# Integrating Healthcare Delivery: Co-Occurring Disorders Treatment Considerations

## Recommended Screening, Assessment, Management, Treatment, Referral and Safe Transition Protocols and Best Practices

***This document provides Network4Health recommendations for the following protocols and best practices:***

- Screening and Assessment Protocols for Co-occurring Disorders Treatment Programs
- Management and Treatment for Co-occurring Disorders Treatment Programs
- Referral from a Co-occurring Disorders Treatment Program
- Referral and Transition Management to a Co-occurring Disorders Treatment Program from another program or agency

### Screening and Assessment Protocols for Co-occurring Disorders Treatment Programs

Network4Health recommends that programs providing integrated treatment of mental health and substance use disorders (co-occurring disorders treatment programs) align their screening and assessment protocols with the recommendations found in TIP 42: Substance Abuse Treatment for persons with Co-occurring Disorders provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), see Source link below.

#### *Screening*

Network4Health recommends that co-occurring disorders treatment programs align their screening protocols with the recommendations found in SAMHSA's TIP 42, Chapter 4, page 66: Screening. As described in this section "The screening process for COD seeks to answer a "yes" or "no" question: Does the substance abuse (or mental health) client being screened show signs of a possible mental health (or substance abuse) problem?" Network4Health also supports the SAMHSA recommendation that screening protocols "indicate what constitutes scoring positive for a particular possible problem (often called "establishing cut-off scores")" and "the screening protocol details exactly what takes place after a client scores in the positive range".

A list of evidence based screening tools approved by Network4Health can be found in the Screening and Assessment Tools section below.

#### *Assessment*

At minimum and as described in Chapter 4 of TIP 42, co-occurring disorders treatment programs should provide basic assessments that cover the following:

- Basic demographic and historical information, and identification of established or probable diagnoses and associated impairments
- General strengths and problem areas
- Stage of change or stage of treatment for both substance abuse and mental health problems
- Preliminary determination of the severity of the COD as a guide to final level of care determination
- Note that medical issues (including physical disability and sexually transmitted diseases), cultural issues, gender-specific and sexual orientation issues, and legal issues always must be addressed, whether basic or more comprehensive assessment is performed.

As co-occurring disorders treatment programs increase skill and capacity, they will move along the dual diagnosis capability continuum and should strive to evolve their assessment protocol as described on page 68 of SAMHSA's TIP 42, Chapter 4.

Finally Network4Health also recommends that programs implement assessment protocols that allow for the continuous collection and revision of assessment information as a patient moves through recovery, as recommended by SAMHSA in TIP 42.

A list of evidence based assessment tools approved by Network4Health can be found in the Screening and Assessment Tools section below.

## *Screening and Assessment Tools*

Per page 69 of SAMHSA's TIP 42, "There is no single gold standard assessment tool for COD." Network4Health recommends that organizations select evidence based screening and assessment tools appropriate to your workflows and agency staff. Network4Health currently recommends use of any of the following screening and assessment tools. These tools will be updated as research evolves around the treatment of patients with co-occurring disorders.

| Standard Assessment Tool Name | Brief Description |
|---|---|

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|---|---|
| **Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index**<br><br>**Organizational Assessment Tool** | The DDCAT index is designed to determine how effectively substance use treatment programs provide services for patients with co-occurring mental health disorders.<br><br>The index is comprised of 35 items that explore an organization's policies, clinical practices, and workforce capacities (e.g., staff education, training, licensure, experience, availability). These items are organized into seven domains that include the following:<br><br>• Program structure<br>• Program milieu<br>• Clinical practice/assessment<br>• Clinical practice/treatment<br>• Continuity of care<br>• Staffing<br>• Training<br>Consultants review and score the data they have collected with the indexes and categorize the organization along a continuum of capability. The continuum for addiction-service organizations assessed with the DDCAT index includes:<br><br>• Addiction-only services (AOS)<br>• Dual-diagnosis capable (DDC)<br>• Dual-diagnosis enhanced (DDE)<br>The index is recognized as a reliable and valid tool for assessing outpatient, residential and hospital-based treatment programs (Gotham, Brown, Comaty, Joseph E., McGovern, & Claus, 2013).<br><br>An important purpose of the DDCAT evaluation process is to encourage treatment programs to improve every aspect of their care. |

| Standard Assessment Tool Name | Brief Description |
|---|---|
| **Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index Organizational Assessment Tool** | Similar to the DDCAT, the DDCMHT index is designed to determine how effectively mental health treatment programs provide services for patients with co-occurring substance use disorders. The DDCMHT utilizes the same 35 items across the 7 domains described above for DDCAT and organizations are scored across the following continuum of capability.<br>• Mental-health-only services (MHOS)<br>• Dual-diagnosis capable (DDC)<br>• Dual-diagnosis enhanced (DDE) |
| **The Mental Health Screening Form-III (Assessment/Screening)** | Screening assessment for clients seeking SUD treatment to identify any co-occurring disorders. (SAMHSA TIP 42) |
| **Simple Screening Instrument for Substance Abuse (SSI-SA) (Assessment/Screening)** | Designed for use within a clinical setting for clients receiving or seeking treatment and for administration and use under the standard conditions found in most substance abuse and/or mental health clinics. (SAMHSA TIP 42) |
| **PHQ-9 Depression Screening (Assessment/Screening)** | The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. |
| **PHQ-2 Depression Screening (Assessment/Screening)** | The PHQ-2, comprising the first 2 items of the PHQ-9, inquires about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder. |
| **Generalized Anxiety Disorder Screening (GAD 7) (Assessment/Screening)** | Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (GAD). |
| **Addiction Severity Index (ASI) (Assessment/Screening)** | The ASI is a general screening tool used extensively for treatment planning and outcome evaluation. (SAMHSA TIP 42) |

| Standard Assessment Tool Name | Brief Description |
|---|---|
| **Alcohol Use Disorders Identification Test (AUDIT)**<br><br>**(Assessment/Screening)** | The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.<br><br>The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. (SAMHSA TIP 42) |
| **Beck Depression Inventory–II (BDI–II)**<br><br>**(Assessment/Screening)** | Used to screen for the presence and rate the severity of depression symptoms.<br><br>The BDI–II consists of 21 items to assess the intensity of depression. The BDIII can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. (SAMHSA TIP 42) |
| **CAGE and CAGE-AID**<br><br>**Questionnaire**<br><br>**(Assessment/Screening)** | The purpose of the CAGE Questionnaire is to detect alcoholism. CAGE-AID detects alcoholism and drug use. The CAGE Questionnaire is a useful bedside, clinical desk instrument. It is a very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present. (SAMHSA TIP 42). |
| **Circumstances, Motivation, and Readiness Scales (CMR Scales)**<br><br>**(Assessment/Screening)** | SAMHSA TIP 42<br><br>The instrument is designed to predict retention in treat ment and is applicabl to both residential and outpatient treatment modalities.<br><br>The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. |

| Standard Assessment Tool Name | Brief Description |
|---|---|
| **Clinical Institute Withdrawal Assessment (CIWA-Ar)**<br><br>**(Assessment/Screening)** | Converts DSMIIIR items into scores to track severity of withdrawal; measures severity of alcohol withdrawal.<br><br>Aid to adjustment of care related to withdrawal severity. (SAMHSA TIP 42) |
| **Drug Abuse Screening Test (DAST)**<br><br>**(Assessment/Screening)** | The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and mis-use.<br><br>Screening and case finding: Level of treatment and treatment/goal planning. (SAMHSA TIP 42) |
| **Global Appraisal of Individual Needs (GAIN) or GAIN SS - Short Screener**<br><br>**(Assessment/Screening)** | The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling. (SAMHSA TIP 42) |
| **Level of Care Utilization System (LOCUS)**<br><br>**(Assessment/Screening)** | To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time. (SAMHSA TIP 42) |
| **Michigan Alcoholism Screening Test (MAST)**<br><br>**(Assessment/Screening)** | Used to screen for alcoholism with a variety of populations.<br><br>(SAMHSA TIP 42) |
| **M.I.N.I. Plus**<br><br>**(Assessment/Screening)** | Assists in the assessment and tracking of patients with greater efficiency and accuracy.<br><br>(SAMHSA TIP 42) |
| **Psychiatric Research Interview for Substance and Mental Disorders (PRISM)**<br><br>**(Assessment/Screening)** | The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples.<br><br>(SAMHSA TIP 42) |
| **Readiness to Change Questionnaire**<br><br>**(Assessment/Screening)** | Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. (SAMHSA TIP 42) |

| Standard Assessment Tool Name | Brief Description |
|---|---|
| **Recovery Attitude and Treatment Evaluator (RAATE)**<br><br>**(Assessment/Screening)** | Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. (SAMHSA TIP 42) |
| **Structured Clinical Interview for DSM-IV Disorders (SCID-IV)**<br><br>**(Assessment/Screening)** | Obtains Axis I and II diagnoses using the DSMIV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence." (SAMHSA TIP 42) |
| **Substance Abuse Treatment Scale (SATS)**<br><br>**(Assessment/Screening)** | To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder. (SAMHSA TIP 42) |
| **University of Rhode Island Change Assessment (URICA)**<br><br>**(Assessment/Screening)** | The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items.<br><br>(SAMHSA TIP 42) |
| **Clinical Opiate Withdrawal Scale (COWS)**<br><br>**(Assessment/Screening)** | The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. |
| **Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Assessment/Screening)** | Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Promoted by SAMHSA and US Preventive Services Task Force |
| **PHQ-A**<br><br>**(Assessment/Screening)** | Identifying depression in adolescents 11-17 |
| **Brief Psychiatric Rating Scale (BPRS)**<br><br>**(Assessment/Screening)** | A rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored. |

| Standard Assessment Tool Name | Brief Description |
|---|---|
| **Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)**<br><br>**(Assessment/Screening)** | Screening to detect and manage substance use and related problems in primary and general medical care settings |
| **Comprehensive Addictions And Psychological Evaluation-5 (CAAPE-5)** | The CAAPE-5 is a comprehensive diagnostic assessment interview providing documentation for substance-specific diagnoses based on DSM-5 criteria. |
| **SOCRATES 8A(alcohol) or 8D(drugs) Stages of Chain Readiness and Treatment Eagerness Scale** | A 19 item instrument designed to assess readiness to change in substance users. |

**Sources**:

SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders; https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

## Management and Treatment Protocols for a Co-occurring Disorders Treatment Programs

Network4Health recommends any of the below evidence based protocols for the treatment or management of patients with co-occurring mental health and substance use disorders.

| Protocol Name | Brief Description |
|---|---|
| **Integrated Treatment for Co-Occurring Disorders (formerly IDDT)**<br>**(Management and Treatment)** | Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery |
| **Multidisciplinary Team**<br>**(Treatment)** | The service team may include the following roles: Team Leader, Nurse, Case Manager, Employment Specialist, SA Specialist, Housing, Counselor, Criminal Justice, and Physician/Psychiatrist. The list is not exclusive and may include additional roles as required for a client. |
| **Stage-Wise Interventions**<br><br>**(Treatment)** | Consumers recovering from substance use disorders and serious mental illnesses go through stages, each of which marks readiness for a specific treatment.<br><br>Integrated treatment specialists must assess consumers' stage of treatment and tailor services accordingly: Engagement, Persuasion, Active Treatment, Relapse Prevention |
| **Motivational Interventions**<br>**(Treatment)** | Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment. These interventions help consumers identify personal recovery goals. |

| Protocol Name | Brief Description |
|---|---|
| **Supported Employment (Treatment)** | Motivational interviewing helps consumers identify their goals for daily living, as well as strategies (activities) for achieving those goals. |
| **Assertive Community Treatment (Treatment)** | Successful integrated treatment of COD programs utilize assertive outreach to keep clients engaged in relationships with service providers, family members, and friends. |
| **Assertive Outreach (Treatment)** | Service providers who utilize assertive outreach meet with consumers in community locations that are familiar to consumers, such as in their homes or at their favorite coffee shops or restaurants. |
| **Substance Abuse Counseling (Treatment)** | Counseling that provides recovery skills |
| **Group Treatment (Treatment)** | Research indicates that individuals with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders. |
| **Self Help Groups (Management)** | Self-help groups are excellent sources of social support for individuals who are motivated to achieve and maintain abstinence. |
| **Family Psychoeducation (Treatment)** | Family psychoeducation fosters social support. It includes consumers, caregivers (family members and friends), and service providers in the treatment process. |
| **Pharmacological Treatment (Treatment)** | Medications are effective in the treatment of persons with severe mental illness and co-occurring disorders. Medications generally include the following: Antipsychotics, Mood stabilizers and Antidepressants |
| **Medication Assisted Treatment (Treatment)** | Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. |
| **Interventions to Promote Health (Treatment)** | Research indicates that individuals with co-occurring disorders are at increased risk for poor health. Treatment team members encourage consumers to live healthy lifestyles |
| **Peer Supports (Management)** | Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. The shared experience of being in recovery from a mental health and/or substance use condition or being a family member is the foundation on which the peer recovery support relationship is built in the behavioral health arena |

## Referral from a Co-occurring Disorders Treatment Program

Network4Health recommends that programs providing integrated treatment of mental health and substance use disorders (co-occurring disorders treatment programs) align their referral protocols with the recommendations found in TIP 42: Substance Abuse Treatment for persons with Co-occurring Disorders

provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), see Source link below.

In particular, Network4Health recommends that organizations review and align with the information found on page 138, Essential Programming for Clients With COD: Screening, Assessment, and Referral:

> "If the screening and assessment process establishes a substance abuse or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of persons with COD."

Additionally, organizations may wish to review and align with the recommendations on page 508: Referral Issues.

**Sources**:

SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders; https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992

## Referral and Transition Management to a Co-occurring Disorders Treatment Program from another program or agency

Successful referrals and transitions for individuals with co-occurring mental health and substance use disorders, be it from the inpatient, addiction treatment, mental health treatment or primary care setting, need to address the needs and goals of both the patient/client and identified by the provider. In accordance with SAHMSA best practices, ideally, referrals made will be to organizations/programs that offer evidence based treatment services to individuals with co-occurring disorders. The organization/programs should support the use of a recovery philosophy (vs. symptom remission only) for both substance use as well as mental health disorders.
Key to successful referrals are:

- Understanding an individual's readiness for change and motivation to change both mental health and addiction issues
- The [provider's/ treatment site's] ability to providing care for individuals with co-occurring disorders who present with mental health symptoms, and if not, can systematically make appropriate referrals to providers/programs that can address the individual's needs
- Including an equivalent focus on needed follow-up services for **both** mental health and substance use disorders

A patient may have a very satisfying encounter with a Mental Health(MH) or Substance Use Disorder(SUD) provider or specialist, but if a PCP fails to send relevant information or the MH/SUD

provider or specialist fails to communicate with the referring provider, care for that patient or others with similar problems may well suffer.

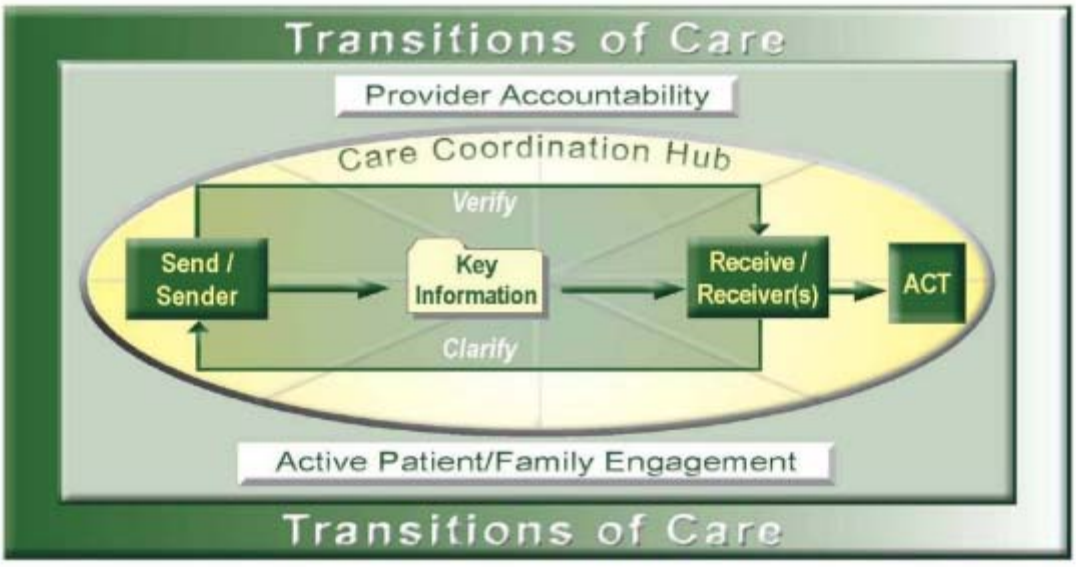
Network4Health recommends aligning referral and transitions management protocols with the following NTOCC Elements of Excellence in Transitions of Care (TOC) TOC Checklist. NH's 1115 waiver requirements, particularly the comprehensive core assessment (CCSA) address many of the NTOCC Elements of Excellence, which include the following:

1. **All members of the multi-disciplinary care team–including patients and their family caregivers–need access to key pieces of information in order to make transitions of care smooth, safe, and effective. NTOCC has described several steps that are critical to achieving this kind of information sharing:**
   • Improve communication during transitions between providers, patients, family caregivers and community supports;
   • Develop standardized processes for medication reconciliation and care coordination;
   • Establish accountability for sending, receiving and acting upon information necessary for safe, effective transitions of care;
   • Increase the use of case management and professional care coordination;
   • Expand the role of the pharmacist in medication reconciliation in transitions of care;
   • Develop performance measures to encourage better transitions of care; and
   • Implement payment systems that align incentives.
   Note: NTOCC believes that for HIT to make a difference in transitions of care, the technology must address each of these critical steps. Without addressing each step, the promise of HIT's affect on overall transition of care improvement will not be realized.
2. **Standardized Processes and Performance Goals Related to Transitions of Care** While some elements of facilitating care transitions might best be left to individual providers to design, the safety and effectiveness of care transitions requires some degree of standardization among providers to ensure the completion of critical activities common to all transitions of care. At a very basic level, there should be a list of key pieces of information to be conveyed to the next care site for every care transition. These standardized processes can be used to develop measures that will indicate provider performance in facilitating safe, effective transitions of care. Ultimately, there should be cross- cutting measures to indicate better outcomes resulting from better coordination among providers during a care transition.
3. **To ensure safe care transitions, standard transition processes must be in place.** Unfortunately, standard processes are generally lacking in rigor, do not include

policies and procedures to make processes enforceable, and simply are not rewarded. Medication reconciliation is one such task that is critical to safe transitions. Medication reconciliation is the process of creating the most current, complete, and accurate list possible of a patient's medications, comparing that list against other medication lists at transitions in care, and resolving any discrepancies. Medication reconciliation can be assessed as a static event (i.e., performance documentation by signature and completion of a medication reconciliation form) and by detecting errors that occurred during the process (i.e., medication discrepancies resolved). These processes address the Joint Commission's National Patient Safety Goal on medication reconciliation.

4. **Expand the Role of the Pharmacist in Transitions of Care** - Many transition of care problems relate to the safe and effective use of medications. HIT has the potential to reduce the rate of medication related problems and improve the rate and accuracy of reconciled medication lists between providers. Pharmacists have an integral part in establishing a smooth transition of care and can provide expertise in a patient's drug therapy regimen. Case managers can help patients navigate to community pharmacists for optimal medication management that can assist prescribers and patients managing complex medication schedules. Appropriate medication management promotes medication compliance and helps avoid unnecessary health care utilization.

### *Elements of Excellence in Transitions of Care (TOC) Checklist*




*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and

other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. **Every element on this checklist may not be relevant to each provider or setting.**

*For purposes of brevity, the term patient/client is used throughout this checklist to describe the client and client system (or patient and family). The patient/client system (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client's informal support network. Depending on the setting in which this checklist is used, providers may wish to substitute resident, consumer, beneficiary, individual, or other terms for patient/client.

## Overarching Concepts

**Engagement**

- Maximize patient/client involvement in all phases of intervention by promoting self-determination and informed decision-making.
- Provide educational information to support the patient/client's participation in the plan of care.
- Protect patient/client's right to privacy and safeguard confidentiality when releasing patient/client information.
- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess and promote the patient/client's efforts to participate in the plan of care.

**Collaboration**

- Define multidisciplinary team participants.
- Build relationships with all team members, with the patient/client at the center of the collaborative model.
- Communicate with other professionals and organizations, delineating respective responsibilities.
- Create awareness of patient/client and provider accountability for receiving and sending patient/client care information to and from care settings. • Provide services within the bounds of professional competency and refer patient/client as needed.

**Strengths-based assessment**

- Use respect and empathy in patient/client interactions.
- Recognize patient/client's strengths and use those abilities to effect change.
- Help patient/client use effective coping skills and insights to manage current crises.

- Recognize and help resolve patient/client's difficulties.
- Distinguish cultural norms and behaviors from challenging behaviors

**Assessment as an ongoing process**

- Keep assessments flexible, varying with presenting problem or opportunity.
- Regularly reassess patient/client's needs and progress in meeting objectives.
- Facilitate goal-setting discussion based upon the patient/client's needs during all phases of care.
- Assess effectiveness of interventions in achieving patient/client's goals.
- Communicate changes in assessment and care plan to the health care team.

**Common Elements for Assessment and Intervention**

- Assess patient/client's understanding of diagnosis, treatment options, and prognosis.
- Evaluate patient/client's life care planning and advance directive status.
- Evaluate impact of illness, injury, or treatments on physical, psychosocial, and sexual functioning.
- Evaluate patient/client's ability to return to or exceed pre-illness or pre-injury function level. Psychosocial functioning
- Assess past and current mental health, emotional, cognitive, social, behavioral, or substance use/abuse concerns that may affect adjustment to illness and care management needs.
- Assess effect of medical illness or injury on psychological, emotional, cognitive, behavioral, and social functioning.
- Determine with patient/client which psychosocial services are needed to maximize coping.

**Cultural factors**

- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess cultural values and beliefs, including perceptions of illness, disability, and death.
- Use the patient/client's values and beliefs to strengthen the support system.
- Understand traditions and values of patient/client groups as they relate to health care and decisionmaking. Health literacy and linguistic factors
- Provide information and services in patient/client's preferred language, using translation services and interpreters.
- Use effective tools to measure patient/client's health literacy.
- Provide easy-to-understand, clinically appropriate material in layperson's language.
- Use graphic representations for patients/clients with limited language proficiency or literacy.
- Check to ensure accurate communication using teach-back methods.
- Develop educational plan based upon patient/client's identified needs.

- Evaluate caregiver's capacity to understand and apply health care information in assisting patient/client.

**Financial factors**

- Identify patient/client's access to, type of, and ability to navigate health insurance.
- Identify patient/client's access to and ability to navigate prescription benefits.
- Evaluate impact of illness on financial resources and ability to earn a living wage.
- Provide feedback on financial impact of treatment options.
- Educate patient/client about benefit options and how to access available resources.
- Assess barriers to accessing care and identify solutions to ensure access.

**Spiritual and religious functioning**

- Assess how patient/client finds meaning in life.
- Assess how spirituality and religion affect adaptation to illness.

**Physical and environmental safety**

- Evaluate patient/client's ability to perform activities of daily living and meet basic needs
- Assess environmental barriers that may compromise the patient/client's ability to meet established treatment goals.
- Determine with patient/client the appropriate level of care.
- Assess ability of family or other informal caregivers to assist patient/client.
- Assess for risk of harm to self or others.

**Family and community support**

- Identify patient/client's formal and informal support systems.
- Assess how patient/client's illness affects family structure and roles.
- Provide support to family members and other informal caregivers.
- Assess for, and if appropriate help resolve, conflicts within the family.
- Evaluate risk of physical, emotional, or financial abuse or neglect, referring to community social services as needed.

**Assessment of medical issues**

- Patient/client diagnosis
- Symptoms
- Medication list and reconciliation of new medications throughout treatment
- Adherence assessment and intention
- Substance use and abuse disorders
- Lab tests, consultations, x-rays, and other relevant test results

**Continuity/Coordination or Care Communication**

- Specific clinical providers
- Date information sent to referring physician, PCP, or other clinical providers

- Necessary follow-up care

Source: (**http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf**)

### *Institute of Medicine (IOM)*

Network4Health also recommends aligning all patient referrals and transitions management protocols with the six Institute of Medicine (IOM) aims of high-quality health care :

- **Timely** - Patients receive needed transitions and consultative services without unnecessary delays.
- **Safe** - Referrals and transitions are planned and managed to prevent harm to patients from medical or administrative errors.
- **Effective** - Referrals and transitions are based on scientific knowledge, and executed well to maximize their benefit.
- **Patient-centered** - Referrals and transitions are responsive to patient and family needs and preferences.
- **Efficient** - Referrals and transitions are limited to those that are likely to benefit patients, and avoid unnecessary duplication of services.
- **Equitable** - The availability and quality of referrals and transitions does not vary by the personal characteristics of patients.

### *Timely communication*

Network4Health recommends the following protocols regarding timely communication and closed loop referrals.

#### *Time Stratified Referrals*

- **Urgent Referral** – referrals that require the patient/client to be seen immediately (the verbal or written handoff is the referral and once completed the referral is considered to be closed)
- **Priority Referral** – referrals that require the patient/client to be seen by the provider within 14 days
- **Priority Patient/Client Preference Referrals** – referrals with appointments that are not in the specified time period due to patient preference
- **Routine Referral** – referrals that require the patient/client to be seen by the provider within 28 days
- **Routine Patient/Client Preference Referrals** – referrals with appointments that are not in the specified time period due to patient preference

#### *Referral Type*

Based on urgency of care required, the referral can be marked as:

- Urgent Referral – immediate referral per phone
- Priority Referral – Referrals that require the patient to be seen within 3-14 days (from referral sent to patient seen)
- Routine Referral – Referrals that require the patient/client to be seen within 28 days (from referral sent to patient seen

*Appointment Scheduling*

The patient/client is scheduled for an appointment with the office schedules per type of referral and patient/client preference

*Closing the Loop*

Once the patient/client is seen by the provider referred to, the provider sends the visit note to the referring provider with the clinical issue answered within one week of the appointment.

*No Shows*

If the patient/client doesn't show up as per the scheduled appointment, the provider referred to marks it as one of the following and sends it back to the referring provider:

No Show – Priority Referral (within 14 days)
No Show – Routine Referral (within 28 days)

*Delayed referral timing due to:*

- Delayed Priority Referral – Patient/client preference
- Delayed Routine Referral – Patient/client preference

## Mutual Agreement for Referral Management

- Review the level of care tables and determine which services you can provide.
- The Mutual Agreement section of the tables reflects the core element of integrated care (aligning with PCMH) and outline expectations from both primary care and mental health care providers.
- The Expectations section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement.
- The Additional Agreements/Edits section provides an area to add, delete, or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.

- When patients/clients self-refer to primary care or mental health provider, processes should be in place to determine the patient's overall needs and reintegrate further care with the primary care or mental health provider, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements necessary to provide timely and necessary medical care to the patient/client.
- Each provider should agree to open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- **Optimally, this agreement should be reviewed every year.**
- Source: https://c.ymcdn.com/sites/www.thepcpi.org/resource/resmgr/Final-CRL-Toolkit-6-19-17.pdf

**For more detail see N4H Protocol for Effective Care Coordination and Referral / Transition Management Recommendations that include:**

- Safety Net Medical Home Initiative referral guidelines that itemize issues and expectations to consider when developing referral and transitions workflows
- Referral/transition tracking system development
- The Joint Commission's important elements of transitions of care

**REFERENCES**

SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders; https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992
Agency for Healthcare Research and Quality (AHRQ); http://integrationacademy.ahrq.gov/about/what-integrated-behavioral-health
Closing the Referral Loop: Improving Communication and Referral Management; http://app.ihi.org/FacultyDocuments/Events/Event-2930/Presentation-15886/Document-13144/Presentation_C6_ClosingtheReferral_Sheth.pdf
Community Care of North Carolina; https://www.communitycarenc.org/what-we-do/clinical-programs/behavioral-health-integration/referral-forms
Integrated Behavioral Health Partners; http://www.ibhpartners.org/?section=pages&cid=123
SAMHSA Business Process Analysis Workbook; https://www.integration.samhsa.gov/search?q=closed+loop+referral
SAMHSA Core Competencies for Integrated Behavioral Health and Primary Care; https://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf

SAMHSA Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit and Dual Diagnosis Capability In Mental-Health Treatment (DDCMHT) Toolkit
; https://www.centerforebp.case.edu/resources/tools/best-of-samhsa-resources-for-ddcat-and-ddcmht
SAMHSA Essential elements of Effective Integrated Primary Care and Behavioral Health Teams; https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/essential-elements-integrated-teams.pdf
SAMHSA Team Based Care Implementation; https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf