice	Any primary care practice, either standalone or within a larger building, that provides care to patients across the lifespan. A family medicine practice shall fulfill requirements specific to both pediatric and adult populations. Each Family Medicine practice shall have a single Tier Designation
Pediatric practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to children and adolescent patients 21 years of age or younger. A pediatric practice shall fulfill requirements specific to pediatric populations. Adult practices that serve a small number of patients under age 21 are not pediatric practices, and do not need to meet the requirements specific to adult populations. Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
Session	≥4 consecutive hours of clinical work time, usually defined as a continuous morning or afternoon block of time in which providers see patients.

Requirements by Tier

TIER 1	TIER 2	TIER 3
Requirement	Requirement	Requirement
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
Oral health screening and referral	E-consults available in at least three (3) specialties	After-hours or weekend sessions (3+ sessions)
BH and substance use disorder screening	After-hours or weekend session (1+ sessions)	Three team-based staff roles
BH referral with bi-directional communication, tracking, and monitoring	Team-based staff role	Maintain consulting BH clinician with prescribing capability
BH medication management	Maintain consulting independent BH clinician	On-site staff with children, youth, family-specific expertise (FT) [P]
Health-Related Social Needs screening	On-site staff with children, youth, and family-specific expertise (part or full time) [P]	LARC provision, at least 1 option [P]
Care coordination	Provide SNAP and WIC assistance [P]	Active Buprenorphine Availability [P]
Clinical Advice and Support Line	Buprenorphine Waivered Practitioner (1) [P]	LARC provision, multiple options [A]
Postpartum depression screening	LARC provision, at least one option [A]	Next-business-day MOUD induction and F/U [A]
Use of Prescription Monitoring Program	Active Buprenorphine Availability [A]	
LARC provision, referral option	Active AUD Treatment Availability [A]	
Same-day urgent care capacity		
Video telehealth capability		
No reduction in hours		
Translation and Interpreter Services		
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]		
Buprenorphine Waivered Practitioners (all) [A]		

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

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.

Find a Provider

Need Help

As the public health emergency related to COVID-19 continues to spread, we are recommending that our providers use telehealth services (where allowed) to ensure patients have access to care while adhering to social distancing. Please call your provider to understand his/her current telehealth capabilities.

To find an in-network provider, select your Insurance Carrier or Employer below

Select Your Insurance Carrier

"More than 4,500 employees nationally, serving more than 40 million people."

English

Requirement 7

- **Conduct Health Related Social Needs Screening (HRSN)**

Practice meets this requirement. Links below

BILH SDoH Screening Tool

Modified PRAPARE

Download Multi-language PREPARE Screening Tool here

Women, Infants & Children (WIC) Program and Supplementatl Nutrition Assistance Program (SNAP) Resources

Community Health Questionnaire

Women, Infants, & Children (WIC) Program and Supplemental Nutrition Assistance Program (SNAP)

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.

Wic eligibility: https://www.mass.gov/service-details/check-eligibility-for-wic

You can participate in WIC if you:

- Live in Massachusetts
- Have a nutritional need (WIC staff can help you determine this)
- Are a child under 5, a new mom, or a pregnant or breastfeeding woman
- Have a family income less than WIC guidelines

You are automatically income eligible for WIC if you currently receive:

- MassHealth/Medicaid insurance plans
- Supplemental Nutrition Assistance Program (SNAP)
- Transitional Aid to Families with Dependent Children (TAFDC) or cash assistance

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.

Snap eligibility: https://dtaconnect.eohhs.mass.gov/screening

https://dtaconnect.eohhs.mass.gov/

https://www.mass.gov/doc/snap-outreach-flyer-english-0/download

SNAP eligibility is based on who is in the household, income and certain expenses.

- What counts as income? DTA counts income from most sources, such as wages, cash assistance, Social Security, unemployment insurance, and child support. When you apply, tell DTA about any money you earn or is given to you.
- Who is in a SNAP Household? A household includes anyone you buy and cook most of your meals with. If your spouse or child(ren) under 22 live with you, they must be included in your household (even if you do not buy and make meals with them).

SNAP Eligibility Chart

Household Size	Maximum Monthly Income (before taxes)	Maximum Monthly SNAP Amount*
1	$2,265	$281
2	$3,052	$516
3	$3,838	$740
4	$4,625	$939
5	$5,415	$1,116
6	$6,198	$1,339
7	$6,985	$1,480
8	$7,772	$1,691
Each additional person	+ $787	+ $211

Household Size Maximum Monthly Income (before taxes) Maximum Monthly SNAP Amount*

* Your household may receive a different monthly amount, depending on income and expenses. During COVID-19 all households get at least the maximum amount.

Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost **help starts here:**

ZIP 01834 Search

21,785,611 people use it (and growing daily)

If you or someone you know is in crisis, call or text 988 to reach the Suicide and Crisis Lifeline (https://988lifeline.org/talk-to-someone-now/), chat with them online via their website, or text HOME to 741741 (multiple languages available). If this is an emergency, call 911.

Community Health Questionnaire

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

Food	Clothing	Utilities	Child Care	Medicine or any HealthCare	Phone	I/we HAVE been able to get these resources	I choose not to answer this question
							

2. **What is your housing situation today?**
   a. I have housing
   b. I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
   c. I choose not to answer this question

3. **Are you worried about losing your housing?**
   a. Yes
   b. No
   c. I choose not to answer this question

4. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Circle all that apply.**
   a. Yes, it has kept me from medical appointments or from getting my medications
   b. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
   c. No
   d. I choose not to answer this question

5. **What is your current work or school situation? (circle all that apply)**
   a. In school
   b. Unemployed
   c. Part-time or temporary work
   d. Full-time work
   e. Otherwise unemployed but not seeking work (examples: student, disabled, retired, unpaid full time caregiver)
   f. I choose not to answer this question

6. **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, visit friends or family, going to church or club meetings)**
   a. Less than once a week
   b. 1 or 2 times a week
   c. 3 to 5 times a week
   d. 5 or more times a week
   e. I choose not to answer this question

7. **Do you feel physically and emotionally safe where you currently live?**
   a. Yes
   b. No
   c. Unsure
   d. I choose not to answer this question

8. **In the past year, have you been afraid of your partner or ex-partner?**
   a. Yes
   b. No
   c. Unsure
   d. I have not had a partner in the past year
   e. I choose not to answer this question

9. **Would you like help with anything that we talked about today?**
   a. Yes
   b. No

FOOD

Project Bread Food Source Hotline (800) 645-8333
Toll-free hotline which provides a comprehensive information and referral service to individuals and families facing hunger in Massachusetts. Project Bread can connect you to resources for a **free hot meal, soup kitchen, emergency groceries and food pantries** in your community.

SNAP Benefits (Food Stamps)
The Department of Transitional Assistance (DTA) administers SNAP benefits. SNAP provides a monthly benefit to buy nutritious foods. Eligibility for SNAP benefits depends on financial and nonfinancial criteria.

DTA Assistance Line: (877) 382-2363
Local DTA office to apply for SNAP in person:
Lawrence Transitional Assistance Office (978) 725-7100
280 Merrimack Street, Lawrence, MA 01843

North Shore Transitional Assistance (978) 825-7300

Lowell Transitional Assistance (978) 446-2400

Local Food Pantries

Pettengill House 978-463-8801
13 Lafayette Road
Salisbury, MA 01952
Pantry Hours: Tuesdays 9am-2pm and 4pm-6pm

Our Neighbors' Table 978-388-1907
Market at Jardis-Taylor Center
194 Main Street
Amesbury, MA 01913
Emergency Hotline: 978.835.3016

Somebody Cares New England
358 Washington Street
Haverhill, MA 01930
P: 978.912.7626
Last Thursday of the Month

Community Service of Newburyport 978-465-7562
Mobile Food Market –Our Neighbors' Table
35 Summer Street (Annex at St. Paul's Church)
Newburyport, MA 01950

First Church Congregational of Boxford 978-887-5841
4 Georgetown Road
Boxford, MA 01835

Groveland Council on Aging
183 Main Street
Groveland, MA 01834
Ph: 978.469.5008

TRANSPORTATION:
Effective July 1, 2015 all MVRTA Ring & Ride for Groveland residents is now FREE. Available to Amesbury, Boxford, Georgetown, Groveland, Haverhill, Lawrence, Methuen, Newbury/Byfield, Newburyport, North Andover and West Newbury as well as the Rowley Train Station and Market Basket in Rowley. This service will allow you to connect to the MVRTA fixed route bus system. Call 978-469-6878 - Option #3 (special services). Brochures are available at the COA office at Town Hall as well as the MVRTA office at 85 Railroad Ave., Bradford MA.

****For additional listings by town, visit foodpantries.org**

HOUSING

Resources for homeless individuals and families

Shelters for individuals:
Mitch's Place – **978-241-3400**
127 How Street, Haverhill, MA 01830

Shelters for families:
Emmaus House **978-241-3400**
127 How Street, Haverhill, MA 01830

Turning Point **978-462-8251 (women/children)**
5 Perry Way, Newburyport, MA 01950

Lazarus House **978-689-8975**
412 Hampshire Street, Lawrence, MA 01840

Family Shelters for families not eligible for emergency assistance:

Inn Between
25 Holten Street
Peabody, MA 01960
978-532-2372

Lazarus House Ministries, Inc.
48 Holly Street
Lawrence, MA 01842
978-689-8575 (x5225)

Family Promise North Shore Boston, Inc.
330 Rantoul St.
Beverly, MA 01915
(978) 922-0787
(wait list)

Resources for individuals and families that are not currently homeless

Community Home Solutions
14 New Zealand Rd
Seabrook, NH 03874-4280
WEBSITE: http://communityhomesolutions.org
PHONE: 603-474-7449

Mortgage Delinquency and Default Resolution Counseling, Financial Management/Budget Counseling, Financial, Budgeting and Credit Repair Workshops,Non-Delinquency Post Purchase Workshops, Pre-purchase Counseling, Pre-purchase Homebuyer Education Workshops, Rental Housing Counseling, Reverse Mortgage Counseling

Resources for individuals and families that are not currently homeless

Lawrence Communityworks, Inc.
168 Newbury Street
Our House Campus
Lawrence, MA 01841-3910
WEBSITE:
http://www.lawrencecommunityworks.org
PHONE:978-685-3115

Mortgage Delinquency and Default Resolution Counseling
Non-Delinquency Post Purchase Workshops
Pre-purchase Counseling
Pre-purchase Homebuyer Education Workshops

Community Action Programs (MASSCAP)

Community Action - Haverhill
978-373-1971
Communities Served: Amesbury, Boxford, Georgetown, Groveland, Haverhill, Merrimack Newbury, Newburyport, Rowley Salisbury, West Newbury

Community Action – Amesbury
978-388-2575

Community Action Seacoast Center – Newburyport
978-499-8357

- Homelessness prevention, eviction assistance
- Fuel assistance
- Emergency food assistance
- Head Start, and early education and care programs
- Senior services and youth programs
- Workforce development, job training, and education
- Access to and training in information technology
- Asset formation, protection, and retention

Personal Safety

****If you are in immediate danger please call 911****

24 Hour Domestic Violence Hotlines:
Referrals to DV shelter and other DV services, safety planning, resources and support
SafeLink: (877) 785-2020
Dove, Inc: (617) 471-1234
Reach Beyond Domestic Violence: (800) 899-4000

Domestic Violence and Violence Prevention Programs:

Jeanne Geiger Crisis Prevention Center (978) 834-9710
5 Market Square, #109, Amesbury, MA 01913
24 Hour Hotline: 978-388-1888
Advocacy, counseling and support

Jeanne Geiger Administrative Offices **978-465-0999**
2 Harris Street, Newburyport MA 01950

Jeanne Geiger Survivor and Prevention Services **978-834-9710**
5 Market Square, #109 Amesbury MA 01913

YWCA – Haverhill **978-374-6121**
Emergency shelter, rape crisis, domestic violence

The Family Safety Project **978-989-0607**
360 Merrimack Street, Building 9, Entry K
Lawrence, MA 01843

The Children's Safety Project **978-989-9361**
360 Merrimack Street, Building 9, Entry I
Suite 309
Lawrence, MA 01843

LGBT Domestic Violence Resources:

The Network/La Red Hotline: (617) 742-4911
Social Justice Organization that works to end partner abuse in lesbian, gay, bisexual, transgender, SM, polyamorous, and queer communities

GMDVP 24 Hour Hotline: (800) 832-1901
Gay Men's Dometic Violence Project provides crisis intervention, support and resources for victims and survivors of domestic abuse.

Protective Services Hotlines:
Department of Children and Families Child at Risk Hotline: **800-792-5200**
Disabled Persons Protection Commission: **800-426-9009**
Elder Abuse Hotline **800-922-2275**

Search for free or reduced-cost services like medical care, food, job training, and more. For COVID-19 specific resources, type in **COVID19** in the "Find" box and your zip code in the "Available in" box below.

Find: (Optional)

Food pantry, rent, etc.

Available in:

01834

Search

Massachusetts COMMUNITY RESOURCE DIRECTORY

Select Language

We recognize that you may be experiencing financial hardship during this time which can impact your health. We have developed Resource Guides to help. These resource guides contain available community, state, and federal resources to support you and your loved ones through the remainder of the coronavirus pandemic.

THRIVE Resource Guides

- Childcare (https://massthrive.org/v2/favorites/public/covid19-childcare)
- Child Educational Supports (https://massthrive.org/v2/favorites/public/covid19-child-educational-supports)
- Domestic Violence (https://massthrive.org/v2/favorites/public/covid19-domestic-violence)
- Financial Support (https://massthrive.org/v2/favorites/public/covid19-financial-support)
- Unemployment Support (https://massthrive.org/v2/favorites/public/covid19-unemployment-support)
- Food (https://massthrive.org/v2/favorites/public/covid19-food)
- FREE Social and Educational Activities (https://massthrive.org/v2/favorites/public/covid19-free-social-and-educational-activities)
- Funeral and Burial Assistance (https://massthrive.org/v2/favorites/public/covid19-funeral-burial-assistance)
- General COVID-19 Informational Resources (https://massthrive.org/v2/favorites/public/covid19-informational-resources)
- Housing (https://massthrive.org/v2/favorites/public/covid19-housing)
- Household Utilities (https://massthrive.org/v2/favorites/public/covid19-household-utilities)
- Internet, Phone & Devices (https://massthrive.org/v2/favorites/public/covid19-internet-phone-devices)
- Legal Services (https://massthrive.org/v2/favorites/public/covid19-legal-support)
- Medication & Prescription Assistance (https://massthrive.org/v2/favorites/public/covid19-medication-prescription-assistance)
- Resources for Seniors (https://massthrive.org/v2/favorites/public/covid19-resources-for-senior)
- Shelter Updates (https://massthrive.org/v2/favorites/public/covid19-shelters)
- Substance Use Disorder Resources (https://massthrive.org/v2/favorites/public/covid19-available-sud-programs)
- Transportation (https://massthrive.org/v2/favorites/public/covid19-transportation)
- Wellness and Mental Health (https://massthrive.org/v2/favorites/public/covid19-wellness-mental-health)
- Resources on Racial Justice and Trauma (https://massthrive.org/v2/favorites/public/covid19-resources-on-racial-justice-and-trauma)

Mass 2-1-1

Need further assistance with a guided search?

CALL 2-1-1

Mass 2-1-1

Need further assistance with a guided search?

Requirement 8

- **Participate in Care Coordination**

Practice meets this requirement. Practice identifies at risk patients via med, BH, HRSN, psychosocial and/or other needs and deploys interventions and approaches to addressing individual patients' needs.
Practice utilizes WellSense Care Coordination Resources and provides this service as a health plan function.

https://www.wellsense.org/members/ma/manage-your-health/care-management-program

WellSense HEALTH PLAN

Care Management Program

Our free Care Management program can make living with conditions like asthma, diabetes, cancer, or other special health needs easier. Call **1-866-853-5241** to see if you or your family members are eligible for this program. Or, take our health survey on the member portal to see if we have special programs to help support you. You can get an instant personalized health report after completing it online.

Programs to help manage special health needs

Members in our Care Management program get:

- Access to a registered nurse
- Help with understanding and managing your disease or condition
- Help with accessing the right services and information
- Personalized phone calls to check on your health
- Coordination of care with your doctors, other healthcare providers, and community partners

Our Care Management Select program offers support to members who are struggling with serious and complicated health concerns. This program offers everything listed above, plus:

- More frequent check-ins from a care manager, including in-person visits, as needed
- Enhanced coordination of care with your healthcare providers

Support is offered for conditions such as:

- Asthma
- Behavioral health
- Cancer
- Congestive heart failure
- COPD
- Coronary heart disease
- Diabetes
- HIV/AIDS
- Hypertension
- Obesity

Page last updated on 08-3-2022

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Requirement 9

- **Offer a Clinical Advice and Support Line**

Practice meets this requirement by providing the WellSense Nurse Clinical Advice Line phone number: 1-800-973-6273 and the link to the WellSense Nurse Clinical Advice Line web page

https://www.wellsense.org/members/ma/masshealth/nurse-advice-line

All practices will meet via WellSense

WellSense HEALTH PLAN

Nurse Advice Line

Not sure whether to see a doctor? Get immediate health advice from a trained nurse 24 hours a day, seven days a week.

Available 24/7

Call the Nurse Advice Line at 1-800-973-6273 to speak with a registered nurse when your doctor's office is closed or if you have a question about your health. All calls are confidential and you can call anytime, seven days a week. You can also log in to the Member Portal to send a secure message to a nurse for health advice.

Note: The Nurse Advice Line is for medical questions and is for members only. If you have questions about your healthcare coverage, you should call our Member Services Department.

Call when you or a family member

- Have a fever, dizziness, back pain, stomach problems or other symptoms and you're not sure where to go or how to treat it
- Don't know if you need to see a doctor, go to the emergency room, or treat the symptom yourself
- Don't know how to take your medications — on an empty stomach, with food, every four hours, etc.
- Need care, but your doctor can't see you or it's after hours

Remember: *While the Nurse Advice Line is a convenient resource, it should not take the place of your doctor or other healthcare provider. In an emergency, always call 911 or visit your nearest emergency room.*

Page last updated on 07-28-2022

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العربية

Requirement 10

- **Postpartum Depression Screening**

Practice meets this requirement with the use of PHQ-2 and PHQ-9 forms (Link 1).
Practice utilized both the Edinburgh Postnatal Depression Scale (EPDS) (Link 2) along with the McPAP recommended Postpartum screening workflow (Link 3)

Link 1 https://www.albertahealthservices.ca/frm-19825.pdf
Link 2 https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf
Link 3 www.mcpapformoms.org/Docs/Pediatric%20Screening%20Algorithm.pdf

Mental Health Screening

Anxiety: GAD-2

Anxiety: GAD-7

Dementia: IHDS

Depression: PHQ-2

Depression: PHQ-9

PTSD: PC-PTSD-5

Substance Use Screening

Alcohol: AUDIT-C

Alcohol: CAGE

CAGE-AID

Drug Use: TICS

Opioid: Risk Tool

Clinical Calculators

APRI Calculator

BMI Calculator

CrCl Calculator

CTP Calculator

FIB-4 Calculator

FEPO4 Calculator

GFR Calculator

Patient Health Questionnaire-2 (PHQ-2)

Share

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

○ 0 ○ +1 ○ +2 ○ +3

2. Feeling down, depressed or hopeless

○ 0 ○ +1 ○ +2 ○ +3

PHQ-2 score obtained by adding score for each question (total points)

Interpretation:

- A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cutpoint when using the PHQ-2 to screen for depression.
- If the score is 3 or greater, major depressive disorder is likely.
- Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.

Operating Characteristics of PHQ-2 as a Screener for Depressive Disorders in 580 Patients Who Had an Independent Mental Health Professional Interview

PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4
2	92.7	73.7	21.1
3	82.9	90.0	38.4
4	73.2	93.3	45.4
5	53.7	96.8	56.4
6	26.8	99.4	78.6

PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	90.6	65.4	36.9
2	82.1	80.4	48.3
3	62.3	95.4	75.0
4	50.9	97.9	81.2
5	31.1	98.7	84.6
6	12.3	99.8	92.9

Notes:

Mental Health Screening
Anxiety: GAD-2
Anxiety: GAD-7
Dementia: IHDS
Depression: PHQ-2
Depression: PHQ-9
PTSD: PC-PTSD-5
Substance Use Screening
Alcohol: AUDIT-C
Alcohol: CAGE
CAGE-AID
Drug Use: TICS
Opioid: Risk Tool
Clinical Calculators
APRI Calculator
BMI Calculator
CrCl Calculator
CTP Calculator
FIB-4 Calculator
FEPO4 Calculator
GFR Calculator

Patient Health Questionnaire-9 (PHQ-9)

Share

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

○ 0 ○ +1 ○ +2 ○ +3

2. Feeling down, depressed or hopeless

○ 0 ○ +1 ○ +2 ○ +3

3. Trouble falling asleep, staying asleep, or sleeping too much

○ 0 ○ +1 ○ +2 ○ +3

4. Feeling tired or having little energy

○ 0 ○ +1 ○ +2 ○ +3

5. Poor appetite or overeating

○ 0 ○ +1 ○ +2 ○ +3

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down

○ 0 ○ +1 ○ +2 ○ +3

7. Trouble concentrating on things, such as reading the newspaper or watching television

○ 0 ○ +1 ○ +2 ○ +3

8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual

○ 0 ○ +1 ○ +2 ○ +3

9. Thoughts that you would be better off dead or of hurting yourself in some way

○ 0 ○ +1 ○ +2 ○ +3

PHQ-9 score obtained by adding score for each question (total points)

Interpretation:

Alberta Health Services

Patient Health Questionnaire (PHQ-2 & PHQ-9)

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.	
Name *(last, first)*	
Birthdate *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female
PHN / ULI	

PHQ 2

1. During the **past two weeks**, have you often been bothered by little interest or pleasure in doing things?	☐ Yes	☐ No
2. During the **past two weeks**, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes	☐ No

If the answer to both questions is No, the screen is negative for depression *(re-screen if indicated)*. If yes was selected for one or both questions, please consult appropriate discipline to complete the PHQ-9.

Date *(yyyy-Mon-dd)*	Signature

PHQ 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ to indicate your answer)*	**Not at all** (score = 0)	**Several days** (score = 1)	**More than half the days** (score = 2)	**Nearly every day** (score = 3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
TOTAL	0 +	+	+	+
TOTAL SCORE				

If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PHQ-9 Score	**Meaning / Action**
Less than 5	Patient not likely depressed, re-screen if affect changes. Communicate results to the team and to any referral sites.
Between 5-9	Watchful waiting - patient to be closely monitored and re-screened if needed. Communicate results to the team and any referral sites.
Greater than 9	Patient has screened positive and requires further assessment by a certified professional for diagnosis and treatment. Notify attending, consider consulting psychiatry or psychology. Communicate results to the team and any referral sites.

http://phqscreeners.com/pdfs/02_PHQ-9/English.pdf

Date *(yyyy-Mon-dd)*	Signature

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week.*** In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (with suggested talking points)

We encourage all providers to use the S3005 billing code that allows the Dept of Public Health to track screening across specialties and regions.

Parent completes the PHQ-2, PHQ-9 or EPDS screen during the following well child visits and during other visits as indicated:

- Within first month
- 2 month visit
- 4 month visit
- 6 month visit
- 9-12 month visit

If first screen for depression

If subsequent screen for depression

Clinical support staff explains screen

Emotional complications are very common during pregnancy and or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby's health. Dads can also experience depression or anxiety before or after the baby is born. We will be seeing you and your baby a lot over the next few months/years and want to support you.

Give screen to parent to complete in the waiting room or in a private exam room.

Give screen to parent to complete in the waiting room or in a private exam room.

Parent completes the **PHQ-2, PHQ-9 or EPDS** screen. Provider/nurse tallies score.

PHQ-2 ≥ 3

Administer PHQ-9 or EPDS

PHQ-2 <3; PHQ-9 or EPDS<10

PHQ-9 or EPDS ≥ 10

Score does not suggest depression

Clinical support staff educates parent about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every parent deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Score suggests depression

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

If positive score on self-harm question

For all positive screens

Suggests parent may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is common for parents to experience these kinds of feelings. Many effective support options are available. I would like to talk to you about how you have been feeling recently.

Do NOT leave parent/baby in room alone until further assessment or treatment plan is established. **Immediately assess further:**

1. *In the past two weeks, how often have you **thought** of hurting yourself?*
2. *Have you ever **attempted** to hurt yourself in the past?*
3. *Have you thought about how you could harm yourself?*

If concerned about the safety of parent/baby: *You and your baby deserve for you to feel well. Let's talk about ways that we can support you.*
If there is a clinical question, call MCPAP regional hub. For safety concerns, refer to emergency services. Document in medical record.

1. If parent is already in mental health treatment, refer to/notify* parent's provider.
2. Give parent community resource information (e.g., MCPAP for Moms card, and website)
3. Refer to/notify* parent's PCP and/or OB/GYN for monitoring and follow-up.
4. Engage natural supports* and encourage parent to utilize them.

*Obtain parent's consent

Provider steps for positive screens

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.

MCPAP for Moms: Promoting maternal mental health during and after pregnancy
Revision 1.15.15

Funding provided by the Massachusetts Department of Mental Health

www.mcpapformoms.org
Tel:855-Mom-MCPAP (855-666-6272)

Massachusetts Child Psychiatry Access Project
MCPAP For Moms

Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits

We encourage all providers to use the S3005 billing code that allows the Dept of Public Health to track screening across specialties and regions.

Parent completes the PHQ-2, PHQ-9 or EPDS screen during the following well child visits and during other visits as indicated:

- Within first month
- 2 month visit
- 4 month visit
- 6 month visit
- 9-12 month visit

If first screen for depression

Clinical support staff explains screen

Give screen to parent to complete in the waiting room or in a private exam room.

If subsequent screen for depression

Give screen to parent to complete in the waiting room or in a private exam room.

Parent completes the **PHQ-2, PHQ-9 or EPDS** screen.
Provider/nurse tallies score.

PHQ-2 ≥ 3

Administer PHQ-9 or EPDS

PHQ-2 <3; PHQ-9 or EPDS<10

Score does not suggest depression
Clinical support staff educates parent about the importance of emotional wellness.

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

PHQ-9 or EPDS ≥ 10

If positive score on self-harm question

Score suggests depression

For all positive screens

1. If parent is already in mental health treatment, refer to/notify* parent's provider.
2. Give parent community resource information (e.g., MCPAP for Moms card, and website)
3. Refer to/notify* parent's PCP and/or OB/GYN for monitoring and follow-up.
4. Engage natural supports* and encourage parent to utilize them.

*Obtain parent's consent

Provider steps for positive screens

Suggests parent may be at risk of self-harm or suicide

Do NOT leave parent/baby in room alone until further assessment or treatment plan has been established. **Immediately assess further.**

If there is a clinical question, provider calls MCPAP regional hub. For safety concerns, refer to emergency services. Document the assessment and plan in medical record.

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.

MCPAP for Moms: Promoting maternal mental health during and after pregnancy
Revision: 1.15.15

Funding provided by the Massachusetts Department of Mental Health

www.mcpapformoms.org
Tel:855-Mom-MCPAP (855-666-6272)

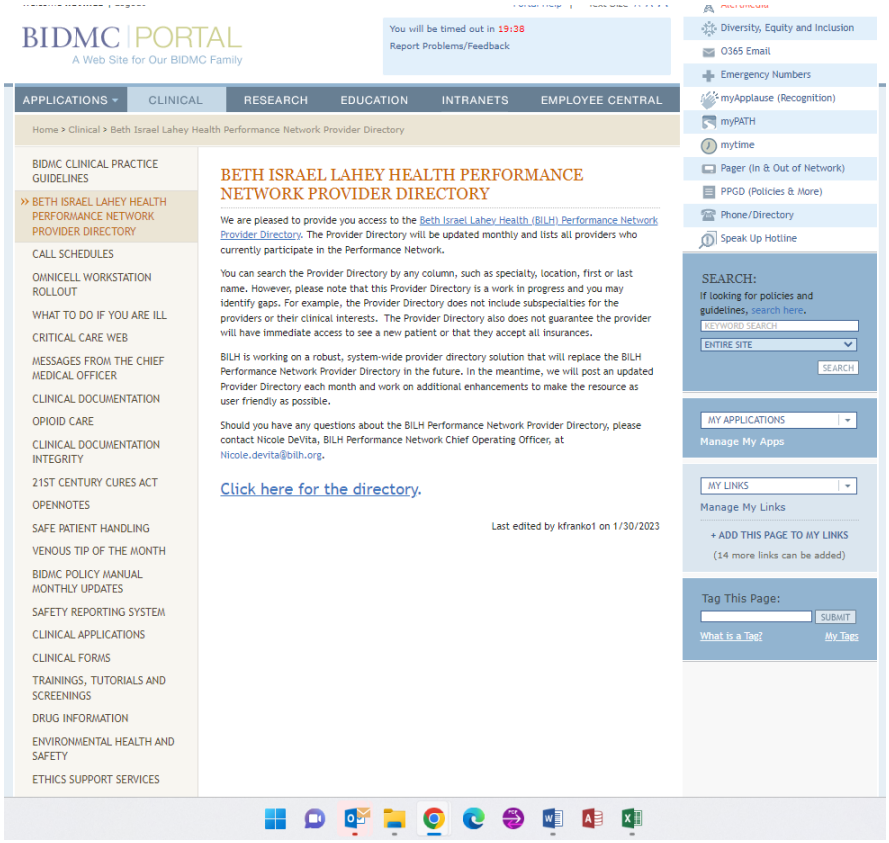
Requirement 11

- **Offer LARC (Long Acting Reversible Contraception) (Provision and/or Referral)**

Practice meets this requirement.
Practice does not perform insertion of IUD and by utilizes referral directory to local OBGYN office(s), leveraging the BILHPN Provider Directory as a resource. Link below.

https://portal.bidmc.org/Clinical/BILH-Performance-Network-Provider-Directory.aspx

You will need to log in with your BILH login and password



Requirement 12

- **Use of Prescription Monitoring Program, MassPAT**

Practice meets this requirement.
Practice logs in to MassPAT (screenshot provided) and records.

Part I	ADMINISTRATION OF THE GOVERNMENT
Title XV	REGULATION OF TRADE
Chapter 94C	CONTROLLED SUBSTANCES ACT
Section 24A	ELECTRONIC MONITORING OF THE PRESCRIBING AND DISPENSING OF CONTROLLED SUBSTANCES AND CERTAIN ADDITIONAL DRUGS

Section 24A. (a)(1) The department shall establish and maintain an electronic system to monitor the prescribing and dispensing of all schedule II to V, inclusive, controlled substances and certain additional drugs by all professionals licensed to prescribe or dispense such substances. For the purposes of this section, "additional drugs" shall mean substances determined by the department to carry a bona fide potential for abuse.

(2) The department shall enter into reciprocal agreements with other states that have compatible prescription drug monitoring programs to share prescription drug monitoring information among the states.

(b) The requirements of this section shall not apply to the dispensing of controlled substances to inpatients in a hospital.

(c) For the purposes of monitoring the prescribing and dispensing of all schedule II to V, inclusive, controlled substances and additional drugs, as authorized in subsection (a), the department shall promulgate regulations including, but not limited to, (1) a requirement that each pharmacy that delivers a schedule II to V, inclusive, controlled substance or a substance classified as an additional drug by the department to the ultimate user shall submit to the department, by electronic means, information regarding each prescription dispensed for a drug included under subsection (a); and (2) a requirement that each pharmacy collects and reports, for each prescription dispensed for a drug under subsection (a), a customer identification number and other information associated with the customer identification number, as specified by the department. Each pharmacy shall submit the information in accordance with transmission methods and frequency requirements promulgated by the department; provided, however, that the information shall be submitted at least once every 24 hours. The department may issue a waiver to a pharmacy that is unable to submit prescription information by electronic means. The waiver shall permit the pharmacy to submit prescription information by other means promulgated by the department; provided, however, that all information required in this section is submitted in this alternative format.

The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants. The regulations shall include the requirement that prior to issuance, participants shall utilize the prescription monitoring program each time a prescription for a narcotic drug that is contained in schedule II or III, or a prescription for a

benzodiazepine, is issued. The department may require participants to utilize the prescription monitoring program prior to the issuance of any schedule IV or V prescription drug, that is commonly misused and may lead to physical or psychological dependence or that causes patients with a history of substance dependence to experience significant addictive symptoms. The regulations shall specify the circumstances under which such narcotics or benzodiazepines may be prescribed without first utilizing the prescription monitoring program. The regulations may also specify the circumstances under which support staff may use the prescription monitoring program on behalf of a registered participant. When promulgating the rules and regulations, the department shall also require that pharmacists be trained in the use of the prescription monitoring program as part of the continuing education requirements mandated for licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs.

(d) Prescription information submitted to the department under this section shall be confidential and exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66. The department shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted and maintained is not disclosed to persons except as provided for in this chapter.

(e) The department shall review the prescription and dispensing monitoring information. If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the department shall notify the appropriate law enforcement or professional licensing,

certification or regulatory agency or entity and provide prescription information required for an investigation.

(f) The department shall, upon request, provide data from the prescription monitoring program to the following:—

(1) persons authorized to prescribe or dispense controlled substances, for the purpose of providing medical or pharmaceutical care for their patients;

(2) individuals who request their own prescription monitoring information in accordance with procedures established under chapter 66A;

(3) persons authorized to act on behalf of state boards and regulatory agencies that supervise or regulate a profession that may prescribe controlled substances; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug-related investigation;

(4) local, state and federal law enforcement or prosecutorial officials working with the executive office of public safety and security engaged in the administration, investigation or enforcement of the laws governing prescription drugs; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug-related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276;

(5) personnel of the executive office of health and human services regarding Medicaid program recipients; provided, however that the data request is in connection with a bona fide specific controlled substance or additional drug-related investigation;

(6) personnel of: (A) the United States attorney or a federal agency; provided, however, that the data request is made pursuant to clause (4) or federal law; (B) the office of the attorney general provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276 or a civil investigative demand; or (C) a district attorney's office; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276;

(7) personnel of the Medicaid fraud control unit within the office of the attorney general; provided, however, that the data request is made in connection with a bona fide specific controlled substance or additional drug related investigation of a practitioner, pharmacist, pharmacy, person required to be a registered participant by this chapter or any other provider subject to the jurisdiction of a Medicaid fraud control unit under federal law, including, but not limited to, 42 U.S.C. section 1396b, et. seq.; and provided further, that, notwithstanding clauses (4) and (6), the department shall provide the data requested pursuant to this clause without a probable cause warrant issued pursuant to chapter 276 or a civil investigative demand; or

(8) personnel within the office of a district attorney; provided, however, that the data request is made in connection with a bona fide investigation into the cause and manner of death of an individual suspected of a drug overdose; provided further, that data provided pursuant to this clause is limited to the prescription information of the individual suspected of the drug overdose; and provided further, that, notwithstanding clauses (4) and (6), the department shall provide the data requested pursuant to this clause without a probable cause warrant issued pursuant to chapter 276.

(g) The department may provide data from the prescription monitoring program to practitioners in accordance with this section; provided, however, that practitioners shall be able to access the data directly through a secure electronic medical record or other similar secure software or information system that enables automated query and retrieval of prescription monitoring program data to a practitioner. This data may be used only for the purpose of diagnosis, treatment or coordinating care of the practitioner's patient, unless otherwise permitted by this section. Any such secure software or information system shall identify the registered participant on whose behalf the prescription monitoring program was accessed. The department may enter into data use agreements to allow summary prescription monitoring program data to be securely retained in the patient's medical record as a clinical note associated with a clinical encounter; provided, however, that prescription monitoring program data shall not be retained separately from said clinical note; and provided further, that no such agreement shall allow for prescription monitoring program data to be used for purposes inconsistent with this section.

(h) The department may provide de-identified information to a public or private entity for statistical research or educational purposes.

(i) The department may contract with another agency or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. A contractor shall be bound to comply with the provisions regarding confidentiality of prescription information in this section.

(j) The department shall promulgate rules and regulations setting forth the procedures and methods for implementing this section.

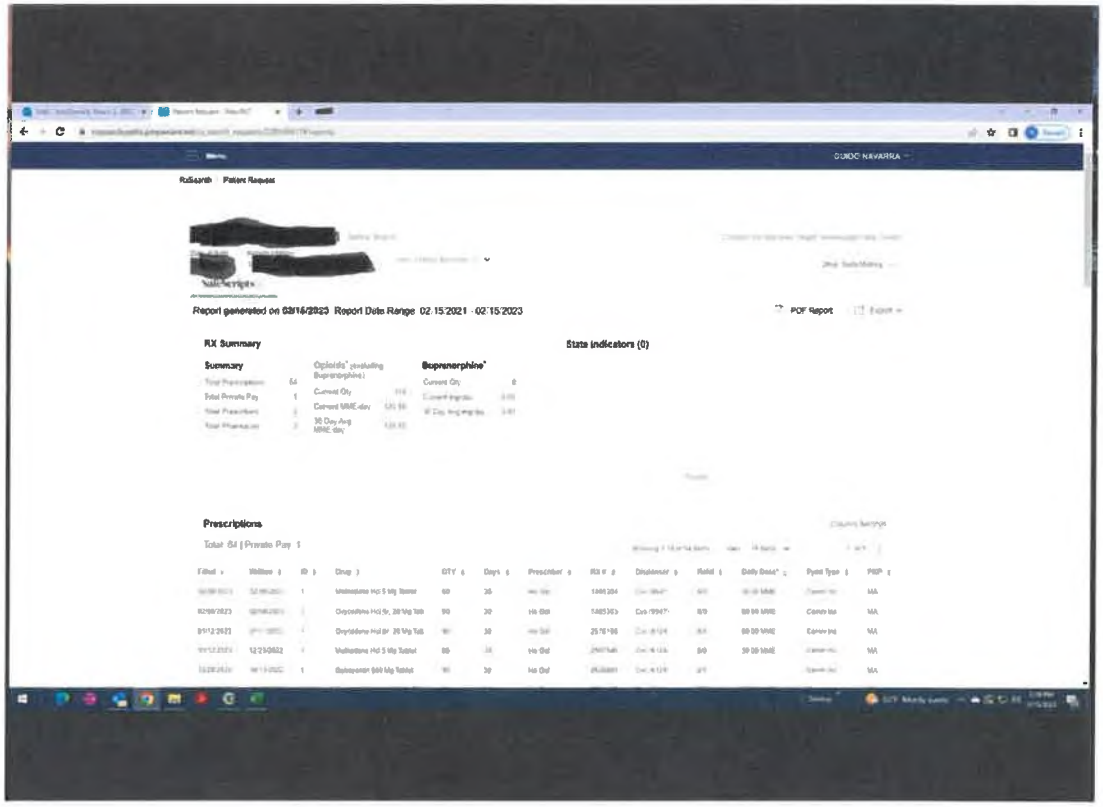
(k) The department shall submit an annual report on the effectiveness of the prescription monitoring program with the clerks of the house and senate, the chairs of the joint committee on public health, the chairs of the joint committee on health care financing and the chairs of the joint committee on public safety and homeland security.

(l) Upon receiving a report of an overdose-related death from the chief medical examiner, under section 16 of chapter 38, or a report of examination or treatment of a person with injuries resulting from an opiate, illegal or illicit drug overdose, under section 12A of chapter 112, the department shall review the prescription monitoring program to determine if a notification should be made under subsection (e).

(m) The department may enter into agreements to permit health care facilities to integrate secure software or information systems into their electronic medical records for the purpose of using prescription monitoring program data to perform data analysis, compilation, or visualization, for

purposes of diagnosis, treatment or coordinating care of the practitioner's patient. Any such secure software or information system shall comply with requirements established by the department to ensure the security and confidentiality of any data transferred.

MassPAT


CUNOC NAVARRA
ReSearch | Patient Request
Report generated on 03/16/2023 Report Date Range 02.15.2021 - 02.15.2023
PDF Report
Rx Summary
State indicators (0)
Summary
Buprenorphine*
Prescriptions
Total 64 | Private Pay 1

Requirement 13

- **Same Day Urgent Care Capacity**

Practice meets this requirement

Practice leaves openings on schedule for same day urgent care visits.

Requirement 14

- **Video Telehealth Capability**

Practice meets this requirement.

Practice utilizes combination of telephonic for elderly unable to operate face to face and combination of Zoom and Doximity as their video based telehealth service.

Doximity.com

DIALER SIGN IN

S ABOUT

The Medical Network

Where **care comes** together

First Name Last Name Find My Profile

Already on Doximity? Sign In

Dialer Video Dialer Voice Search

CME Fax

The easiest way to reach your patients face-to-face.

Dialer Video connects you to your patient through a no-reply text message. Your cell number is kept private — you designate the callback number. And it works with any smartphone. Your patient does not need to download an app or create an account. With a simple tap, you're practicing telemedicine.

Download App

Learn More

The reviews are in

Here's what doctors, nurse practitioners, physician assistants and pharmacists are saying about Doximity.

I transferred a patient to another hospital several years ago and was able to quickly fax and send patient info via the Doximity app to my former medical school classmate who was working at the other hospital. It was 3am and the patient was admitted directly to the ICU. It was fantastically smooth and saved us so much time rather than having to traditionally fax medical records and information. Every little bit of time helps.

- Gavin Harris, Internal Medicine

The Professional Medical Network for Physicians

Connect

Stay connected with colleagues, classmates and co-residents

Careers

Network with colleagues and employers at leading hospitals

News

Stay on top of the latest medical news, and earn CME.

Secure Messaging

Send HIPAA-compliant messages to your colleagues.

Download on the App Store

GET IT ON Google Play

Doximity by the numbers

Our vision is a future where medical communication is effortless — fast, simple, seamless and secure.

Millions of Calls

Our users love Dialer. Doximity allows you to call patients using your cell phone, while displaying your office number. Call patients privately, without *67.

80% of Doctors

And 50% of all NPs and physician assistants as verified members.

#1 for Clinicians

Aside from the iPhone, there's never been a piece of technology adopted by clinicians as quickly as Doximity.

Requirement 15

- **Avoid Reduction in Hours**

  Not Applicable to Practice

Requirement 16

- **Access to Translation / Interpreter Services**

Practice meets this requirement.
Practice utilizes **WellSense Interpretation Services:** Language interpretation can be accessed through the call center via the numbers listed below. Providers call and use this telephonic service for in-office/facility needs if they do not have access to an interpreter as needed.

- 1-888-566-0010 (English and other languages)
- 1-888-566-0012 (Spanish)

Practice can also utilize the following additional links to Interpreter Services
Interpreter Services: Lahey Hospital and Medical Center

Interpreter Services: Beth Israel Deaconess Medical Center

Interpreter Services: Mount Auburn Hospital

Population-specific Requirements (age 21 and under)

Requirement 17

- **Conduct BH, Developmental, Social Screenings as Required Under EPSDT (Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

  Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medical Protocol and Schedule

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medical Protocol and Periodicity Schedule (the Medical Schedule) and EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule)

I. The Medical Schedule

The EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule) consists of screening procedures arranged according to the intervals or age levels at which each procedure should be provided. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. This schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's medical record, including the provider's clinical judgment and justification for that deviation.

The Medical Schedule reflects guidance from several sources, including, but not limited to:

- The United States **Centers for Disease Control and Prevention** (CDC).
- The **Bright Futures Guidelines** (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx) and the **Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule** (https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx).

  The Periodicity Schedule presents recommendations for each age-related visit in the Bright Futures Guidelines, including recommendations for screenings, assessments, physical examinations, and procedures. The Periodicity Schedule is updated between editions of the Bright Futures Guidelines.
- **The Massachusetts Health Quality Partners (MHQP) Pediatric Preventive Care Guidelines** (www.mhqp.org/resources-professionals/clinical-guidelines/pediatric-preventive-care-guidelines/). MHQP is an independent, nonprofit organization that includes healthcare providers, payers, and patients in Massachusetts with the goal of improving patient care in the state of Massachusetts.

I.A. Frequency of Pediatric Preventive Healthcare Visits

Pediatric preventive healthcare visits should contain the components explained in the descriptions in the Medical Schedule and, at a minimum, occur at the following ages:

- newborn;
- three to five days;
  - newborns discharged from the hospital *fewer than 48 hours after delivery* should be evaluated within 48 hours of discharge;
  - newborns discharged from the hospital *48 hours or more after delivery* should be evaluated within 48 to 72 hours after discharge;
- one, two, four, six, and nine months;
- 12, 15, 18, 24, and 30 months; and
- annually from three to 21 years.

I.B. Components of Pediatric Preventive Healthcare Visits

i. HISTORY

Health histories should be taken at each preventive healthcare visit. An initial health history that is taken at a member's first visit with a provider typically is more comprehensive than health histories taken during interval preventive healthcare visits.

Interval history may be obtained according to the concerns of the family and the health care professional's preference or style of practice. History that is relevant to the age-specific health supervision encounter is gathered to assess strengths, accomplish surveillance, and enhance the health care professional's understanding of the child and family and to guide their work together. Past medical history and pertinent family history are important elements of the initial and interval history. Some visits also include relevant social history questions.

Health histories should include age-appropriate history regarding the member, including but not limited to

(a) family history;
(b) birth, growth, and nutrition, and developmental history;
(c) immunization history;
(d) current and past medications, including any alternative or complementary medicine;
(e) medication allergies and other allergies;
(f) medical history, including previous diagnoses, surgeries, and hospitalizations;
(g) review of systems;
(h) risk-taking behaviors, including alcohol, marijuana, tobacco, opiate, and other substance use;
(i) sexual health and development, including sexual activity; and
(j) other medical, psychosocial, and behavioral health concerns.

ii. MEASUREMENTS

- **Length/Height and Weight** - Length/height and weight measurements should be obtained for children aged birth to 21 years at every preventive healthcare visit and plotted using appropriate, standard growth charts such as those available through the CDC.

- **Head Circumference** - Head circumference measurements should be obtained at every preventive healthcare visit from newborn to 24 months and plotted using appropriate, standard growth charts such as those available through the CDC.

c) **Weight for Length** - Weight for length should be plotted using appropriate, standard growth charts such as those available through the CDC at every preventive healthcare visit from newborn to 18 months.

d) **Body Mass Index (BMI) Screen for Obesity** - BMI should be plotted using appropriate, standard growth charts such as those available through the CDC or calculated at every preventive healthcare visit from 24 months to 20 years. Use the WHO Growth Charts for monitoring weight in children ages one to two years.

e) **Blood Pressure** - Blood pressure measurement should be done at every preventive visit starting at age three. For infants and children with certain chronic conditions (including obesity, sleep-disordered breathing, and those born preterm), blood pressure measurement should be done at preventive visits before age three.

iii. SENSORY SCREENING

a) Vision Screening

For ages 0 to one years old:

- Assess newborn before discharge or at least by age two weeks using red reflex.
- Evaluate fixation preference, alignment, and eye disease by age six months.

For ages one to 17 years old:

- Perform visual acuity test at ages three, four, five, six, eight, 10, 12, 15, and 18 years. Document in medical record if test is performed in another setting such as a school.
- Screen for strabismus between ages three and five years.
- Perform vision screening at entry to kindergarten if not screened during the prior year, as recommended by the Massachusetts Preschool Vision Screening Protocol (www.mass.gov/eohhs/docs/dph/com-health/school/preschool-vision-protocols.pdf).

b) Hearing Screening

For newborns: Confirm initial screen was completed, verify results, and follow up, as appropriate.

For ages three to five days to three months: Verify results of newborn hearing screening, and follow up, as appropriate.

For ages four months to three years: Perform risk assessment for hearing problems at each preventive visit.

For ages four to 10 years: Perform hearing screening at ages four, five, six, eight, and 10 years.

For ages 11 to 21 years: Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years.

iv. DEVELOPMENTAL / BEHAVIORAL HEALTH

a) Developmental Screening

Ongoing surveillance is supplemented and strengthened by standardized developmental screening tests that may be used at certain visits (i.e., nine months, 18 months, and 30 months) and at other times at which concerns are identified.

If concerns are identified, refer the child to the local Early Intervention Program of the Massachusetts Department of Public Health if they are age 0 to 30 months, and to the local public school system if they are above age 30 months. The Early Intervention Program, the local public school, or both will conduct assessments to determine eligibility and service needs.

b) Autism Spectrum Disorder Screening

Screening using an autism-specific tool should occur at the 18-month and 24-month preventive healthcare visits.

c) Developmental Surveillance

Developmental surveillance should occur at each preventive healthcare visit from newborn to age 21 except at visits when developmental screening is being done. Comprehensive child development surveillance may include

- Eliciting and attending to the parents' concerns;
- Maintaining a developmental history;
- Making accurate and informed observations of the child;
- Identifying the presence of risk and protective factors;
- Periodically using screening tests; and
- Documenting the process and findings.

d) Psychosocial and Behavioral Assessment

Psychosocial and behavioral health assessment should occur at every preventive healthcare visit, including initial and periodic visits, from newborn to 21 years, with standardized behavioral health screening performed if there are concerns. In performing behavioral health screening, providers should use one of the clinically appropriate tools from the following list of standardized behavioral health screening tools:

i. Ages and Stages Questionnaires (ASQ: SE) and the Ages and Stages Questionnaires, Second Edition (ASQ: SE-2);

ii. Brief Infant-Toddler Social and Emotional Assessment (BITSEA);

iii. Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) and the Car, Relax, Alone, Forget, Friends, Trouble 2.1 (CRAFFT 2.1);

iv. Early Childhood Screening Assessment (ECSA);

v. Edinburgh Postnatal Depression Scale (EPDS);

vi. Modified Checklist for Autism in Toddlers - Revised (M-CHAT-R);

vii. Modified Checklist for Autism in Toddlers - Revised with Follow-up (M-CHAT-R/F);

viii. Parents' Evaluation of Developmental Status (PEDS);

ix. Patient Health Questionnaire-9 (PHQ-9);

x. Patient Health Questionnaire-9 Modified for Adolescents (PHQ-9 Modified);

xi. Pediatric Symptom Checklist (PSC-35), Pediatric Symptom Checklist (PSC-17), and Pediatric Symptom Checklist-Youth Report (PSC-Y);

xii. Strengths and Difficulties Questionnaire (SDQ); and

xiii. Survey of Well-being of Young Children (SWYC) and Survey of Well-being of Young Children–MA (SWYC-MA).

If there is evidence of a psychosocial or behavioral health concern or need for further assessment, the provider should offer the necessary behavioral health services or make a referral to another provider who can provide them. To determine which providers may be available to provide the needed behavioral health services and how to use out-of-network providers, if necessary, contact the MassHealth Customer Service Center at (800) 841-2900 (TTY: (800) 497-4648) or the member's health plan.

Psychosocial and behavioral health assessments should include issues such as food insecurity, domestic violence, substance use, housing situations, and other matters that impact child and family health.

e) **Tobacco, Alcohol, and Drug Use Assessment**
Risk assessment for tobacco, alcohol, and drug use should be performed at every preventive healthcare visit from 11 years to 21 years.

f) **Depression Screening**
Screening specifically for depression should occur at every preventive healthcare visit from 12 to 21 years using an appropriate depression screen such as the Patient Health Questionnaire Modified for Adolescents (PHQ-9 Modified), or other tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit.

g) **Maternal and Caregiver Depression Screening**
Screening for maternal and caregiver postpartum depression should occur at one-month, two-month, four-month, and six-month preventive healthcare visits.

v. PHYSICAL EXAMINATION

A physical examination should be performed at every preventive healthcare visit, including initial visits and periodic visits. The components of the physical examination should be age-appropriate. Infants should be completely unclothed and other children undressed, draped, and chaperoned, as indicated. The use of a chaperone should be a shared decision between the patient, the patient's parent or guardian, and physician.

vi. PROCEDURES

a) **Newborn Blood Screening**
Verify at the newborn or the three- to five- day preventive healthcare visit that all required newborn screenings were performed, especially if the newborn was not born in a hospital setting or was born outside Massachusetts. Verify results and follow up as appropriate. Additional information about the Massachusetts newborn screening program is available from the New England Newborn Screening Program (https://nensp.umassmed.edu/).

b) **Newborn Bilirubin Screening**
Confirm at the newborn preventive healthcare visit that the initial screening was completed, verify results, and follow up as appropriate.

c) **Critical Congenital Heart Defect Screening**
Screening for critical congenital heart defect or disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital. Confirm at the newborn preventive healthcare visit that the screening has been done.

d) Immunization Assessment and Administration

Immunize according to the Massachusetts Department of Public Health's Immunization Program. Immunization status should be assessed at every preventive healthcare visit from newborn to 21 years.

e) Anemia Screening

For ages 0 to one years old: Screen once between age nine and 12 months. At clinician discretion, conduct assessment of infants at high risk for iron deficiency. Consider screening at 15 and 30 months, based on risk factors.

For ages one to 10 years old: Conduct risk assessment or screening, including dietary iron sufficiency, at clinician discretion. Screen those with risk factors annually from ages two to five.

For ages 11 to 21: Conduct risk assessment or screening. Screen all non-pregnant female adolescents for anemia every five to 10 years during well visits starting at age 12. Screen those with known risk factors (i.e., excessive menstrual blood loss, low iron intake, or previous diagnosis of iron deficiency anemia) annually.

f) Lead Exposure Screening

Screen for lead exposure according to the guidance set forth by the Massachusetts Childhood Lead Poisoning Prevention Program (MCLPPP). As described in the MCLPPP's *Changes to the Lead Regulation for Pediatric Healthcare Providers* updated in October 2017 (www.mass.gov/doc/lead-fact-sheet-for-providers-111417-0/download), initial screening is recommended between nine and 12 months and again at two and three years of age. Screen at four years of age if a child lives in a city or town with a high risk for childhood lead exposure. Screen at entry to daycare, preschool, or kindergarten if not screened before.

A list of high-risk communities can be found at www.mass.gov/lists/view-annual-screening-and-blood-lead-level-reports-and-high-risk-community-list and additional information about screening may be found at www.mass.gov/dph/clppp.

Pursuant to M.G.L. c. 111,§ 191 (https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section191), physicians, other healthcare providers, and private laboratories must report all cases of childhood lead poisoning known to them to the agency director within three working days of identification, unless previously reported. If a child suffers multiple episodes of lead poisoning, the provider must report each episode.

g) Tuberculosis Assessment and Testing

Risk for tuberculosis should be assessed at the one-month, six-month, 12-month, and 24-month preventive healthcare visit and then annually from three years to 21 years of age. Testing should be performed as indicated by the results of the risk assessment.

h) Dyslipidemia Assessment and Testing

Assess for dyslipidemia risk factors every two years at age two, four, six, and eight, and then annually from age 12 to 16. Screen for dyslipidemia once between age nine and 11, and once between age 17 and 21.

i) **Sexually Transmitted Infections (STIs) Assessment and Testing**
Assess for risk of sexually transmitted infections annually starting at the 11-year preventive healthcare visit, with screening as indicated by the risk assessment.

j) **Human Immunodeficiency Virus (HIV) Assessment and Testing**
Assess for risk of human immunodeficiency virus annually starting at the 11-year preventive healthcare visit, and test as indicated by the results of the risk assessment. Adolescents should be tested as least once between the ages of 15 and 18. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

k) **Cervical Dysplasia Screening**
Cytology screening for cervical cancer should begin at the 21st year preventive healthcare visit. In compliance with guidance from the U.S. Preventive Services Task Force, human papillomavirus (HPV) testing is not recommended at age 21 (www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening).

vii. ORAL HEALTH

By one year of age, it is recommended that every child have a dental home. A dental home is the ongoing relationship between a dentist and a child, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

More details regarding oral health appear in Section II of this Appendix W, regarding the Dental Schedule. Fluoride varnish and fluoride supplementation are two aspects of oral health that are addressed by both primary care providers and dental providers.

a) **Fluoride Varnish**
Assess the need for fluoride varnish at all preventive visits from six months to five years old. Once teeth are present, fluoride varnish may be applied to all children every three to six months in the primary care or dental office.

b) **Fluoride Supplementation**
Assess the need for dietary fluoride supplementation at six months, nine months, 12 months, and then at all preventive visits from 18 months to 16 years old. Dietary fluoride supplements should be considered for children if their primary water source is deficient in fluoride.

viii. ANTICIPATORY GUIDANCE

Anticipatory guidance should be provided at every preventive healthcare visit with discussion topics including, but not be limited to

a) developmental expectations and sound parenting practices;

b) behavioral risks, such as avoidance of the use of alcohol, drugs, tobacco, e-cigarettes (also known as vaping), opiates, cannabis, and other substances;

c) safe environments at home, in school, and in the community, which are free of violence, toxic stress, bullying, and ostracism;

d) mental health, including depression and anxiety, based on risk factors and individual patient presentation in adolescence;

e) academic or behavioral problems that may be signs of attention deficit hyperactivity disorder (ADHD);

f) safe and healthy sexual behaviors, including abstinence and contraception, with sensitivity to sexual orientation and gender identity;

g) benefits and components of a healthy diet and safe weight management, ways to maintain adequate calcium and vitamin D, and counseling against sugar-sweetened and caffeinated drinks;

h) benefits of daily physical activity, opportunities for daily physical activity, and parents as role models;

i) healthy sleep habits and encouraging proper sleep amounts and safe sleep practices, including placing infants on their backs when putting them to sleep, avoiding co-sleeping, and use of a firm sleep surface without soft bedding or toys;

j) impact of electronic media as a risk factor for being overweight, low school performance, and violent behavior. Encourage limiting of screen time. Discourage placement of computers and TVs in bedrooms;

k) safety related to online activity, social networking, and use of smartphones and other handheld devices;

l) chronic and communicable disease prevention;

m) safety measures and injury prevention, including childproofing, car seats and seat belts, bike and motorcycle helmets, poison prevention, firearm safety, and other age-appropriate counseling;

n) skin protection, including using sunscreen, minimizing exposure to the sun, and discouraging use of indoor tanning;

o) potential risks of body piercing and tattooing;

p) nutrition, which primary care providers may assess and promote by doing the following:

   i. Ask about dietary habits;

   ii. Promote breastfeeding as the best form of infant nutrition and assess breastfed infants between two and five days of age;

   iii. Starting in middle childhood, screen annually for eating disorders and ask about body image and dieting patters; and

   iv. 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.

II. The Dental Schedule

The EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) consists of procedures arranged according to the intervals or age levels at which each procedure is to be provided. The Dental Schedule is based on the *Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling* from the American Academy of Pediatric Dentistry (AAPD) Reference Manual 2019-2020. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. This schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's dental record, including the provider's clinical judgment and justification for that deviation.

II.A. Dental Schedule Table

The Dental Schedule is included in the following table. Explanations of each component are included in section II.B.

	6 – 12 Months	12 -24 Months	2 - 6 Years	6 - 12 Years	12 - 20 Years
Clinical oral examination (1)	x	x	x	x	x
Assessment of oral growth and development (2)	x	x	x	x	x
Caries-risk assessment (3)	x	x	x	x	x
Radiograph assessment (4)			x	x	x
Prophylaxis and topical fluoride (5)	x	x	x	x	x
Fluoride supplementation (6)	x	x	x	x	x
Fluoride varnish (7)	x	x	x	x	x
Anticipatory guidance/ counseling (8)	x	x	x	x	x
Oral hygiene counseling (9)	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling (10)	Parent	Parent	Patient/Parent	Patient/Parent	Patient
Injury prevention counseling (11)	x	x	x	x	x
Counseling for nonnutritive habits (12)	x	x	x	x	x

	6 – 12 Months	12 -24 Months	2 - 6 Years	6 - 12 Years	12 - 20 Years
Pit and fissure sealants (13)			x	x	x
Counseling for speech/language development (14)	x	x	x		
Tobacco control education Substance abuse screening (15)				x	x
Screening for intraoral/perioral piercing (16)				x	x
Assessment and treatment of developing malocclusion (17)			x	x	x
Assessment and/or removal of third molars (18)					x
Transition to adult dental care (19)					x

II.B. Explanations of the Dental Schedule Table

The explanations in this section are numbered and align with the numbers that appear in the Dental Schedule Table in section II.A.

1. The first clinical oral examination should occur at the eruption of the first tooth and no later than 12 months of age. Clinical examinations should take place every six months or as indicated by the child's risk status and susceptibility to disease. The clinical examination includes assessment of all hard and soft tissues, as well as pathology and injuries.
2. Oral growth and development are assessed by clinical examination.
3. Caries risk assessment should be repeated during each clinical examination to monitor changes in risk status.
4. Radiographic assessments are an important component of the clinical assessment. Timing, selection, and frequency are determined by child's history, clinical findings, and susceptibility to oral disease and in compliance with FDA guidance (www.fda.gov/radiation-emitting-products/medical-x-ray-imaging/selection-patients-dental-radiographic-examinations).
5. Prophylaxis and fluoride treatments are important preventive measures. Prophylaxis and fluoride treatments should be a component of the periodic examination and assessment process.
6. Evaluate when systemic fluoride exposure is suboptimal or fluoride supplementation is otherwise indicated by guidance of the American Academy of Pediatric Dentistry and the Bright Futures Periodicity schedule. See list of Massachusetts fluoridated communities at www.mass.gov/files/documents/2016/07/xv/fluoride-census.pdf.

7. Fluoride Varnish - Once teeth are present, fluoride varnish may be applied every three to six months in the dental office or primary care setting (https://pediatrics.aappublications.org/content/pediatrics/134/3/626.full.pdf).
8. Anticipatory guidance is an integral component of the initial comprehensive exam and each subsequent exam.
9. Oral hygiene instruction should be provided to parents of young children. Age-appropriate instruction should be provided to the child throughout childhood and adolescence.
10. Dietary counseling is an integral component of each dental visit. For very young children, this should include a discussion of appropriate feeding practices and prevention of early childhood caries. By age one, the counseling should include the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11. Injury prevention counseling should initially include information about play objects, pacifiers, and car seats for infants. As the child nears age one, counseling should include learning to walk, sports, and routine playing, and the importance of mouth guards.
12. Counseling related to non-nutritive sucking habits should include information about the need for additional sucking (e.g. pacifiers). As the child grows, counseling should include the need to wean from the sucking habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counseling should include any existing habits such as fingernail biting, clenching, or bruxism.
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; dental sealants should be placed as soon as possible after eruption. Sealants are an essential component of preventive dental care.
14. Appropriate referrals for speech and language development should be made at age-appropriate intervals.
15. Education regarding prevention of tobacco use and substance abuse should begin as early as age six according to the National Cancer Institute and American Dental Association.
16. The oral health consequences of oral piercings should be discussed with pre-adolescents and adolescents.
17. Assessment and treatment of developing malocclusion should begin in the two- to six-year age range and referrals made to an orthodontist as indicated by the patient's needs.
18. Third molars erupt between ages 17-20. Clinical and radiographic evaluation of eruption pattern of third molars should begin at age 16 and assessments made for impactions and interference with periodontal health of adjacent teeth. A decision regarding extraction of third molars should occur after all four third molars are erupted, or radiographic assessment indicates impaction.
19. Transition to adult dental care should occur before the 21st birthday of the child.

Requirement 18

- **Screen for SNAP and WIC Eligibility and Referral to WIC When Eligible**

Practice meets this requirement.

Practice utilizes the Social Determinates of Health (SdoH)/HRSN screening requirements

Utilizing the food security question of your practices SDOH/HRSN screening will screen for WIC/SNAP eligibility.

Options for providing SNAP / WIC resources include:

SNAP OnePager to give in AVS

WIC Contact Information in AVS:

- If you need WIC, call 800-942-1007 or e-mail wicinfo.dph@massmail.state.ma.us.

WIC and SNAP Program and Contact Info

Need help buying groceries? SNAP can help!

USDA Supplemental Nutrition Assistance Program
Putting Healthy Food Within Reach

Department of Transitional Assistance

SNAP can help you buy healthy food.

- It is fast & easy to apply
- Buy food in stores & online (multiple retailers)
- SNAP is not considered in a "public charge" test
- If you are not a US citizen or eligible immigrant, it is safe for you to get SNAP for an eligible family member (like your US citizen child)

Am I Eligible for SNAP?

Household Size	Your Monthly Income (before taxes)*	Monthly Maximum SNAP Amount**
1	$2,430	$281
2	$3,287	$516
3	$4,143	$740
4	$5,000	$939
5	$5,857	$1,116
8+	+ $857	+$211

*Effective 2/1/2023

**Effective 10/1/2022

For more information/ apply for SNAP:

Scan code with phone camera to apply online

DTAConnect.com

877-382-2363 Mon – Fri 8:15 am-4:45 pm

Mail or Fax a paper application
Get a paper application: Mass.gov/SNAP

In the community: local kiosk, SNAP outreach partner, DTA office
Find a location near you: Mass.gov/ContactDTA

Rev. 2/01/2023

DO YOU HAVE A CHILD UNDER 5?

ARE YOU PREGNANT OR BREASTFEEDING?

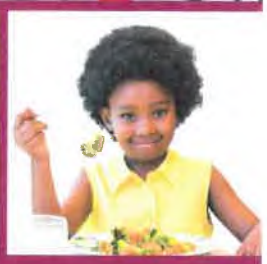
WIC

OFFERS FAMILIES:

- Free healthy food
- Personalized nutrition consultations
- Tips for eating well to improve health
- Referrals for medical and dental care, health insurance, child care, housing and fuel assistance, and other services that can benefit the whole family!

Check these guidelines to decide if WIC might be right for your family:

HOUSEHOLD	YEARLY	MONTHLY	WEEKLY
1	$23,828	$1,986	$459
2	$32,227	$2,686	$620
3	$40,626	$3,386	$782
4	$49,025	$4,086	$943
5	$57,424	$4,786	$1,105
6	$65,823	$5,486	$1,266
7	$74,222	$6,186	$1,428
8	$82,621	$6,886	$1,589



TO LEARN MORE ABOUT WIC, CALL 1-800-WIC-1007 OR VISIT MASS.GOV/WIC

GOOD FOOD *and* A WHOLE LOT MORE!

@MassWIC

Form #355

This institution is an equal opportunity provider.

2021

Women, Infants, & Children (WIC) Program and Supplemental Nutrition Assistance Program (SNAP)

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.

Wic eligibility: https://www.mass.gov/service-details/check-eligibility-for-wic

You can participate in WIC if you:

- Live in Massachusetts
- Have a nutritional need (WIC staff can help you determine this)
- Are a child under 5, a new mom, or a pregnant or breastfeeding woman
- Have a family income less than WIC guidelines

You are automatically income eligible for WIC if you currently receive:

- MassHealth/Medicaid insurance plans
- Supplemental Nutrition Assistance Program (SNAP)
- Transitional Aid to Families with Dependent Children (TAFDC) or cash assistance

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.

Snap eligibility: https://dtaconnect.eohhs.mass.gov/screening

https://dtaconnect.eohhs.mass.gov/

https://www.mass.gov/doc/snap-outreach-flyer-english-0/download

SNAP eligibility is based on who is in the household, income and certain expenses.

- What counts as income? DTA counts income from most sources, such as wages, cash assistance, Social Security, unemployment insurance, and child support. When you apply, tell DTA about any money you earn or is given to you.
- Who is in a SNAP Household? A household includes anyone you buy and cook most of your meals with. If your spouse or child(ren) under 22 live with you, they must be included in your household (even if you do not buy and make meals with them).

SNAP Eligibility Chart

Household Size	Maximum Monthly Income (before taxes)	Maximum Monthly SNAP Amount*
1	$2,265	$281
2	$3,052	$516
3	$3,838	$740
4	$4,625	$939
5	$5,415	$1,116
6	$6,198	$1,339
7	$6,985	$1,480
8	$7,772	$1,691
Each additional person	+ $787	+ $211

Household Size	Maximum Monthly Income (before taxes)	Maximum Monthly SNAP Amount*

* Your household may receive a different monthly amount, depending on income and expenses. During COVID-19 all households get at least the maximum amount.

Requirement 19

- **Establish/Maintain relationship with local Children's Behavioral Health Initiative (CBHI)**

Practice meets this requirement.
Practice utilizes the ACO reference guide and the contact numbers on the CBHI Brochure for MassHealth

CBHI Brochure

ACO BH Quick Reference Resource Guide

CBHI Guide for Children and Youth Aged 20 and Younger

MASSHEALTH PLAN CONTACT INFORMATION

Health Plan Name	Customer Service Phone	Behavioral Health Phone	Website
Be Healthy Partnership	(800) 786-9999	(800) 495-0086	www.behealthypartnership.org
Berkshire Fallon Health Collaborative	(855) 203-4660	(888) 877-7184	www.fallonhealth.org/Berkshires
BMC HealthNet Plan	(888) 566-0010	(888) 217-3501	www.bmchp.org
BMC HealthNet Plan Community Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/community
BMC HealthNet Plan Mercy Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/mercy
BMC HealthNet Plan Signature Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/signature
BMC HealthNet Plan Southcoast Alliance	(888) 566-0010	(888) 217-3501	www.bmchp.org/southcoast
Community Care Cooperative (C3)	(866) 676-9226	(800) 495-0086	www.c3aco.org
Fallon 365 Care	(855) 508-3390	(888) 877-7182	www.fallonhealth.org/365care
My Care Family	(800) 462-5449	(844) 451-3519	www.mycarefamily.org
Partners HealthCare Choice	(800) 231-2722	(800) 495-0086	www.partners.org/MassHealthACO
Primary Care Clinician (PCC) Plan	(800) 841-2900	(800) 495-0086	www.mass.gov/service-details/primary-care-clinician-pcc-plan-for-massheath-members
Steward Health Choice	(855) 860-4949	(800) 495-0086	www.stewardhealthchoice.org/massachusetts
Tufts Health Together	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/together
Tufts Health Together with Atrius Health	(888) 257-1985	(888) 257-1985	www.tuftshealthplan.com/public-plan/atrius-health
Tufts Health Together with BIDCO	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/BIDCO
Tufts Health Together with Boston Children's ACO	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/BCACO
Tufts Health Together with CHA	(888) 257-1985	(888) 257-1985	www.TuftsHealthTogether.com/CHA
Wellforce Care Plan	(855) 508-4715	(888) 877-7183	www.fallonhealth.org/wellforce

CBHI-MB (Rev. 3/19)

MASSHEALTH SERVICES FOR CHILDREN & YOUTH

Did you know that MassHealth offers many services for children and youth up to age 21?

Most of the services in this brochure are home and community-based. All of them can help families support their children in difficult times. Read on to learn more about these services and how you can find providers.

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.

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.

How can I find providers?

For Home- and Community-Based services, you can search for providers and get their contact information at www.mabhaccess.com. You can see if a provider is accepting new clients. If they are, make sure to call for an appointment.

For Youth Substance-Use Services, you can find a provider by

- going to www.mabhaccess.com,
- accessing https://helplinema.org, or
- calling **(800) 327-5050**.

For Outpatient Therapy and Applied Behavioral Analysis, call the Behavioral Health Customer Service line of your MassHealth Plan. See back page for phone numbers.

If you have questions or need help finding any of the services in this brochure, call the Behavioral Health Customer Service line of your MassHealth Plan.

For more information, go to www.mass.gov/masshealth/CBHI, where you can find guides and tip sheets and watch videos about some of the services described in this brochure.

What if my child doesn't have MassHealth?

If your child is under 21 and doesn't have health insurance, call MassHealth Customer Service at **(800) 841-2900** and find out if they can get MassHealth. You can learn more about applying to MassHealth by visiting www.mass.gov/masshealth.

*Youth under 21 on MassHealth Family Assistance who are enrolled in managed care may be able to get this service if it is medically necessary. Youth on MassHealth Standard or CommonHealth can get ANY service that is medically necessary. Youth with a mental or physical disability can apply to get CommonHealth. Contact MassHealth Customer Service at (800) 841-2900 for more information.

Community Behavioral Health Centers (CBHC) - Serving specific, regionally-defined catchment areas, CBHCs will supplement the broad array of existing behavioral health providers already available to MassHealth members and offer coordinated and integrated mental health and substance use disorder treatment, including new and enhanced behavioral health services, for MassHealth members of all ages. These services include:

- Routine and urgent outpatient services, including same-day evaluation and referral to treatment, evening and weekend hours, timely follow-up appointments, and evidence-based behavioral health treatment. Services may be provided in-person, at CBHC and community-based locations, and via telehealth;
- Mobile crisis intervention services for adults and youth, including 24/7 site- and communitybased mobile crisis assessment, intervention and stabilization, as an alternative to hospital emergency departments; and
- Community crisis stabilization services for adults and youth, offering short-term, 24/7, staffsecure, safe, and structured crisis treatment services in a community-based program that serves as a medically necessary, less-restrictive, and voluntary alternative to inpatient psychiatric hospitalization

Organization name	24/7 Phone	Alt Phone	Address	City	Zip	Catchment area	Tax ID
Advocates	800-640-5432	508-661-2020	354 Waverly St	Framingham	01701	Acton, Ashland, Arlington, Bedford, Belmont, Boxborough, Burlington, Carlisle, Concord, Framingham, Holliston, Hopkinton, Hudson, Lexington, Lincoln, Littleton, Maynard, Marlborough, Natick, Northborough, Sherborn, Southborough, Stow, Sudbury, Waltham, Watertown, Wayland, Westborough, Wilmington, Winchester, and Woburn	237451423
Advocates	800-640-5432	508-661-2020	675 Main St	Waltham	02452	Acton, Ashland, Arlington, Bedford, Belmont, Boxborough, Burlington, Carlisle, Concord, Framingham, Holliston, Hopkinton, Hudson, Lexington, Lincoln, Littleton, Maynard, Marlborough, Natick, Northborough, Sherborn, Southborough, Stow, Sudbury, Waltham, Watertown, Wayland, Westborough, Wilmington, Winchester, and Woburn	237451423
Aspire Health Alliance	800-528-4890	781-399-5030	460 Quincy Avenue	Quincy	02169	Braintree, Cohasset, Hingham, Hull, Milton, Norwell, Quincy, Randolph, Scituate, and Weymouth	042677185
Bay Cove Human Services	833-229-2683	(508) 815-5375	116 Camp Street	Hyannis	02601	Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham, Falmouth, Harwich, Hyannis, Mashpee, Orleans, Osterville, Provincetown, Sandwich, Truro, Wellfleet, Woods Hole, and Yarmouth	042518575
BHN	800-437-5922	413-747-0705	417 Liberty St.	Springfield	01104	Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, and Wilbraham	042103756
BHN	800-437-5922	413-747-0705	77 Mill St. Westfield MA 01085	Westfield	01085	Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, and Wilbraham	042103756
BILH Behavioral Services	877-255-1261	617.414.8386	12 Methuen St	Lawrence	01840	Andover, Lawrence, Methuen, and North Andover	042777145
Boston Medical Center	800-981-4357	617-414-8386	85 E Newton	Boston	02118	Boston, Alston, Brighton, and Brookline	043314093
Cambridge Health Alliance	833-222-2030		1493 Cambridge St	Cambridge	02139	Cambridge, Somerville, Everett, Malden, and Medford	043320571
Center for Human Development	833-243-8255	413-531-3904	1109 Granby Road	Chicopee	01020	Belchertown, Bondsville, Chicopee, Granby, Holyoke, Ludlow, Monson, Palmer, South Hadley, Southampton, Thorndike, Three Rivers, and Ware	042503926
Child and Family Services	877-996-3154		543 North St	New Bedford	02740	Acushnet, Carver, Dartmouth, Duxbury, Fairhaven, Halifax, Hanover, Hanson, Kingston, Marion, Marshfield, Mattapoisett, New Bedford, Pembroke, Plymouth, Plympton, Rochester, and Wareham	042104754
Child and Family Services	877-996-3154		1061 Pleasant St	New Bedford	02740	Acushnet, Carver, Dartmouth, Duxbury, Fairhaven, Halifax, Hanover, Hanson, Kingston, Marion, Marshfield, Mattapoisett, New Bedford, Pembroke, Plymouth, Plympton, Rochester, and Wareham	042104754
Child and Family Services	877-996-3154		68 Industrial Park Rd	Plymouth	02360	Acushnet, Carver, Dartmouth, Duxbury, Fairhaven, Halifax, Hanover, Hanson, Kingston, Marion, Marshfield, Mattapoisett, New Bedford, Pembroke, Plymouth, Plympton, Rochester, and Wareham	042104754
Child and Family Services	508-676-5708	774 488 5000	160 Osborn Street	Fall River	02720	Fall River, Freetown, Somerset, Swansea, and Westport	042104754
Child and Family Services	877-996-3154		1052 Pleasant St	Fall River	02723	Fall River, Freetown, Somerset, Swansea, and Westport	042104754
Clinical Support Options	800-562-0112	978-632-9400	205 School Street	Gardner	01440	Ashburnham, Gardner, Hubbardston, Templeton, Westminster, and Winchendon	042206041
Clinical Support Options	800-562-0112	(413) 774- 1000	1 Arch Place 1st Floor	Greenfield	01301	Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Millers Falls, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Turners Falls, Warwick, Wendell, and Whately	042206041
Clinical Support Options	800-562-0112		8 Atwood Dr	Northampton	01060	Amherst, Chesterfield, Cummington, Easthampton, Florence, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, and Worthington	042206041
Community Counseling of Bristol County	800-660-4300	508-828-9116	1 Washington Street	Taunton	02780	Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleborough, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, and Taunton	043035697
Community HealthLink	800-977-5555	978-466-8376	40 Spruce Street	Leominster	01453	Ashby, Ayer, Barre, Berlin, Bolton, Clinton, Fitchburg, Groton, Hardwick, Harvard, Lancaster, Leominster, Lunenburg, New Braintree, Oakham, Pepperell, Princeton, Rutland, Shirley, Sterling, and Townsend	042626179
Community HealthLink	866-549-2142		12 Queen St	Worcester	01610	Auburn, Boylston, Grafton, Holden, Leicester, Millbury, Paxton, Shrewsbury, Spencer, West Boylston, and Worcester	042626179
Eliot Community HS	866-523-1216	781-861-0890	10 Harbor St.	Danvers	01923	Amesbury, Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Groveland, Hamilton, Haverhill, Ipswich, Manchester by the Sea, Marblehead, Merrimac, Middleton, Newbury, Newburyport, Peabody, Rockport, Rowley, Salem, Salisbury, Topsfield, Wenham, and West Newbury	042316924
Eliot Community HS	800-988-1111	781-861-0890	95 Pleasant St.	Lynn	01901	Lynn, Lynnfield, Melrose, Nahant, North Reading, Reading, Saugus, Stoneham, Swampscott, and Wakefield	042316924
Fairwinds - Nantucket's Counseling Center	888-323-3447		20 Vesper Ln	Nantucket	02554	Nantucket	042308993
High Point Treatment Center	888-725-9066	508-638-6022	30 Meadowbrook Road	Brockton	02301	Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Holbrook, Rockland, Stoughton, West Bridgewater, and Whitman	043357938
North Suffolk Mental Health Assoc.	888-309-1989	617-912-7900	14 Porter St	E. Boston	02128	Chelsea, Revere, East Boston, Winthrop, and Charlestown	042317215
Riverside Community Care	800-529-5077	781-769-8670X6075	190 Lenox Street	Norwood	02062	Canton, Dedham, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood, and Wrentham	043097170
Riverside Community Care	800/294-4665	508-529-7000 x6334	176 West Street	Milford	01757	Bellingham, Blackstone, Brimfield, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Holland, Hopedale, Medway, Mendon, Milford, Millville, Northbridge, North Brookfield, Oxford, Southbridge, Sturbridge, Sutton, Upton, Uxbridge, Wales, Warren, Webster, and West Brookfield	043097170
The Brien Center	800-252-0227	413-629-1062	334 Fenn Street	Pittsfield	01201	Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesboro, Lee, Lenox, Monroe, Monterey, Mount Washington, New Ashford, New Marlboro, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, and Windsor	042081870
Vinfen	866-388-2242	978-674-6744x 338	40 Church Street	Lowell	01852	Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsboro, and Westford	042632219

MassHealth Behavioral Health Services for Children and Youth Aged 20 and Younger

A Guide for Staff Who Work with Children, Youths, and Families

Table of Contents

This guide was produced by the Children's Behavioral Health Initiative (CBHI), an interagency initiative of the Commonwealth of Massachusetts Executive Office of Health and Human Services.

The mission of CBHI is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care, and to ensure that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success in home, school, and community, and throughout life.

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1. Introduction

When working with children, teens, or young adults, you may find yourself concerned about one in particular. Perhaps she isn't getting along with others or he's having a hard time controlling his behavior. Maybe worried parents have turned to you for advice or support.

(This publication uses the terms "parent" and "caregiver" to describe a person who nurtures and cares for a child. A parent may be a biological, foster, or adoptive parent; a grandparent, relative, caregiver, or guardian. Although this publication generally refers to how parents and families can help children access services, it also covers MassHealth members aged 20 and younger, including members who do not need parental consent to obtain treatment services.)

This guide was created for staff working in education, social services, health care, and other community-based organizations who serve children, youths, and their families. It contains practical information on home- and community-based behavioral health services to assess and treat mental health and substance abuse issues that are available to MassHealth-enrolled children and youths aged 20 and younger.

In this Guide you will find

- Basic information on MassHealth and eligibility
- Descriptions of MassHealth's home- and community-based behavioral health services
- Guidance on how to help families select the right starting point for their child
- Specific steps to take to help families access services

At the end of the Guide you will also find additional resources for your program and the families of the children and youths you interact with, including

- Ordering information for Worried about the way your child is acting or feeling?, a MassHealth brochure that provides family-friendly descriptions of MassHealth home- and community-based behavioral health services
- A guide for applying for health care coverage through MassHealth
- A family guide to behavioral health assessment using the Child and Adolescent Needs and Strengths (CANS) tool
- A worksheet to help families prepare for initial appointments with providers
- Links to other helpful resources

We hope that you will find this guide a useful source of information when speaking with families seeking help for their children.

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2. Who Is Eligible for MassHealth Behavioral Health Services?

MassHealth is our state's Medicaid program. It provides comprehensive health insurance to more than one million Massachusetts children, families, seniors, and people with disabilities. In 2009, MassHealth, as part of the Children's Behavioral Health Initiative (CBHI), significantly expanded home- and community-based behavioral health services (mental health and substance abuse services) for MassHealth-eligible children and youths aged 20 and younger. The goal of the service expansion was to ensure that children and youths with serious mental health challenges, and their families, obtain the services they need for success in home, school, and community, and throughout life.

In order to get the services described in this Guide, a child or youth must be enrolled in MassHealth and must have a medical need for the services. There are various "coverage types" within MassHealth. Most MassHealth-enrolled children have either the Standard or CommonHealth coverage type. A child or youth enrolled in MassHealth "Standard" or "CommonHealth" may access any "medically necessary" MassHealth service.

- To be enrolled in MassHealth Standard, a family's income must be less than 150% of the federal poverty level.
- CommonHealth is available to a child or an adult with a disability, regardless of income. However, higher-income families must pay a "sliding scale" premium, based on income. The definition of disability includes behavioral health conditions; the disability standard for children and youths younger than age 18 is less stringent than the standard for adults.

Some families who are not eligible for MassHealth Standard, and either have not applied for CommonHealth or are not eligible for CommonHealth, are covered by MassHealth's Family Assistance program. Children and youths enrolled in Family Assistance may access certain medically necessary MassHealth behavioral health services (see table below).

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If a child's or youth's family is covered by MassHealth but is unsure of the coverage type, they can do one of the following.

- Call MassHealth's Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).
- Call the health plan (the name and phone number will be on the insurance card that the child or youth uses when going to the doctor).

If a child is not already a MassHealth member, you can help by encouraging the family to apply. See Appendix A for a guide on how to apply for MassHealth coverage.

Below is a summary of MassHealth coverage types and the behavioral health services for children and youths aged 20 and younger. Descriptions of these services can be found in Section 4. Note: This list of services covered by MassHealth provides only general information. Parents and youths should call their MassHealth health plan for the most up-to-date, accurate information.

(Note: Some members younger than 19 who are eligible for Family Assistance receive premium assistance as their only MassHealth benefit. For these members, MassHealth pays the premium for commercial insurance but does not reimburse providers directly for services. These members are not eligible for MassHealth behavioral health services. Additionally, some families with Family Assistance also have commercial health insurance coverage. As a result, their children are not eligible for enrollment in any of MassHealth's managed-care programs, nor are they eligible for community-based MassHealth behavioral health services (with the exception of Mobile Crisis Intervention). Families can call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) to learn more.)

Behavioral Health Service
MassHealth Coverage Types

Outpatient Therapy
Standard, CommonHealth, Family Assistance*

Mobile Crisis Intervention
Standard, CommonHealth, Family Assistance*

Structured Outpatient Addiction Program
Standard, CommonHealth, Family Assistance*

In-Home Therapy
Standard, CommonHealth, Family Assistance*

Intensive Care Coordination
Standard, CommonHealth

Family Support and Training (Family Partners)
Standard, CommonHealth

In-Home Behavioral Services
Standard, CommonHealth

Therapeutic Mentors
Standard, CommonHealth

Understanding coverage and eligibility guidelines can be stressful and confusing for many families (and professionals). You can help by encouraging families to call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648). Knowledgeable staff can provide information helpful for the family's decision-making.

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3. When Is It Time to Seek Services?

Behavioral health needs, including mental health, emotional, and substance abuse concerns, can be hard to recognize. Too often, it takes a crisis for families to get the help they need. But research shows that earlier interventions for children and youths with mental or behavioral health needs can prevent more serious problems in young adulthood and beyond.

With your help, families could start getting the services they need sooner, which can mean better outcomes for the child or youth.

If you have concerns about a child or youth in your program, it may help to write them down. Consider the following questions.

- Is this a dramatic change in behavior or mood for the child or youth?
- How severe is it?
- Does this behavior occur at specific times of day?
- How long has it been occurring?
- How does this behavior compare with the behavior of peers?
- Is there a possible health or developmental issue that could be causing the behavior/mood change?
- Are there changes within the child's home life or other events (i.e., death, divorce, new child, remarriage, move to new home/housing instability, etc.) that could be affecting his or her behavior?
- Is the child or youth experimenting, using, or abusing alcohol and other drugs?
- Is the child or youth having trouble at school resulting in disciplinary actions, academic concerns, and/or relationship problems?
- Is the child or youth having relationship problems with friends outside of school or with other family members?

Whenever you have any concerns, follow your organization's procedures for communicating concerns with families.

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When talking with a parent about your concerns, it may help to keep the following in mind.

1. Plan ahead. Think carefully about what you want to say and what you hope the conversation will accomplish.
2. Make yourself available. Find a good time with no distractions that works for both of you. Depending on the parent's availability, this can mean a face-to-face meeting or a phone call.
3. Start with the positive. You can share an observation about something you appreciate in the child or youth.
4. Let the parent know that your goal is to help his or her child be successful and that your program is doing everything it can to make that happen, but that you need help from the parent. Describe what you are seeing without attaching a meaning or judgment to the behavior.
5. Ask the parent if he or she has similar concerns or has experienced similar situations and what solutions have worked at home. Parents often have ways of working with their children that can help in other settings. If they do not have solutions, this can be the opening they need to share their concerns
6. Be ready with information and useful resources to share with the parent. Understand that parents may not be ready to address a need immediately, but they may appreciate being able to look into these resources later. Offer the parent a few options for moving forward and allow the parent to choose. You can always check in at a later time if he or she shows little interest at the moment.
7. Above all, listen to the parent. Keep your mind open for new information. Be mindful and respectful of cultural differences. Be sure to check your tone, body language, and facial expression, because your nonverbal communication can speak just as loudly as your words.

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Of course, a worried parent could come to you first. The same principles of good communication described above apply here as well. When a parent approaches you, set aside time without distraction so that you can really listen to his or her concerns. Parents who approach you first are demonstrating their trust in you, so it is important to honor that trust.

Parents who approach you first are also being proactive. They may simply want your reassurance, or they may have serious concerns and are unsure what to do next. Make space for them to share their worries and ask them to share their observations. You can ask them the same questions (see above in this section) that you would consider yourself if you were worried about a child.

Asking parents these questions shows that you take their concerns seriously and that you are being systematic by considering all explanations for a behavior. You are also helping them to make concrete observations that could help them describe their concerns to a pediatrician (see Behavioral Health Screening below) if they decide to seek a more in-depth evaluation.

If you have concerns of your own, this can be your opportunity to share them. Even if you have no concerns of your own, you can support parents by providing information and resources (listed at the end of this guide) and by encouraging them to talk with their pediatricians. The pediatrician's or primary care provider's (PCP's) office is often the best place for a concerned parent to start in order to determine if there is an underlying medical or developmental issue.

Behavioral Health Screening

If the child or youth receives MassHealth benefits, the pediatrician/PCP must offer to conduct a behavioral health screening during the yearly well-child visit, or when the parent requests it at any other office visit. If the child has private insurance, the parent can still ask the pediatrician about a behavioral health screening. Screening helps to spot potential concerns early so a child can get help sooner.

MassHealth requires PCPs to offer to use a standardized screening tool to check the child's or youth's behavioral health. The tools typically consist of a short list of questions or a checklist, which the parent (or age-appropriate youth) fills out during the visit. The pediatrician will review the results and talk about them with the parent or youth. If there are concerns about a child's or youth's behavioral health, the pediatrician will work with the parent or youth to decide if a referral to a behavioral health provider for further assessment and treatment is needed, or if the child or youth's needs can be managed by the pediatrician.

The PCP can also help the parent or youth connect with needed services. MassHealth offers several kinds of mental health services that may help children and youths aged 20 and younger.

Appendix B includes a worksheet that parents can use to help prepare for an appointment with the pediatrician (or other provider).

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4. What Services Are Available?

MassHealth uses the term "behavioral health" to refer to mental health and substance abuse services. The following pages provide brief descriptions of MassHealth's home- and community-based services. This information guides staff on how to help families and youths to access appropriate MassHealth behavioral health services. It is important to note that MassHealth members may also self-refer to any behavioral health service that they think might be helpful. Families and youth are always welcome to inquire with a provider about a particular service.

This guidance is intended to be informative and to illustrate the potential usefulness of each service. It does not replace the Medical Necessity Criteria that providers of each of the services will use to evaluate whether the child or youth has a medical need for the service. Medical Necessity decisions made by providers may be reviewed by the child's or youth's MassHealth managed-care plan. To read the Medical Necessity Criteria for each service described in the guide, please click here to view, or go to www.mass.gov/masshealth/cbhi and then click on "Home- and Community-Based Behavioral Health Services for Families and Children."

NOTE: These services are not for the treatment of the parents of a child with behavioral health needs. Behavioral health services for parents should be sought through their health care insurer, or MassHealth, if they are eligible.

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Hub Services

To help families get the right level of service and better-coordinated care for their children, MassHealth behavioral health services have been organized around three clinical "hub" services: Outpatient Therapy, In-Home Therapy, and Intensive Care Coordination (ICC). Hub service providers are the primary behavioral health care provider for a child or youth receiving MassHealth home- and community-based behavioral services. Each hub is responsible for overseeing a comprehensive behavioral health assessment, which includes using the CANS tool (see text box on page 13 for more information on the CANS) and developing an overall care plan for the child.

A hub-service provider is responsible for coordinating care and collaborating with other service providers who work with the child and family (e.g., making regular phone calls to people involved in the child's or youth's life, such as parents, providers, teachers, therapists, coaches, etc.; holding meetings with the family and other treatment providers; or convening Care Planning Teams for ICC).

Hub services, in order of increasing level of care coordination capacity, are: Outpatient Therapy, In-Home Therapy, and Intensive Care Coordination (ICC). When the child or youth is involved in more than one hub service, care coordination is provided by the hub with the highest level of care-coordination capacity.

The hub service provider and family work together in developing the treatment plan for the child, including additional services and supports if necessary. A family that is unsure which services would be appropriate can always seek guidance from a provider. Descriptions of these hub services follow.

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Outpatient Therapy

Outpatient Therapy is the service closest to the community and a foundation of mental health treatment for children and youth. Alone, it meets the needs of many who need mental health treatment. Moreover, it is usually the place that families go first when they need help, and where children and youth return after being in higher level of care.

Outpatient Therapy can be used to treat a variety of behavioral health and/or substance abuse issues that significantly interfere with functioning in at least one area of the child's life (e.g., family, social, school, job). It may include individual, family, and group therapies.

Outpatient Therapy is usually delivered in a clinician's office, although it may take place in other settings.

Who is likely to need Outpatient Therapy?

If the child or youth has not previously received counseling or other behavioral health services, or has benefited from Outpatient Therapy before, Outpatient Therapy is a good place to start. An outpatient therapist can provide an initial assessment for other needed services that the clinician or family identify.

Outpatient Therapy can also provide follow-up support for children and youths who are "stepping down" from more intensive services or settings.

Who may need a different behavioral health service?

- A child or youth in an immediate behavioral health crisis. The family should immediately call for Mobile Crisis Intervention through their local Emergency Services Provider (ESP). Mobile Crisis Intervention is a MassHealth service that offers face-to-face, onsite crisis intervention wherever the child or youth is located. See Emergency Services: Mobile Crisis Intervention in this guide for more information.
- A child or youth who already has an outpatient clinician or psychiatrist but who continues to struggle at home, school, or in the community. The family or youth should be encouraged to talk with their provider about changing the treatment plan or the need for additional behavioral health services. The child's outpatient clinician or psychiatrist may also recommend additional behavioral health services.
- A child or youth with significant behavioral health needs or history of trauma who is not currently seeing an outpatient clinician or psychiatrist. Review the three hub services with the family or youth to help them decide where to start. If the family or youth selects ICC or In-Home Therapy, tell them that they can call a nearby ICC or In-Home Therapy provider directly to schedule an appointment for a behavioral health assessment and determination of medical need for the service.

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In-Home Therapy

In-Home Therapy is a flexible service that allows providers to deliver intensive family therapy to the child or youth in the home, school, or other community settings. In-Home Therapy providers work with the family to understand how the family functions and how relationships can be strengthened to benefit the child.

In this service, a clinician and a trained paraprofessional work with the family to develop and implement a treatment plan, identify community resources, set limits, establish helpful routines, resolve difficult situations, or change problematic patterns that interfere with the child's development.

In-Home Therapy offers greater flexibility than Outpatient Therapy, not only in intensity, but also in treatment setting. Therapeutic work in a natural environment can offer opportunities for rehearsing new strategies not available in a clinical setting.

Who is likely to need In-Home Therapy?

- Families whose home dynamics are affected by a child or youth's behavioral health needs and who need more urgent or intensive help with a child's emotional and behavioral challenges than can be addressed through Outpatient Therapy
- Families who have identified their primary need as learning new ways to relate to one another, or new ways to set limits or regulate their child's behavior, or who have tried Outpatient Therapy but have not found it effective

Who may need Intensive Care Coordination instead of (or in addition to) IHT?

- A child or youth who needs or is receiving MULTIPLE services
- A child or youth who needs or is receiving services from state agencies or special education
- A child or youth whose caregivers need help learning how to be effective advocates for their child or coordinate their child's care
- A child or youth whose caregivers need help restoring or creating social support systems for themselves and their child

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Intensive Care Coordination (ICC)

Unlike the other hubs, ICC is not therapy. It is an intensive, individualized care-planning and management process for children and youths with serious emotional disturbance that uses the Wraparound process. Thirty-two Community Service Agencies provide ICC. A Wraparound facilitator is a master's- or bachelor's-level mental health clinician called the Care Coordinator, who works with a family to convene a team whose purpose is to create and implement an Individual Care Plan for the child or youth.

The Care Planning Team often includes therapists, school administration or school support staff (i.e., nurses, adjustment counselors, behavioral health staff, psychologists, etc.), social workers, and representatives of all child-serving agencies involved with the youth. It also includes "natural supports," such as family members, friends, and people from the family's neighborhood or community. In partnership with the team, the family actively guides the child's care. Together they come up with ways to support the family's goals for the child (or youth's goals, in the case of an older child) set in the individual care plan, which builds on the family's strengths and respects its cultural preferences.

The Individual Care Plan lists all behavioral health, social, therapeutic, or other services needed by the child and family, including informal and community resources. It guides the child's care and involves all of the child's providers and various state agencies to integrate services.

The Care Planning Team may meet monthly or with greater frequency for a child or youth with more complex needs. At these meetings the team seeks to

- Help the family obtain and coordinate all services that the child needs and/or receives from providers, state agencies, special education, or a combination thereof
- Create a structured process that facilitates collaboration between team members to help the child reach the goals in the Individual Care Plan
- Chart progress, solve problems, and make adjustments to the Individual Care Plan
- Find creative and sustainable solutions for the child and family beyond their involvement in ICC

Who is likely to need ICC?

A child or youth who needs or receives services from multiple providers, schools, or state agencies may benefit from ICC. ICC can help prioritize goals and monitor progress, ensuring that interventions and services are effective and coordinated. ICC can also address needs other than behavioral health, such as connecting families or youths to a variety of sustainable supports, like recreational activities for the child or youth, support groups, faith communities, and community-based social events.

For more information on Wraparound, see the National Wraparound Initiative website at www.nwi.pdx.edu.

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Geographically Based CSAs

There are 29 Community Service Agencies (CSAs) that correspond to the catchment areas of the Department of Children and Families.

Culturally and Linguistically Specialized CSAs

In addition, there are three culturally and linguistically specialized CSAs. These CSAs were chosen for their demonstrated ability to serve specific cultural or linguistic communities. Like all CSAs, specialized CSAs are expected to serve any family seeking appropriate service without regard to race, ethnicity, or language.

- Children's Services of Roxbury specializes in serving the African-American population in Greater Boston.
- The Gandara Center specializes in serving the Latino population in the Springfield/Holyoke area.
- The Learning Center for the Deaf at the Walden School specializes in serving the deaf and hard-of-hearing population, both in eastern and western Massachusetts.

Families are not required to choose a CSA in their area or a culturally or linguistically specialized CSA, but may choose to work with any CSA.

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Standardized Behavioral Health Assessment: Using the Child Adolescent Needs and Strengths Tool (CANS)

MassHealth requires behavioral health providers to use a uniform assessment process for children and youths aged 20 and younger. This process includes a comprehensive needs assessment using the Child and Adolescent Needs and Strengths (CANS) tool.

Hub services (Outpatient Therapy, In-Home Therapy, and ICC) must use the CANS as part of their behavioral health assessment process with each child or youth.

The CANS organizes information gathered through initial assessments and regular updates. It provides a common framework and language for families, providers, state agency staff, and others to use to talk about the child's and family's strengths and needs. It is also used as a decision-support tool to guide care-planning and to track changing strengths and needs over time.

There are two forms of the Massachusetts CANS: CANS Birth through Four and CANS Five through Twenty. Both versions also include questions that enable the assessor to determine whether a child meets the criteria for Serious Emotional Disturbance (SED). Meeting the definition of SED is a component of the Medical Necessity Criteria for the Intensive Care Coordination.

To help explain the CANS, you can share a copy of the CANS Family Guide in Appendix C. You can help parents/caregivers prepare for the assessment by encouraging them to think about important information they want to share with the provider about their child's needs and strengths. Appendix B contains a worksheet that parents can use to prepare for an appointment with a pediatrician or any other provider.

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How Do I Help Families Access Hub Services (Outpatient Therapy, In-Home Therapy, and Intensive Care Coordination)?

Hub services do not require a referral from a doctor or other "gatekeeper." Families choose the hub that they think may be best, and call the provider directly to learn more. The provider will work with the family to see if the service is right for the child's needs and the family's situation, and, if not, the provider will help the family get a more appropriate service.

There are several ways to help families find hub providers.

- To find In-Home Therapy (IHT) and Intensive Care Coordination (ICC), parents can search for available providers by zip code at www.mabhaccess.com. You can see a provider's ability to accept new referrals, though this does not guarantee an appointment or placement.
- To find Intensive Care Coordination, you can refer to the directory of the 32 Community Service Agencies (CSA) in Appendix D.
- To find Outpatient Therapy, parents can call their MassHealth plan customer service line. A directory of MassHealth Customer Service lines is included in Appendix E.
- Parents can also find provider contact information in a MassHealth brochure, Worried about the way your child is acting or feeling? It describes MassHealth behavioral health services and lists local contact information for providers. It is available in English, Spanish, Portuguese, Haitian Creole, Chinese, and Vietnamese. You can order free copies of the brochure for your agency by calling the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-790-4130). You may also order copies online—go to www.mass.gov/masshealth/cbhi and click on CBHI Brochure and Companion Guide. Scroll down until you come to the order form.
- You can also call hub providers directly on behalf of a child with a parent's or guardian's permission. The providers will then contact the parent/guardian directly to complete the intake process and schedule an appointment.

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"Hub-Dependent" MassHealth Behavioral Health Services

MassHealth also pays for additional, hub-dependent home- and community-based behavioral health services—Family Support and Training, In-Home Behavioral Services, and Therapeutic Mentoring. These are specialty services that support the interventions of the hub service.

Enrollment in these services usually requires a referral from a hub service provider (Outpatient Therapy, In-Home Therapy, or ICC described previously) because the services should address goals set in a treatment plan developed through a hub service. Together with the family, the hub provider would determine which of these hub-dependent services should be included in the treatment plan.

Tell families interested in the following services to first contact a hub provider (i.e., a provider of Outpatient Therapy, In-Home Therapy, or ICC). The family and provider can discuss whether to include these hub-dependent services in the child's treatment plan.

As with all services, the child must meet medical necessity criteria in order to enroll in these services.

Family Support and Training (Family Partners)

A Family Partner is an individual with lived experience as the caregiver of a child or youth with behavioral health or special health care needs. Family Partners are trained to assist families in either of two MassHealth services—Family Support and Training (FS&T, a hub-dependent service through a Community Service Agency), or Mobile Crisis Intervention (MCI).

Most Family Partners provide the FS&T service, and while they often pair with Care Coordinators to implement the Wraparound process with families, they can also work with families in other hubs, either In-Home Therapy or Outpatient Therapy.

On MCI teams, Family Partners pair with clinicians to provide support to youth in crisis and their families. The Family Partner provides emotional support for the caregiver, fosters empowerment, and encourages the expression of family voice. Family Partners often share parts of their own stories with the intention of helping caregivers develop insight and the motivation to act on their child's and family's behalf.

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In-Home Behavioral Services (IHBS)

In-Home Behavioral Services offer valuable support to a child or youth who has challenging behaviors that interfere with everyday life. A clinician and a trained paraprofessional work closely with the child and family to create and implement treatment plans that diminish, extinguish, or improve specific behaviors. The trained paraprofessional, also known as a behavior management monitor, works with the child and his or her family to implement the child's behavior plan.

In-Home Behavioral Services are generally available to members in their home, but also can be provided in locations such as school, child care, and other community settings.

Therapeutic Mentoring Services (TM)

Therapeutic Mentoring is a support service that pairs a child or youth with an adult mentor for the purpose of building and enhancing the child's social, communication, and life skills. The Therapeutic Mentor works one-on-one with the child to achieve goals in the plan written by an outpatient therapist, In-Home Therapy provider, or an Intensive Care Coordination (ICC) team. Therapeutic Mentoring services can be delivered in the home, school, child care, and other community settings, as well as in social and recreational settings.

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Emergency Services: Mobile Crisis Intervention (MCI)

MCI is the youth-serving component of an Emergency Services Program (ESP) and is a short-term treatment service that is available 24-hours a day, seven days a week, to children and youths aged 20 and younger, and their families. Unlike older models of crisis intervention, MCI does not simply assess the need and refer for hospitalization or medication. Instead, MCI is a treatment service.

MCI staff are available to identify, assess, treat, stabilize, and otherwise help children and families to resolve crisis situations to reduce the immediate risk of danger to the child or others. Interventions may take the form of counseling; problem-solving; collaborating with family members, schools, or treatment providers; and safety planning.

MCI may include psychiatric consultation and urgent psychopharmacology intervention as needed, as well as referrals and linkages to all medically necessary behavioral health services and supports. MCI may stay involved for up to seven days offering additional support, ensuring that a plan is working, or helping to coordinate care. MCI may also step a youth up to an emergency department or inpatient hospital unit when necessary.

The MCI service can be provided nearly anywhere in the community, based on the preferences of the child or family and in consideration of any coexisting medical conditions or safety needs of the child in crisis. Settings that are most conducive to crisis resolution are those that are natural to the child—home, school, or community. For families who prefer that their child is seen in an office setting, each ESP operates a walk-in, community-based crisis facility. All of the walk-in facilities are open seven days a week, and several are open around the clock.

Eligibility

MCI services are available to persons who are enrolled in any type of MassHealth plan; those who are uninsured; and many who contract with commercial insurance companies. However, some providers offer mobile crisis services for all children regardless of type of insurance. The best way to know is to contact the MCI manager for your local Emergency Service Provider (ESP). You can call your local ESP for more detail about service eligibility for the children in your program. Call 1-877-382-1609 to find the closest ESP/MCI by zip code.

Consent

Anyone can contact MCI for a child in crisis. It is recommended that programs contact a parent or legal guardian before requesting the MCI service, or at least before the team arrives at the program. Discussion can include the best setting for the intervention; the availability of the parent to join the intervention; or whether the child already has a treatment provider who could conduct the crisis intervention. If the parent or guardian is unreachable, an MCI team may start treatment services while continuing attempts to reach the parent or guardian.

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Emergency Service Provider

Mobile Crisis Intervention is provided by the Emergency Service Provider (ESP) in the region. Call 1-877-382-1609 or see Appendix E for a directory.

Other MassHealth Behavioral Health Services

A child or youth does not need to be enrolled in one of the hub services in order to access these services. For more information about how to access the following services, a parent can contact MassHealth or the child's MassHealth managed care plan. You can also call on behalf of the child with the parent's permission.

Structured Outpatient Addictions Program (SOAP) for Adolescents

SOAP is a short-term, clinically intensive, structured day or evening service for substance-use disorder. It provides multidisciplinary treatment to address the subacute needs of teens with addiction or co-occurring addiction and mental health conditions, while allowing them to continue to work or attend school and be part of family life.

Partial Hospitalization Program

The partial hospitalization program is a nonresidential treatment program that may be hospital-based. The program provides clinical, diagnostic, and treatment services at a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu; nursing; psychiatric evaluation and medication management; group and individual or family therapy; psychological testing; vocational counseling; rehabilitation recovery counseling; substance-use disorder evaluation and counseling; and behavioral plans.

Psychiatric Hospitalization

Psychiatric hospitals are designed to be safe settings for intensive mental health treatment, including observation, diagnosis, individual and group psychotherapy, and medication management. Inpatient treatment should be part of an overall plan of care—a coordinated effort between the individual, the family or other supporters, the inpatient treatment team, and outpatient service providers

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5. Additional Resources

How to Apply for Health Coverage for Your Child

CBHI developed a step-by-step application guide that provides instructions for applying for MassHealth coverage. It contains practical tips to ensure a smooth application process, links to required application forms, and instructions for finding these forms on the MassHealth website.

To view or download the guide, click here, or go to www.mass.gov/masshealth/cbhi and then click on "CBHI Information for Members & Families." A copy of this guide is also included as Appendix A.

CANS: A Family Guide

This handout explains what the Child and Adolescent Strengths and Needs (CANS) tool is and how providers use it during the assessment process.

To view or download the guide, click here or go to www.mass.gov/masshealth/CANS, and select "Clinical Guidance on the CANS." A copy of this guide is also included as Appendix C.

The Children's Behavioral Health Initiative (CBHI)

You can find many of the resources referenced throughout this guide on the CBHI website at www.mass.gov/masshealth/cbhi.

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Bureau of Substance Abuse Services—Office of Youth and Young Adult Services (BSAS-OYYAS)

BSAS-OYYAS promotes comprehensive, high-quality, integrated services for youth and young adults and their families experiencing substance use and co-occurring disorders. To find services, call the Youth Central Intake line at 617-661-3991 or 866-705-2807 (TTY: 617-661-9051).

To learn more, visit www.mass.gov/dph/youthtreatment.

The Family Resource Centers (FRCs) of Massachusetts

FRCs is a statewide network providing community-based, multicultural parenting programs, support groups, early childhood services, information and referral resources, and education for families with children from birth to 18 years old. Supported through funding from the Massachusetts Executive Office of Health and Human Services in collaboration with the Department of Children and Families, a Family Resource Center is located in each of the 12 Massachusetts counties.

To locate your local FRC, visit www.frcma.org.

Massachusetts Behavioral Health Access

Families can identify available MassHealth service providers and their contact information using this site. Anyone can search for available providers by zip code and service type, as well as determine a provider's current capacity to accept new referrals, though this does not guarantee a family will get an appointment or placement.

For more information, visit www.mabhaccess.com.

MassHealth

The MassHealth website, at www.mass.gov/masshealth, is a good starting place for all things Medicaid-related.

Mass 2-1-1

211 is an easy-to-remember telephone number that connects callers to information about critical health and human services available in their community. It serves as a resource for finding government benefits and services, nonprofit organizations, support groups, volunteer opportunities, donation programs, and other local resources. Always confidential, Mass 2-1-1 maintains the integrity of the 9-1-1 system, so that 9-1-1, a vital community resource, is reserved for life-and-death emergencies.

Mass 2-1-1 is available 24 hours a day, seven days a week, and is an easy way to find or give help in your community. The website is www.mass211.org.

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Massachusetts Child Psychiatry Access Project (MCPAP) For Moms

MCPAP For Moms is a program that promotes maternal and child health by building the capacity of certain providers—those who serve pregnant and postpartum women and their children up to one year after delivery—to effectively prevent, identify, and manage depression. The website offers several resources for parents and caregivers, including contact information for local parenting support groups and links to other family and parenting supports.

For more information, visit www.mcpapformoms.org and click on "Mothers and Families."

Mobile Crisis Intervention (MCI)

To find your local provider, call 1-877-382-1609 and enter your zip code, or see Appendix F.

National Wraparound Initiative

For more information on Wraparound, the process used in ICC, please visit http://nwi.pdx.edu.

Systems of Care Philosophy—Technical Assistance Partnership on Children and Family Mental Health

At the heart of CBHI and MassHealth's home- and community-based behavioral health services is Systems of Care, a philosophical and organizational framework that involves collaboration across agencies, families, and youths. Its purpose is to improve access and expand the array of coordinated community-based, culturally and linguistically competent services and supports for children and youths with a serious emotional disturbance, and their families.

For more information on Systems of Care, please visit www.tapartnership.org/systemsOfCare.php.

Worried about the way your child is acting or feeling?

CBHI created a full-color family friendly brochure, Worried about the way your child is acting or feeling?, that includes brief descriptions of MassHealth home- and community-based services,

including information on how to access them. This publication is distributed in five regional versions and multiple languages, each containing contact information for local providers delivering Mobile Crisis Intervention, In-Home Therapy, and Intensive Care Coordination (ICC).

You can order bulk copies of the brochure here, or go to www.mass.gov/masshealth/cbhi and then click on CBHI Brochure and Companion Guide.

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Appendices

Appendix A. How to Apply for Health Care Coverage for Your Child

Appendix B. Preparing for Your Appointment

Appendix C. CANS Family Guide

Appendix D. Community Service Agency (CSA) Directory

Appendix E. MassHealth Customer Service Lines

Appendix F. Emergency Service Provider/Mobile Crisis Intervention (ESP) Directory

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MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth/cbhi

Children's Behavioral Health Initiative (CBHI)

How to Apply for Health Coverage for Your Child

MassHealth is the Massachusetts Medicaid program. More than 1 million people in the state get health care services with help from MassHealth.

This guide explains options you have in applying for health coverage for your child.

If you are a parent or caregiver who wants your child to get MassHealth Standard or CommonHealth for behavioral health services, this guide will help you. The guide also may be useful for anyone else who would like to apply for coverage under MassHealth.

MassHealth Standard

MassHealth Standard offers a full range of health care benefits. To obtain MassHealth Standard for your child aged 0-18 years, your family's income must be less than or equal to 150% of the federal poverty level.

As of March 1, 2015, 150% of the federal poverty level for a family of four is $36,372. If you are not sure if your household income meets this requirement, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

MassHealth CommonHealth

MassHealth CommonHealth offers health care benefits similar to MassHealth Standard to disabled adults and disabled children who cannot get MassHealth Standard.

- There is no income limit for CommonHealth.
- There is a sliding-scale premium based on family income, and some adults may have to meet a one-time deductible.

For more detailed information on MassHealth, please see the Member Booklet for Health Coverage and Help Paying Costs (ACA-1), available at www.mass.gov/masshealth under Applications and Member Forms.

How do I apply for MassHealth Standard or CommonHealth for my child?

1. You must fill out the Application for Health Coverage and Help Paying Costs (ACA-3) form. You can get the ACA-3 form in a several ways.

    - Go online and create an account at www.MAhealthconnector.org. Applying online may be a faster way for you to get coverage than mailing a paper application.
    - Go to www.mass.gov/masshealth and click on Applications and Member Forms in the lower right corner. You can print out the ACA-3 form and fill it out by hand.
    - Call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). They can mail you an ACA-3 form.
    - Visit a MassHealth Enrollment Center (MEC) to apply in person. See the Member Booklet for Health Coverage and Help Paying Costs for a list of MEC addresses.

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2. When you fill out the ACA-3 form

    - You will need to include all household members on the application. Tell us about all the household members who live with you. If you file taxes, we need to know about everyone on your tax return. You do not need to file taxes to get MassHealth.
    - Be sure to answer all questions on the application.
    - Be sure to answer YES to question 12 about injury, illness, or disability in Step 2 of the paper application for each person with a disability. If you complete your application by telephone or online, you will also be asked this question.

Navigators and Certified Application Counselors can help you apply for MassHealth. These trained individuals can help you from application through enrollment and answer your questions. To find a Navigator or Certified Application Counselor organization near you, go to www.betterMAhealthconnector.org/get-help.

3. You can submit your completed application in any of the following ways.

    - Go online and sign in to your account at www.MAhealthconnector.org.
    - Mail your filled-out, signed Application for Health Coverage and Help Paying Costs (ACA-3) form to Health Insurance Processing Center, P.O. Box 4405, Taunton, MA 02780
    - Fax your filled-out, signed ACA-3 application to 1-857-323-8300.
    - Call the MassHealth Customer Service Center at 1-800-841-2900 and apply over the phone (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you mail your application at the post office, make sure to ask for a return receipt. This way you have proof that MassHealth got your application.

- The date MassHealth gets your application affects the date that MassHealth can pay for medical services if you are found eligible.
- Do not send more than one copy of your application. An application review can take up to 45 days. The extra paperwork will delay review.
- Keep a copy of everything you send for your records.

What happens after I submit the application?

MassHealth will try to verify the information on the application. If additional information (such as proof of income, citizenship, or immigration status) is needed, we will send you a Request for Information notice that will list all the required documents and the deadline for submitting them.

MassHealth works with UMass/Disability Evaluation Services (DES) to look at disability requests. DES will follow up with you and may send you more paperwork to complete. The paperwork DES sends you helps them review your child's disability request for MassHealth. This process can take up to 90 days.

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You can speed up the disability review process by following the three steps below. (To download the forms described below from a computer, go to www.mass.gov/masshealth. In the lower right corner, click on Applications and Member Forms.)

4. When you get the ACA-3 form, also get one of the two forms below. (You can download them or ask for them if you call the MassHealth Customer Service Center.)

    - MassHealth Child Disability Supplement Form
      Fill out this form if your child is age 17 or younger. It tells MassHealth about your child's medical and mental health providers, daily activities, and educational background.
    - MassHealth Adult Disability Supplement Form
      If your child is age 18 or older, you or your child needs to fill out this form.
      Some work requirements may apply to youths between the ages of 18 and 21.

5. When you get the ACA-3 form, also get the MassHealth Medical Records Release form. (You can download it or ask for this form if you call the MassHealth Customer Service Center.) Sometimes MassHealth needs more information about your child's medical conditions. When you fill out the MassHealth Medical Release form, you give DES permission to contact your child's providers for such information.

    - The information helps DES decide if your child is disabled under state and federal law. Fill out one form for each provider by name.
    - If your child is in an Early Intervention Program or has an IEP or 504 Plan at school, you will need to fill out a release form for these providers/teachers.
    - Five blank copies of this form are also included in the Disability Supplement Form.

6. Send the completed Disability Supplement and Medical Records Release forms to Disability Evaluation Services, P.O. Box 2796, Worcester, MA 01613-2796

If you have any of the following, send copies with the Medical Records Release and Disability Supplement forms. Sending the documents below can help speed up the review process.

- Your child's medical records
- Individualized Family Services Plan (IFSP)

OR

- Individualized Educational Plan (IEP), testing results, or other records that describe your child's condition(s).

After you have mailed this information, a staff member from the UMass/Disability Evaluation Services may contact you if MassHealth needs more information.

- Keep a copy of everything you send for your records.
- If you mail your application at the post office, make sure to ask for ask for a return receipt. This way you have proof that DES got your forms.
- Check with all your child's providers to make sure they sent the requested information to the UMass/Disability Evaluation Services.

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My child already has MassHealth Family Assistance. How do I apply for CommonHealth?

If your child has a disability, he or she may be eligible for CommonHealth. You will need to fill out the MassHealth Child Disability Supplement and MassHealth Medical Records Release forms. (Five of these forms are included in the disability supplement.) You can get these forms by requesting them from the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

You also can get the forms by visiting www.mass.gov/masshealth and clicking on Applications and Forms. Scroll down the screen until you get to Member Forms. Fill out the forms and send them to Disability Evaluation Services (DES), P.O. Box 2796, Worcester, MA 01613-2796

- If you mail these forms at the post office, make sure to ask for a return receipt. This way you have proof that DES got your forms.
- If you need help filling out these forms, you can call the UMass/Disability Evaluation Services Help Line at 1-888-497-9890.
- Keep a copy of everything for your records.

Reminder: required documents to apply for MassHealth/CommonHealth.

If you want to apply for MassHealth/CommonHealth, you will need to mail or submit two separate sets of documents.

7. Send your Application for Health Coverage and Help Paying Costs Instructions (ACA-3) form by Mail to Health Insurance Processing Center, P.O. Box 4405, Taunton, MA 02780
   or Fax: 857-323-8300
   or Go Online and sign into your account at www.mahealthconnector.org
8. The following documents also are required for MassHealth CommonHealth.

    - Completed MassHealth Child Disability Supplement or Adult Disability Supplement form for children aged 19 years and older
    - Completed MassHealth Medical Records Release Form(s)
    - Copies of records that describe your child's condition. Examples include medical records, an Individualized Educational Plan (IEP), an Individualized Family Services Plan (IFSP), and psychological testing results.

Send these documents to Disability Evaluation Services, P.O. Box 2796, Worcester, MA 01613-2796

Where can I get additional help? If you have questions or need help completing the ACA-3 form, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). You can also find help located near you by visiting https://betterhealthconnector.com/enrollment-assisters.

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Appendix B: Preparing for Your Appointment

Take some time before your child's appointment to think about what you want to talk about or ask your pediatrician (or other provider). It will be helpful to you and to your pediatrician if you write it down!

Areas to Consider

- My child's strengths are…
- Things about my child that I wonder or worry about right now…
- Things about my child that I wonder or worry about that may be in the future…
- My child's behavior at home and at school or in early education and care…(What is his or her behavior like in different environments? Do you wish it to be different?)
- My child's routine is (consider eating/sleeping/transitions/relationships)…
- Things I wish for my child/family…

Notes

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CANS: A Family Guide

Children's Behavioral Health Initiative (CBHI)

MassHealth

What Is the CANS?

MassHealth requires behavioral health providers to do a comprehensive assessment when they first start working with children and youth aged 20 years and younger.* The provider will spend time getting to know you and your child, the problems your child is facing, and your hopes for treatment. The first time you meet with your child's behavioral health provider (for example, a clinical social worker, family therapist, mental health counselor, or psychologist), he or she will probably begin a "CANS" for your child.

The CANS is a form that providers use to gather information during the assessment process. It may be filled out by hand on paper, or electronically with a computer.

CANS stands for Child and Adolescent Needs and Strengths. Strengths are areas of your child's life where he or she is doing well or has an interest or ability. Perhaps your son loves art or your daughter has volunteered in an animal shelter. Or your family has many caring friends and relatives. Needs are areas where your child requires help or serious intervention. Perhaps your child seems depressed or is having behavior problems.

Providers use the assessment process to get to know the children and families they work with and to understand their strengths and needs. The CANS can help you decide which of your child's needs are the most important to address in a treatment plan. The CANS also helps you and your child pick out strengths, which can be the basis of a treatment plan. By working with the provider during the assessment process and talking together about the CANS, you can develop a treatment plan that works with your child's strengths and needs.

* MassHealth offers several types of behavioral health services for children and youth aged 20 years and younger. Certain services involve complete assessment and coordination of care when the child is involved in other services. Known as "Hub Services," these include Intensive Care Coordination, In-Home Therapy, and Outpatient Therapy. Some children may be involved in more than one Hub Service. As a MassHealth provider, each Hub Service provider is required to use the CANS form and must complete and update it every 90 days.

Another set of services includes Family Support and Training (Family Partners), In-Home Behavioral Health Services, and Therapeutic Mentors. They are "Hub-Dependent Services," that is, they need a referral from a Hub Service. Providers of these services do not need to complete the CANS but should review the CANS done in the Hub Service.

You should get copies of your child's CANS from his or her provider to share with other providers who work with your family.

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How Are CANS Ratings Given?

The CANS is made up of seven sections that focus on different areas in the child's life. Each section consists of a group of items that include how your child functions in everyday life, specific emotional or behavioral concerns, risk behaviors, strengths, and for older children, skills needed to move into adult life. One section asks about your family's beliefs and preferences, while another asks about general family concerns. The provider gives a number rating to each of these items. These ratings help the provider understand where intensive or immediate action is most needed, and where your child has strengths that could be a major part of the treatment plan.

Of course, ratings do not tell the whole story of a child's strengths and needs. Each CANS section also has a comment space where a provider can give more information about that area of life. The provider can note questions that need to be explored further, or areas where people involved with the child have different ideas about him or her.

Updating the CANS

Providers can update the CANS to track progress and revise plans. Each provider normally updates the CANS every 90 days. This is a good time for you to talk with your provider about what has been accomplished through treatment, how the plan is working, and any changes that should be made.

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What Is CANS Consent? Why Is Consent So Important?

Your child's provider will ask for your consent or permission to enter the CANS ratings and comments into MassHealth's secure online database known as the Virtual Gateway. When you give permission, you are allowing MassHealth, your child's managed-care plan, and other providers at the same organization who work with your child to see his or her CANS records. Your child may work with other providers from different organizations. They will also ask for your permission to enter your child's CANS information into the Virtual Gateway and to see CANS records entered by other providers. Only providers who have your permission can do this. Providers who do not have your permission must complete the CANS on paper and keep it in your child's medical record.

Your consent does not allow other state agencies, such as the Department of Youth Services or Department of Children and Families, to see your child's CANS record. To protect your child's privacy MassHealth keeps tight control over who has access to the database. Access to your CANS record is restricted and protected under state and federal privacy laws.

What Are the Benefits of Giving Consent?

With your permission, all providers caring for your child will be able to share the CANS online. Sharing the CANS helps everyone to be "on the same page" for your child, and may save you from having to answer the same questions for different providers.

Giving permission for the provider to enter your child's CANS information into the database allows him or her to print a CANS report for you at any point in your child's treatment. If you wish to share a CANS assessment that was completed on paper with other providers, you will need to ask for a copy.

Updating the CANS in the database is easy for your provider. He or she can simply edit the CANS that was done the last time, leaving more time to focus on your child's treatment plan.

Finally, MassHealth uses the CANS to understand how its services are helping families. Having this information allows MassHealth to improve services in ways that can help your child and others in the future.

CBHI-CANS-FG (05/15)

Produced by MassHealth Publications.

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Appendix D: Community Service Agency (CSA) Directory

CSAs provide Intensive Care Coordination for children and youth who require or are already using multiple services, or are involved with multiple child-serving systems, such as child welfare, special education, juvenile justice, or mental health. There are 32 CSAs throughout the state.

One of the things that CSAs do is to convene local System-of-Care (SOC) Committee meetings. Contact your local CSA to find out the schedule for these meetings.

Metro Boston

Bay State Community Services (Coastal) 617-471-8400, Ext. 163

Children's Services of Roxbury (Boston) 617-989-9499

Justice Resource Institute (Jamaica Plain) 617-522-0650

The Guidance Center (Cambridge) 617-354-1519, Ext. 114

Home for Little Wanderers (Boston) 1-855-240-4663

The Learning Center for the Deaf, Walden School (Statewide) 1-508-875-9529

- Videophone 1-774-999-0949 and 1-774-406-3723

North Suffolk Mental Health Association (Harbor) 617-912-7792

Riverside Community Care (Arlington) 1-877-869-3016

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Central

Community Healthlink

- North Central 1-877-240-2755
- Worcester 1-877-778-5030

The Learning Center for the Deaf, Walden School (statewide) 1-508-875-9529

- Videophone 1-774-999-0949 and 1-774-406-3723

Wayside Youth & Family Support Network (Framingham) 1-508-309-0369

Y.O.U., Inc. 1-855-4YOUINC (1-855-496-8462)

Northeast

Children's Friend and Family Services

- Lawrence 1-978-682-7289
- Lynn 1-781-593-7676

Eliot Community Human Services (Malden) 1-781-395-0457

The Learning Center for the Deaf, Walden School (statewide) 1-508-875-9529

- Videophone 1-774-999-0949 and 1-774-406-3723

Lahey/Northeast Behavioral Health Corporation (formerly HES)

- Cape Ann 1-978-922-0025
- Haverhill 1-978-374-0414

Wayside Youth & Family Support Network (Lowell) 1-978 460-8712

Western

Behavioral Health Network (Chicopee, Springfield, Ware) 1-413-737-0960/1-866-577-8860

Brien Center for Mental Health and Substance Abuse Services (Pittsfield) 1-413-499-0412

Carson Center for Human Services (Holyoke) 1-888 877-6346/1-413-572-4111

Clinical & Support Options

- Athol, Orange 1-978-249-9490
- Greenfield 1-413-774-1000
- Northampton 1-413-582-0471
- Gandara Center 1-413-846-0445 or
- Springfield, Holyoke 1-413-846-0446

The Learning Center for the Deaf, Walden School (statewide) 1-508-875-9529

- Videophone 1-774-999-0949 and 1-774-406-3723

Southeast

BAMSI (Brockton) 1-508-587-2579, Ext. 30

Bay State Community Services (Plymouth) 1-508-830-3444, Ext. 321

Child & Family Services (New Bedford) 1-508-990-0894

Community Counseling of Bristol County, Inc. (Attleboro) 1-508-977-8185

Family Service Association (Fall River) 1-508-730-1138

Justice Resource Institute (Cape Cod) 1-508-771-3156

The Learning Center for the Deaf, Walden School (statewide) 1-508-875-9529

Videophone 1-774-999-0949 and 1-774-406-3723

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Appendix E: MassHealth Customer Service Lines

MassHealth Customer Service Center

- 1-800-841-2900
- TTY: 1-800-497-4648

MassHealth Website

- www.mass.gov/masshealth

MassHealth Managed Care Plans Customer Service Lines

Boston Medical Center (BMC) HealthNet Plan

- 1-888-566-0010
- TTY: 1-781-994-7660

Fallon Community Health Plan

- 1-800-341-4848
- 1-888-421-8861
- TTY: 1-877-608-7677

Health New England (HNE)

- 1-800-786-9999
- TTY: 1-800-439-2370

Neighborhood Health Plan

- 1-800-462-5449
- TTY: 1-800-655-1761

Tufts Health Plan-Network Health

- 1-888-257-1985
- TTY: 1-888-391-5535

Primary Care Clinician (PCC) Plan

- 1-800-841-2900
- TTY: 1-800-497-4648

Massachusetts Behavioral Health Partnership

- 1-800-495-0086
- TTY: 1-877-509-6981

Massachusetts Behavioral Health Access

You can find available mental health service providers and their contact information by using the www.mabhaccess.com website, which allows anyone to search for available providers by zip code and service type. It also allows anyone to determine a provider's current capacity to accept new referrals, although this does not guarantee that a family will get an appointment or placement.

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Appendix F: Mobile Crisis Intervention (MCI)

Emergency Services Programs (ESP)

Emergency mental health and/or substance abuse services are available in your community!

Who Can Receive ESP Services?

People of ALL AGES with the following insurance coverage

- All MassHealth (Medicaid) plans
- Medicare

You can receive ESP services even if you're uninsured. And many ESPs also contract with commercial insurance companies.

Operating Hours

Every ESP has its own toll-free number. ESPs are open and ready to provide services 24 hours a day, 365 days a year.

To get the toll-free number for your ESP, see the listing on the next page.

You can also call the free statewide number (1-877-382-1609). Just enter your zip code to get the phone number.

There are alternatives to hospital emergency departments!

Please go to www.masspartnership.com/member/esp for more details and an electronic version of this flyer.

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BOSTON REGION

Boston

Boston (Dorchester, South Boston, Roxbury, West Roxbury, Jamaica Plain, Mattapan, Roslindale, Hyde Park, Lower Mills), Brighton, Brookline, Charlestown, Chelsea, East Boston, Revere, Winthrop

Boston Medical Center/Boston Emergency Services Team (B.E.S.T.)

24-hour access number: 1-800-981-4357

METRO BOSTON REGION

Cambridge, Somerville

Cambridge, Somerville

Boston Medical Center/Cambridge Somerville Emergency Services Team (C.S.E.S.T.)

24-hour access number: 1-800-981-4357

Norwood

Canton, Dedham, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood, Wrentham

Riverside Community Care

24-hour access number: 1-800-529-5077

South Shore

Braintree, Cohasset, Hingham, Hull, Milton, Norwell, Quincy, Randolph, Scituate, Weymouth

South Shore Mental Health (SSMH)

24-hour access number: 1-800-528-4890

WESTERN REGION

The Berkshires

Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Florida, Great Barrington, Hancock, Hinsdale, Lanesboro, Lee, Lenox, Monroe, Monterey, Mount Washington, New Ashford, New

Marlboro, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor

The Brien Center for Mental Health and Substance Abuse

24-hour access number: 1-800-252-0227

Greenfield

Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Millers Falls, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Turners Falls, Warwick, Wendell, Whately

Clinical & Support Options

24-hour access number: 1-800-562-0112

Northampton

Amherst, Chesterfield, Cummington, Easthampton, Florence, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, Worthington

Clinical & Support Options

24-hour access number: 1-800-322-0424

Southern Pioneer Valley

Agawam, Belchertown, Blandford, Bondsville, Chester, Chicopee, East Longmeadow, Granby, Granville, Hampden, Holyoke, Huntington, Indian Orchard, Longmeadow, Ludlow, Monson, Montgomery, Palmer, Russell, South Hadley, Southampton, Southwick, Springfield, Thorndike, Three Rivers, Tolland, Ware, Westfield, West Springfield, Wilbraham

Behavioral Health Network

24-hour access number: 1-800-437-5922

CENTRAL REGION

MetroWest

Acton, Ashland, Arlington, Bedford, Belmont, Boxborough, Burlington, Carlisle, Concord, Framingham, Holliston, Hopkinton, Hudson, Lexington, Lincoln, Littleton, Maynard, Marlborough, Natick, Northborough, Sherborn, Southborough, Stow, Sudbury, Waltham, Watertown, Wayland, Westborough, Wilmington, Winchester, Woburn

Advocates

24-hour access number: 1-800-640-5432

North County

Ashburnham, Ashby, Ayer, Barre, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hardwick, Harvard, Hubbardston, Lancaster, Leominster, Lunenburg, New Braintree, Oakham, Pepperell, Princeton, Rutland, Shirley, Sterling, Templeton, Townsend, Westminster, Winchendon

Community HealthLink, Inc.

24-hour access number: 1-800-977-5555

South County

Bellingham, Blackstone, Brimfield, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Holland, Hopedale, Medway, Mendon, Milford, Millville, Northbridge, North Brookfield, Oxford, Southbridge, Sturbridge, Sutton, Upton, Uxbridge, Wales, Warren, Webster, West Brookfield

Riverside Community Care

24-hour access number: 1-800-294-4665

Worcester

Auburn, Boylston, Grafton, Holden, Leicester, Millbury, Paxton, Shrewsbury, Spencer, West Boylston, Worcester

Community HealthLink, Inc.

24-hour access number: 1-866-549-2142

NORTHEASTERN REGION

North Essex

Amesbury, Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Groveland, Hamilton, Haverhill, Ipswich, Manchester by the Sea, Marblehead, Merrimac, Middleton, Newbury, Newburyport, Peabody, Rockport, Rowley, Salem, Salisbury, Topsfield, Wenham, West Newbury

Northeast Behavioral Health

24-hour access number: 1-866-523-1216

Lawrence

Andover, Lawrence, Methuen, North Andover

Northeast Behavioral Health

24-hour access number: 1-877-255-1261

Lowell

Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsboro, Westford

Northeast Behavioral Health

24-hour access number: 1-800-830-5177

Tri-City

Everett, Lynn, Lynnfield, Malden, Medford, Melrose, Nahant, North Reading, Reading, Saugus, Stoneham, Swampscott, Wakefield

Eliot Community Services

24-hour access number: 1-800-988-1111

SOUTHEASTERN

Southern Coast

Acushnet, Carver, Dartmouth, Duxbury, Fairhaven, Halifax, Hanover, Hanson, Kingston, Marion, Marshfield, Mattapoisett, New Bedford, Pembroke, Plymouth, Plympton, Rochester, Wareham

Child and Family Services of New Bedford

24-hour access number: 1-877-996-3154

Brockton

Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Holbrook, Rockland, Stoughton, West Bridgewater, Whitman

Brockton Multi-Service Center

24-hour access number: 1-877-670-9957

Cape Cod and The Islands

Aquinnah, Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham, Edgartown, Falmouth, Gosnold, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Osterville, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Woods Hole, Yarmouth

Cape & Islands Emergency Services

24-hour access number: 1-800-322-1356

Fall River

Fall River, Freetown, Somerset, Swansea, Westport

Corrigan Mental Health Center

24-hour access number: 1-877-425-0048

Taunton, Attleboro

Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleborough, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Taunton

Norton Emergency Services

24-hour access number: 1-800-660-4300

Children's Behavioral Health Initiative (CBHI)

CBHI-Guide (Rev. 10/15)

Produced by MassHealth Publications.

Document ends.

Requirement 20

- **Coordination with Massachusetts Child Psychiatry Access Program (MCPAP)**

Practice meets this requirement.
Practices are enrolled in aggregate at the ACO level by Wellsense. Active use is not required if BH care otherwise addressed Massachusetts Child Psychiatry Access Program (MCPAP) Summary Enrollment link for individuals:

https://www.mcpap.com

https://www.mcpap.com/Provider/McPAPservice.aspx

Contents

No table of contents entries found.

MCPAP (Massachusetts Child Psychiatry Access Program)

https://www.mcpap.com/Provider/McPAPservice.aspx

Basics: system of regional children's behavioral health consultation teams designed to help primary care providers and their practices to promote and manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness

Mission: MCPAP provides collaborative support to pediatric primary care providers (PCPs) and their patient-care teams to enhance their ability to promote and manage their patients' behavioral health as a fundamental component of overall health and wellness. Through consultation and education, MCPAP improves the pediatric team's competencies in screening, identification, and assessment; treating mild to moderate cases of behavioral health disorders; and in making effective referrals and coordinating the care for patients who need community-based specialty services.

Services:

MCPAP's core services include:

- Telephone consultation with either a Child and Adolescent Psychiatrist or independently licensed Behavioral Health Clinician
- Face-to-face consultation with either a Child and Adolescent Psychiatrist or independently licensed Behavioral Health Clinician when indicated
- Resource and Referral
- Practice-focused training and education

Consultation
Practices use MCPAP most frequently for consultation. Phone inquiries are usually patient-specific, but can also be about any general question related to child psychiatry, behavioral health, or community resources. Telephone consultation can be with the Regional Team's psychiatric consultant, the behavioral health clinician or resource & referral specialist.
MCPAP team members respond to a request for consultation within 30 minutes and often immediately.

Resource and Referral
The behavioral health system is complex and difficult to navigate. There are often lengthy waits for services, especially for child psychiatry services. MCPAP resource and referral specialists are experts at identifying and maintaining up-to-date behavioral health resources in the community.

Education & Practice-Focused Consultation Services
Over time, PCPs increase their knowledge and comfort level from the telephone consultations around specific patients. MCPAP team members are also available for education and training relative to psychiatric disorders and medications, as well as practice transformation processes to improve integration of behavioral health with primary care. At times MCPAP is involved with implementing a new or updated screening or treatment protocol and the regional teams will proactively contact enrolled practices to provide training for providers.

Requirement 21

- **Coordination with Massachusetts Child Psychiatry Access Program For Moms (M4M)**
  Please note: **BILH does NOT have any obstetric PCP's in our ACO so this requirement does not apply** However this is a great resource for providers when caring for familiesEnrollment link:

  https://www.mcpapformoms.org

  Providers can call MCPAP for Moms: (855-666-6272), Monday-Friday, 9am-5pm and speak with a Resource specialist who will work with the provider and determine their needs - I.e., consultation regarding psychiatric care, community resource and referrals, or both

Requirement 22

- **Flouride Varnish for 6m – 6y Once Teeth Present – 2x/year**

  Practice meets this requirement

  Practice refers to the Oral Health Requirements PowerPoint

  Review the Oral Health Requirements PowerPoint

  Oral Health Screening Questions

- Did your child have a dental visit in the last 12 months for preventive dental care such as checkups/dental cleaning?

  Yes/No • No will indicate a positive screen

- Did your child have a dental problem in the last 6 months?

  Yes/No • Yes will indicate a positive screen Pediatric Oral Health Questions:

- 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

MassHealth ACO 2023
Oral Health Screening & Fluoride Varnish Implementation

Beth Israel Lahey Health
Performance Network

Contents


Tier Requirement Review
Oral Health Screening Implementation
Fluoride Varnish Implementation
Documenting on EMR platforms
Workflows
Additional Resources

Review of Tier 1 Requirements:

Annual Oral Health Screening:

Population: All members

- An annual oral health screening for MH enrollees should assess if the enrollee has access to a reliable dentist. If the patient does not have access to a dentist then the PCP should provide a referral resource to a MassHealth dentist.
- Screening has to be documented appropriately to be counted as completed. It can be a template included in a visit note, a separate questionnaire, or a scanned paper.
- The screening must be available on-site but a virtual option me be implemented for patient and provider ease.

Biannual Pedi Fluoride Varnish:

Population: Pediatric (6 mo. – 6 years)

- Starting at 6 months and when the first tooth errupts, MH pediatric providers should apply fluoride varnish every 6 months to this population or until the patient has a regular MH dentist. If the patient does not have a regualr dentist the PCP should provide a referral resource to a MassHealth dentist
- The application of Fluoride Varnish should be documented somewhere in visit note.
- This application must be provided on-site.

Implementation:
Annual Oral Health Screening
Population: All Members

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Performance Network

Oral Health Screening Questions

Adult

- Do you have a dentist you see annually?
  - No = Positive Screen, Refer to the MassHealth Dental OnePager
- In the last 6 months did you have a dental concern that was not addressed?
  - Yes = Positive Screen, Refer to the MassHealth Dental OnePager

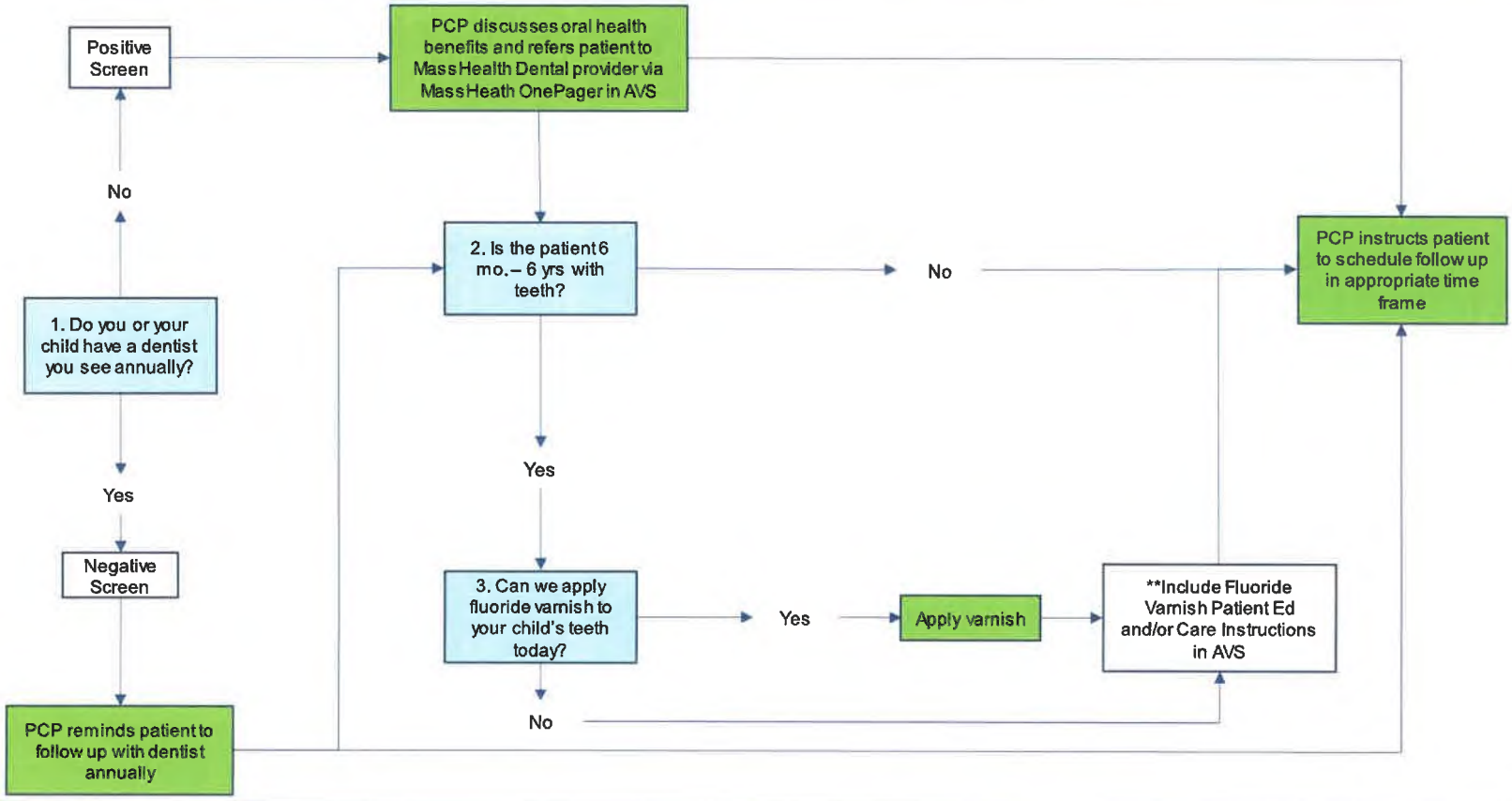
Pediatric

- Does your child have a dentist that provides oral care twice a year?
  - No = Refer to MassHealth OnePager
- Has your child received oral care in the last 6 months?
  - No = Refer to MassHealth OnePager
- Can we apply Fluoride Varnish to your child's teeth today as a preventative care measure?
  - Be prepared to more forward with Fluoride Varnish workflow

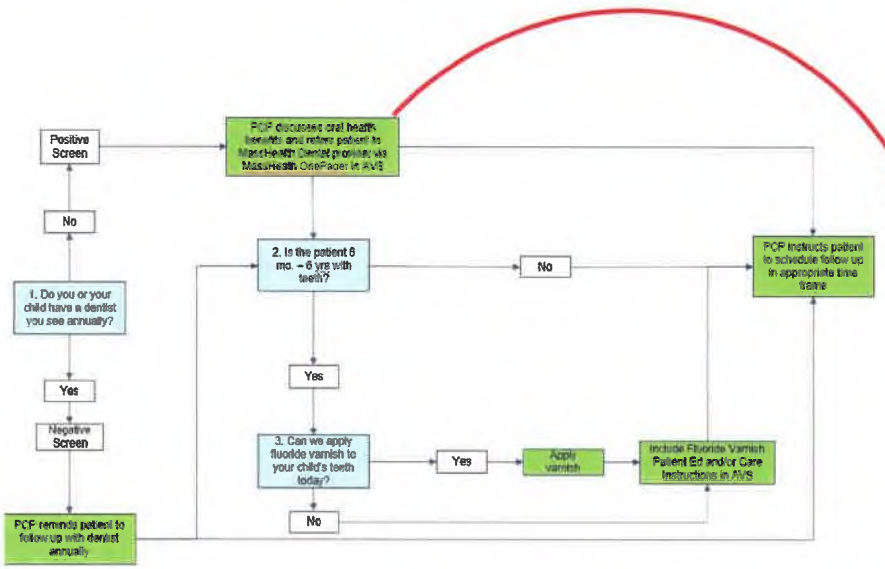
Combined (Recommended)

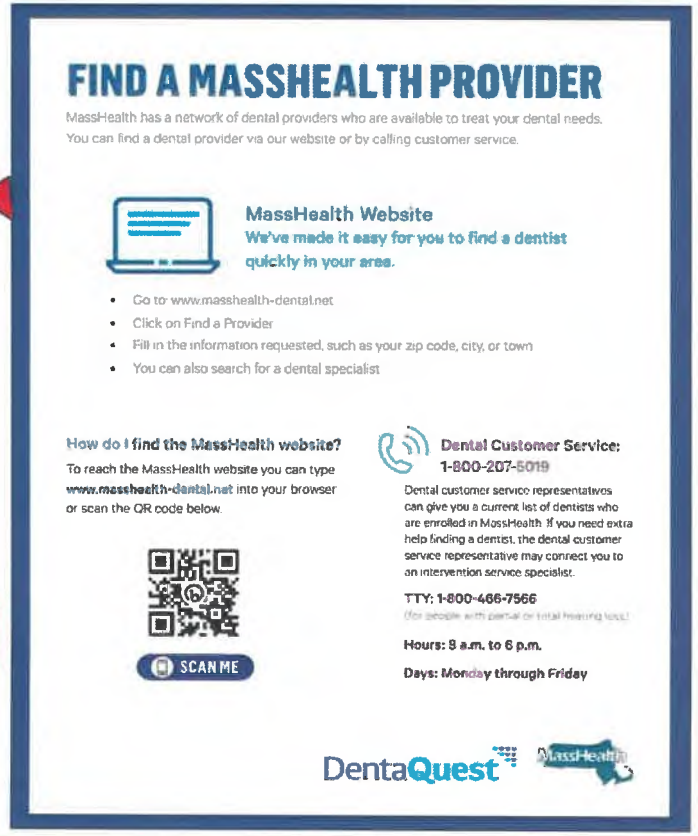
- Do you or your child have a dentist you see regularly?
  - No = Refer to MassHealth OnePager
- Have you or your child received oral healthcare in the past 6 mo?
  - No = Refer to MassHealth OnePager
- Can we apply Fluoride Varnish to your child today as a preventative care measure?
  - Be prepared to move forward with Fluoride Varnish workflow

Combined Oral Health Screening + Fluoride Varnish Workflow



When to Refer to the MassHealth Dental OnePager





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

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

Days: Monday through Friday

DentaQuest MassHealth

Providing a patient who has a positive oral health screening with the MassHealth OnePager or equivalent and documenting the screening and referral in the visit note is sufficient for the Oral Health Screening and Referral Tier 1 Requirement.

Implementation

Paediatric Fluoride Varnish

Population: (6 mo. – 6 years)

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Performance Network

Implementing Fluoride Varnish Workflow in Practice

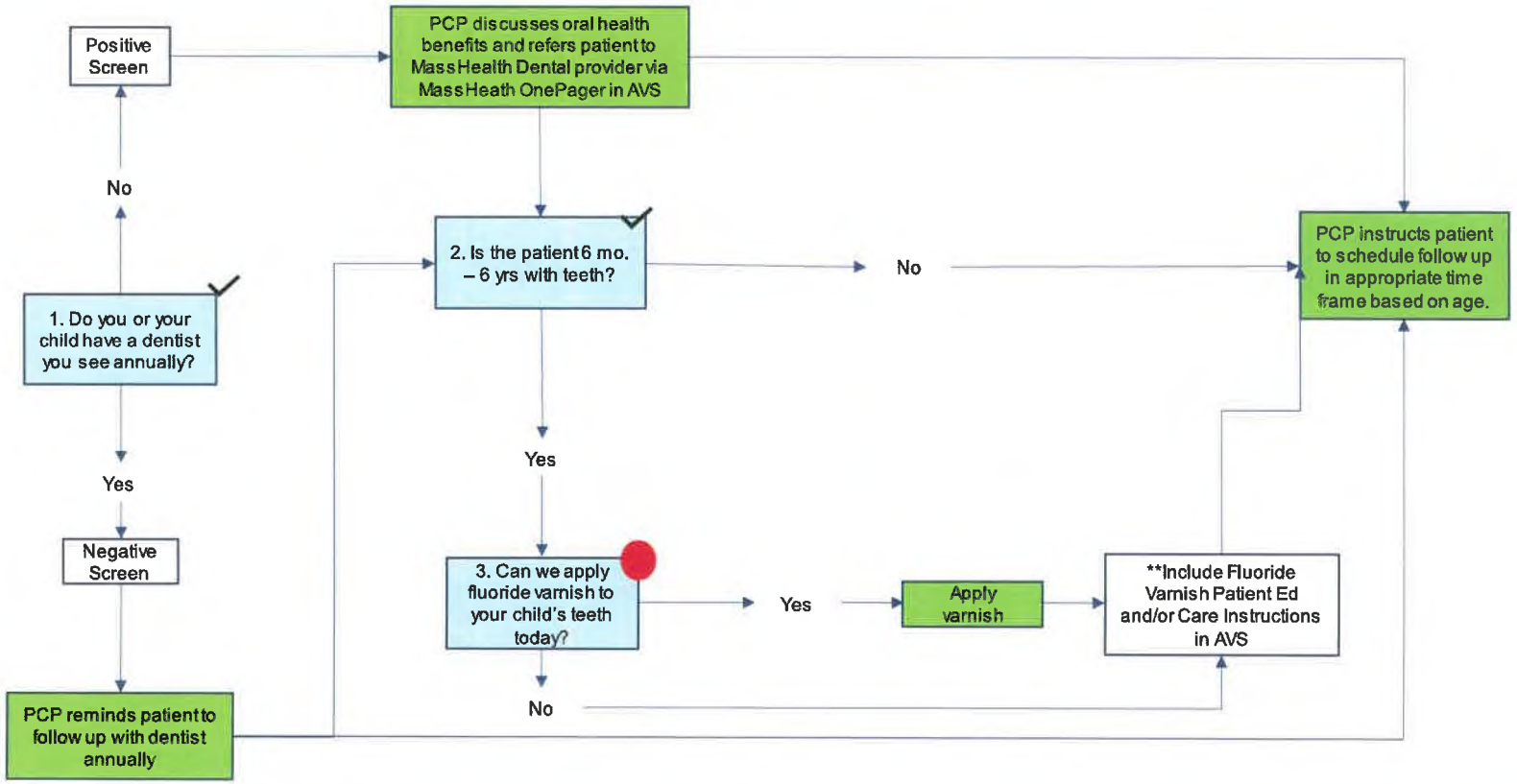
Communicate with Staff

1. Communicate the July 1, 2023, start date.
2. Include operational updates through newsletters.
3. Share optional training resources with staff.

Employ a Task Force & Responsabilities

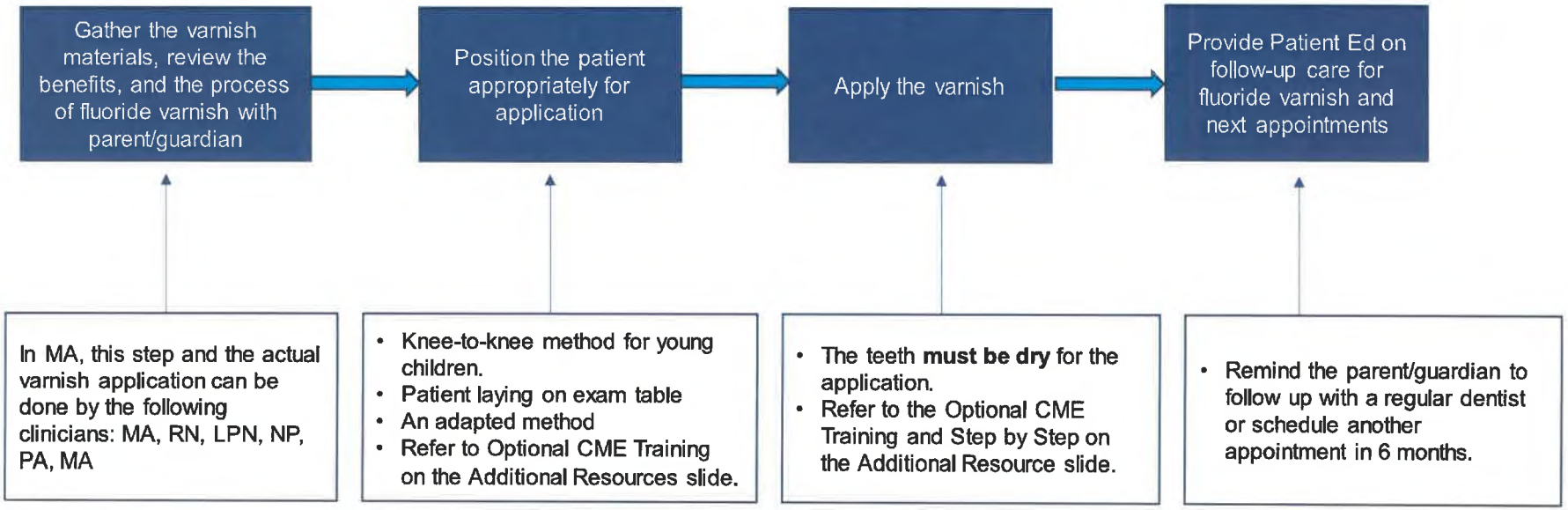
1. Download the "MassHealth Fluoride Varnish Training Manual" and make the manual accessible to all staff.
2. Add a Fluoride Varnish Progress Note Template, Patient Ed. and Billing Codes to your practice and EHR.
3. Order and stock fluoride varnish. See Vendor Resources
4. In Mass., Fluoride Varnish can be applied by an MD, DO, PA, NP, RN, LPN, or MA. Practices should decide where in a visit flow the fluoride application fits best. (Rooming, PCP visit, at visit close by MA/RN)
5. Add Fluoride Varnish supplies to inventory and exam rooms
    1. Patient Education, Fluoride Varnish, Progress Notes (if no EHR), Gloves, Gauze (See the Provider Application Review Sheet on the Fluoride Varnish Resource slide)
6. Stand up workflows and implement trial runs before July 1.
7. Advertise the Fluoride Varnish through Patient Education materials through the practice and website. See Fluoride Varnish Resources slide

Oral Health Screening + Fluoride Varnish Workflow



Fluoride Varnish Application Workflow

1. For patients 6 mo. – 6 years, the fluoride varnish application should be administered following the oral health screening. If there is a question whether the patient already received fluoride varnish in the past 6 months, continue with the workflow. There is no harm in an additional fluoride application.
2. Practices should decide where the application of the varnish fits best into their Wellness visit:
    1. We recommend at the end of the appointment when other procedures like vaccinations are administered.



Oral Screening + Fluoride Varnish Progress Note Examples

Oral Health Screening and Fluoride Varnish Template

Combined Screening Questions:

Question	Check Box			Additional Comments
Do you or your child have a dentist you see regularly?	Yes	No		
Have you or your child received oral healthcare in the past 6 –12 months?	Yes	No		
Can we apply Fluoride Varnish to your child today as a preventative care measure?	Yes	No	N/A	
Referral to MassHealth Dentist was given?	Yes	No		

Pediatric Fluoride Varnish Application **(6 mo. – 6 years)**

Event	Documentation	
Fl. Varnish Order Given	Yes	No
Patient was positioned appropriately	Yes	No
Teeth were dried with gauze	Yes	No
Fl. Varnish Applied	Yes	No
Review of Oral Hygiene	Yes	No

Fluoride Varnish Claim Submission:

Encounter	Service	Billing Code	Reimbursement
Well-Child Visit	Topical application of fluoride varnish; therapeutic application for moderate to high caries risk patients	CPT: 99188 **AND** ICD-10: Z00.129 " "Routine Child Health Check"	$28.00 per application, includes all materials and supplies needed for the application. **Can be billed up to 4 times a year.**
All other visit types	Fluoride varnish Application	CPT: 99188 **AND** ICD-10: Z41.8 "Need for Prophylactic Fluoride Administration"	

- **Reminders:**
  - Although claims will be "zero paid" under the sub cap, it is important that all providers continue to submit claims for services that fall under the primary care sub-capitation program. If claims are not submitted, future rate development and payments will be impacted
  - FFS medical providers can bill for an office visit and the application of fluoride varnish when the procedure is provided during a well-child visit. When the sole purpose of the visit is for the application of fluoride varnish, the medical provider may bill only for the fluoride varnish.

Workflows:
Oral Health Screening & Paediatric Fluoride Varnish

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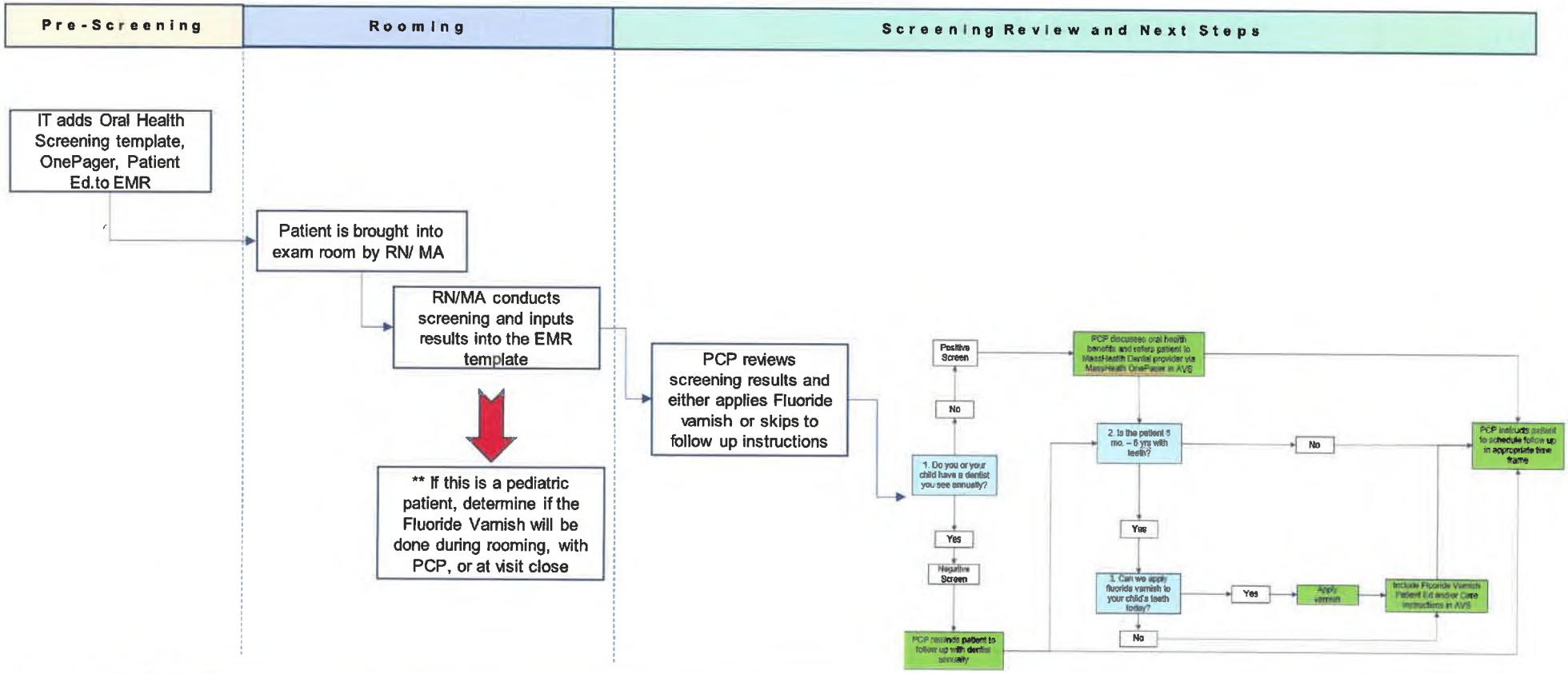
Workflow:
In-Person Oral Health Screening by RN/MA during Rooming



Task Force Responsibility Matrix: Clinical Fluoride Varnish Implementation

	Procedure	Operations Team	IT	Admin Support	Clinical Staff	APP
Implementation Stages	Download Masshealth Fluoride Varnish Training Manual to clinic shared drive for easy access	✓		✓		
	Upload Oral Health Screening Template, MassHealth Referral OnePager, Patient Ed. and billing code to EMR.		✓			
	Select a vendor and order Fluoride Varnish supplies – See Vendor Resources Slide	✓				
	Add fluoride varnish supplies to inventory and distribute fluoride varnish to clinic exam rooms	✓			✓	
	Distribute Patient Ed. about fluoride varnish and oral health in lobby and throughout practice.			✓		
	Following Pedi Oral Health Screen at Visit:					
Clinical Application Process	Gather FV materials and explain the application process				✓	✓
	Apply Fluoride Varnish using best practice techniques				✓	✓
	Provide Patient/ Parent Ed. about Fluoride Varnish care and follow up instructions				✓	✓

Additional Resources

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Oral Health Screening Referral Resources

MassHealth OnePager Dental Referral	MassHealth-Accepting Dental Schools + Clinics	MassHealth Patient Education

• Add the OnePager for MassHealth Dental Referral to EMR or practice shared drive
  • English
  • Spanish
  • Vietnamese
  • Portuguese
	Benefits: May provide lower OOP prices for services that an insurer won't cover.
	
	• Boston University School of Dental Medicine, 635 Albany Street, (617) 358-8300
	• Harvard School of Dental Medicine, 188 Longwood Avenue, (617) 432-1434
	• Tufts School of Dental Medicine, 1 Kneeland Street, (617) 636-6828
	
	Boston Medical Center, Yawkey Ambulatory Care Center, 850 Harrison Avenue, 6th Floor, Boston, MA 02118, (617) 414-2243 - This clinic is for pulling teeth. They do not make appointments - you must call the same day to have a visit.
		These are direct links that can also be accessed via the QR code on the OnePager
		• Find a MassHealth Dentist
		• MassHealth Dental Program Website
		• MassHealth Dental / DentaQuest Program Manual

Fluoride Varnish Application Resources

Optional CME Training

- Online Training: Carries Risk Assessment, Fluoride Varnish and Counseling
  - Select '**Register for Courses**'
  - This course provides information on Early Childhood Carries (ECC) and the oral hygiene benefits of applying fluoride varnish at WellChild visits. This gives a demonstration of how to appropriately apply fluoride varnish to a pediatric patient.
  - Course slides can be accessed here

- **In-Person Training**: Contact Jenna Blanchette, DentaQuest Outreach Coordinator/MassHealth Jenna.Blanchette@dentaquest.com or 617-886-1797

Implementation Resources

- 2022 MassHealth Fluoride Varnish Training Manual

- NCDHHS Fluoride Varnish Clinic Implementation Video
  - Varnish Application (5:55)

Optional Resources:

- Why Should we apply Fluoride Varnish
- Provider Fluoride Varnish Application Review Sheet

Patient Ed. and Marketing Tools

Add the following to EMR or shared drive to include in AVS

- Fluoride Varnish Patient Ed Handout

Marketing Tool:

- What is Child Fluoride Varnish – MassHealth

Vendor Resources

- 0.25 ml is the recommended dose of fluoride varnish for children under 6 and 0.4 ml for children 6 and up.

- List of Fluoride Varnish Vendors and the doses they offer

Contacts:

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Emily Chin: Emily.chin@lahey.org