Integrating Healthcare Delivery - Recommended Protocols and Best Practices

Networ4Health Integrated Healthcare Project (B1)

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"Integrated behavioral health and primary care is anchored in inter-professional practice. The clinician does not work independently but rather contributes to a dynamic in which the "whole of the team" is greater than the sum of its parts (e.g., individual team members). Characteristics of effective clinical teams include an understanding of roles, responsibilities, values, and ethics for inter-professional practice and communication."

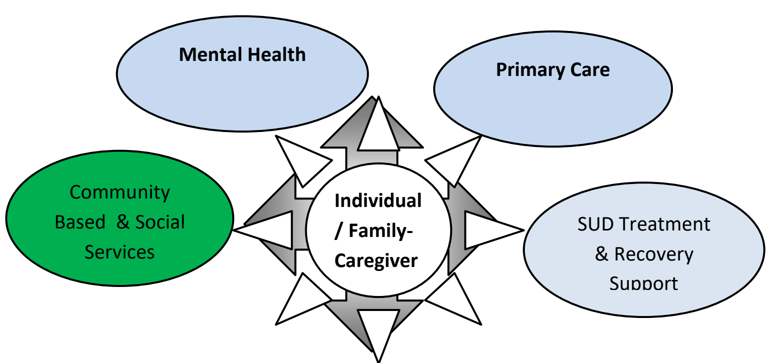
- Agency for Health Research and Quality (AHRQ)

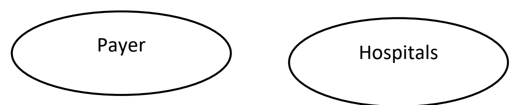
This document provides Network4Health recommendations for the following protocols and best practices:

- Multi-disciplinary core teams
- Interactions between providers and community based organizations
- Timely communication and referrals
- Privacy
- Interactions between providers
- Safe transitions from institutional settings back to primary care, behavioral health and social support service providers
- Intake procedures
- Adherence to NH Board of Medicine guidelines on opioid prescribing

Multi-Disciplinary Core Teams

According to AHRQ's Academy Integrating Behavioral Health and Primary Care, multi-disciplinary or inter-professional teams involve "medical and behavioral health clinicians [who] collaborate with each other and with patients/clients and families to address health concerns identified during… visits… Behavioral health clinicians often work right in the medical setting, or, if not onsite, are thoroughly integrated into the established procedures, team, and information systems." Interdisciplinary team meetings create awareness among clinicians from different backgrounds that help them develop and understand each other's work and services … Interdisciplinary team meetings and conversations afford opportunities for more in-depth dialogue to develop care plans for very complex patients/clients."





Network4Health's (N4H) Integrating Healthcare Delivery - Recommended Protocols and Best Practices are adapted from evidence-based practices from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) and AHRQ Integration Academy, including the SAMHSA/Cambridge Health Alliance (CHA) Model of Team-Based Care Implementation Guide and Toolkit, and National Transitions of Care Coordination. The CHA, model states, "It is critical to have a team model of care to sustainably meet the acute care, preventative care, and chronic care needs of our safety net patient population. This involves both creating an expanded primary care team and clearly defining roles, responsibilities, and workflows so that the care needs of the population can be met. In addition, there needs to be sufficient attention to training team members to function at the top of their license or scope of practice and to developing tools to help them provide care effectively. Above all, the team model of care needs to facilitate the development of a trusted relationship between the consumer and key care team members."

1. Define Goals and develop a shared aim collaboratively between primary care and mental health care. Create a sense that these are **our** patients/clients

Examples:

- Improvement of patient's and community's health based through evidence-based practice
- Improvement in access to care
- Improvement in service to patients/clients
- Provider and staff satisfaction and joy in work
- Improvement in practice's financial performance

2. Define specific, measurable outcomes and objectives. Align with your other initiatives and metric reporting

Examples:

- At least 90% of patients/clients with diabetes will have > 2 HgbA1c per 12 months
- Members of the assigned team will attend at least 80% of scheduled team meetings

3. Assign roles for each team member and define and delegate functions and tasks

- Determine which people on the team are best qualified to perform the tasks within the clinical and administrative systems of the practice (efficiency)
- Introduce team members so they know who each other are
- Introduce each members role (skills) so members on the team know what each other does and can do in their role
- Maximize the role of each team member within the scope of their licensure and skills, "working to the top of the license."

- Ensure that the right person is doing the right task for the right patient at the right time (is the team efficient in their workflow?)
- Ensure that each team member is competent to perform their defined and delegated functions and tasks
- Provide education and training for the functions and tasks that each team member performs
- Provide adequate IT training. Include electronic health record (EHR), secure messaging / email, closed loop referral system, intranet.
- Provide education and cross-training to substitute for other roles (in cases of absences, vacations, or periodic heavy demands on one part of the team)
- Provide all team members with communication training for effective teamwork, for example, motivational interviewing
- Assess competency of team members at least once each year (performance review) and have team members set goals which contribute to team performance
- Communicate each member's competencies to the other team members!

5. Ensure that clinical and administrative systems support team members in their defined work

Examples:

- Procedures for providing prescription refills
- Procedures for informing patients/clients of laboratory results
- Procedures for making patient appointments
- Policies on how decisions are made in the practice
- Work schedules allow time for team members to perform all parts of their job
- Adequate level of permissions in EHR which allow teams to perform
- Create communication structures and processes – a communication plan is helpful

  Examples:

  - Schedule team meetings and/or "huddles"
  - Hold team members accountable for attending and participating in team meetings and "huddles"
  - Clearly communicate expectations, assignments, tasks, roles to all team members
  - In between team meetings, routinely communicate through electronic information. These communications will help team members know the work is getting done
  - In between meetings, share important information through brief verbal interactions among team members
  - Provide feedback to care team members on a daily basis re: work well done and opportunities for improvement
  - Decide on a process for conflict resolution among team members and implement the process

6. Use data to assess team progress and performance at least every month, ideally every week.

- Are we accomplishing the work we set out to do as a care team?
- Are we meeting our goals and objectives?
- Where are our opportunities for improvement? What will we test to see if it results in an improvement?

Teamwork takes practice. Share your learning with other care teams at your site, organization and other organizations in the integrated delivery network (IDN).

Considerations in Forming Teams

How many teams should be organized at a site? One per panel

HINT: Let the number of patients/clients per team be your guide…

- Consider Planned Care Teams as the smallest number of people who can accountably be responsible for achieving the population health outcomes for patients/clients.
- Consider forming coverage teams as pairs or clusters of providers and staff who can cover for each other during planned and unplanned absences. This can help the covering teams know the patients/clients.
- Each care team at a particular site should have a balanced patient population in order to balance the workload
- Some teams have organized around a language of a patient population, especially if team members speak that particular language.
- A pharmacist, RN, MA, Front Desk, RD, SW, etc. may be on more that one team depending on the number of staff at a site
- One team may have more than one RN, MA, Front Desk, RD, SW, etc. depending on the number of staff at a site.
- HINT: Assign everyone at your site to a team!
- Schedules of team members may influence who is on the team. In order to facilitate communication, consider overlap of schedules among team members
- Literature suggests that < six team members is the optimal size and teams with greater that twelve members are too large.

HINT: If the team is too large:

- There may be too many hand-offs which can increase the risk of errors (of omission)
- Communication among larger teams may require more effort

HINT: if the team is too small:

- There may be staff who touch the patient who are not included in the team's
- Planning, communication, or work effort leading to redundancies, inefficiencies, and missed opportunities

Source: https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf

Privacy Protocol Recommendations

Network4Health recommends that the privacy protocol aligns with the following from the AHRQ Integration Academy Playbook:

- **Ensure conversation with Patient/Client on Information Sharing and Confidentiality**

- Be prepared for the possibility that a patient may not want a shared record. Integrated care involves sharing of information but the clinician has a responsibility to initiate dialogue with the patient that explains why it is important to have a shared record and then to listen to patient concerns and negotiate a resolution. This could be applicable to privacy issues for HIV, STDs, and other conditions as well as behavioral health aspects of care.
- The general principle is that the patient came to the primary care/MH/SUD site to get health care. When the practice is integrated and therefore charted for the team to view (and potentially others if the patient releases information), the patient has a right to refuse providers outside the practice access to their medical information.

- Source: https://integrationacademy.ahrq.gov/sites/default/files/playbook/Lexicon.pdf#Approach

Additionally, in accordance with the 1115 waiver special terms and conditions, and the SAMHSA finalized proposed changes to the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2 the privacy recommended protocols should include the following:

- Ability to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).
- Ability for additional disclosures of patient identifying information, with patient consent, to facilitate payment and healthcare operations such as claims management, quality assessment, and patient safety activities.
- Ability for additional disclosures of patient identifying information to certain contractors, subcontractors, and legal representatives for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation.
- Ability for permitting use of an abbreviated notice of prohibition on re-disclosure more easily accommodated in EHR text fields for users of electronic health records (EHRs).

Intake and Patient/Client Visit Protocol

The work of care teams is to deliver proactive, population-based, patient-centered care. The following SAMHSA model divides the delivery into 3 domains of work: pre-visit, visit, and between visit work.

Previsit	**Visit**	**Between visit**
The time of recognized need or risk by system or time of patient contact to check-in Care team plans for the encounter	Time of check-in to departure from health center Patient's encounter with clinician and care team	Completion of visit plans/actions to previsit Care management

Consideration for an effective intake and patient/client visit begins during the Pre-Visit phase to better prepare the patient/client and promote self-management abilities, and is reinforced during the visit and between visits.

Work Domain (Pre-Visit, Visit, Between Visit)	**Activity/Task**	**Multi-disciplinary Team Member**
Pre-Visit	**Assist patient to prepare for visit:** • **bring medications to visit** • **prepare questions to ask provider** • **come in for pre-visit lab tests** • **invite family member/caregiver to visit if patient prefers** • **confirm need for interpreter**	**E.g., MA, receptionist**
Visit-Before Pt/client arrives	**Prepare intake packet in advance for each patient and place at the reception desk.** • **Pre-visit forms to identify patient goals for the visit** • **Medication lists** • **Patient-specific screens, E.g., CCSA** **Huddle**	**E.g., MA, receptionist** **E.g., Provider, MA, Nurse, BHC, Receptionist**
Visit	**Give intake form(s) to the patient: meds, allergies, family history, past medical history** **Assess patient's educational needs** **Give med reconciliation list to patient and verify pharmacy** **Help patients/clients identify their goals for the visit and for their health** **Share care plan with Pt/client** **Provide appropriate educational/self-management tools for patient** **Give after visit summary to patient and review with the patient** **Schedule patient for primary care follow-up, specialty appointments**	**E.g., MA, receptionist** **E.g., MA, nurse or provider** **E.g., Nurse or provider** **E.g., MA, nurse or provider** **E.g., receptionist**
Between Visits	**Follow-up on test results** **Monitor Health Maintenance and use Planned Care outreach process to help patients/clients address gaps.** **Track all important appointments to completion** **Follow-up on missed appointments and/or referrals** **Schedule additional primary care and specialty appointments**	**E.g., nurse or provider** **E.g., MA, receptionist, patient navigator/community health worker** **E.g., referral coordinator** **E.g., referral coordinator** **E.g., care coordinator, nurse, social worker**

	Routine care management/care coordination	

Source: https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf

Referral and Transition Management

Successful referrals and transitions need to address the needs and goals of both the patient/client and identified by the provider. A patient may have a very satisfying encounter with a MH/SUD provider or specialist, but if the 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.

N4H 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.

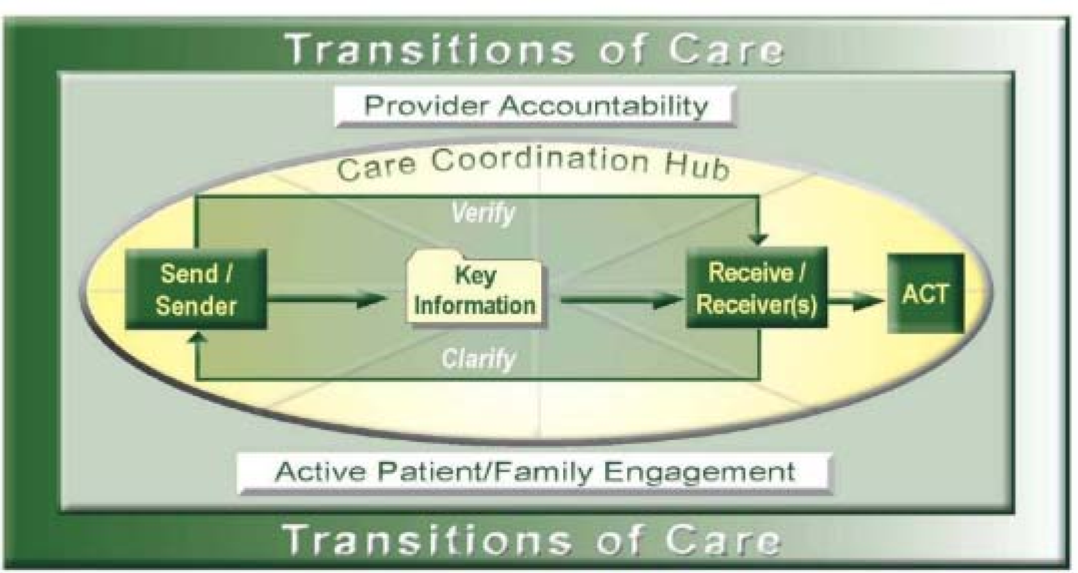
Source: (**http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf**)

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.

Protocol for Effective Care Coordination and Referral/Transition Management

N4H strives to align the many initiatives practices may be involved with to minimize duplication and create synergies. With that in mind, the following that aligns with Patient Centered Medical Homes (PCMH) was used for N4H's recommendations for care coordination and referral/transition management protocols. The Safety Net Medical Home Initiative, supported by The Commonwealth Fund, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute, developed the following to help 65 primary care safety net sites in five states to support high-performing patient-centered medical homes. These elements align well with AHRQ's integrated care best practices

Design Element	Major Changes	Activities	Tools and Resources
Accountability	1. Decide as a primary care clinic to improve care coordination.	Develop a quality improvement (QI) plan to implement changes and measure progress.	National Committee for Quality Assurance (NCQA). Care Coordination Measures.
			Care Coordination Questions from Validated Instruments.
	2. Develop a tracking system.	Design the clinic's information infrastructure to internally track and manage referrals/ transitions including specialist consults, hospitalizations, ED visits, and community agency referrals.	Referral Tracking Guide.
Patient Support	3. Organize a practice team to support patients and families.	Delegate/hire and train staff to coordinate referrals and transitions of care, and train them in patient-centered communication, such as motivational interviewing or problem solving.	Referral Coordinator job description.
			Case Study of Wright Center.
		Assess patient's clinical, insurance, and logistical needs.	Referral Coordinator Curriculum.
		Identify patients with barriers to referrals/transitions and help patients address them.	The Care Transitions Program Patient Activation Assessment Form.
		Provide follow-up post referral or transition.	

Design Element	Major Changes	Activities	Tools and Resources
Relationships & Agreements	4. Identify, develop, and maintain relationships with key specialist groups, hospitals, and community agencies.	Complete internal needs assessment to identify key specialist groups and community agencies with which to partner.	Referral Coordinator job descriptions.
	5. Develop agreements with these key groups, hospitals, and agencies.	Initiate conversations with key consultants and community resources.	Case Study of Family Care Network.
			Patient-Centered Primary Care Collaborative: Colorado Primary Care–Specialty Care Compact.
		Develop verbal or written agreements that include guidelines and expectations for referral and transition processes.	Federal Expert Work Group on Pediatric Subspecialty Capacity Promising Approaches for Strengthening the Interface between Primary and Specialty Pediatric Care. (Maternal and Child Health Policy Research Center American Academy of Pediatrics and the Maternal and Child Health Bureau Department of Health and Human Services, March 2006.) Carrier E, Dowling MK, Pham HH. Care coordination agreements, facilitators and lessons learned. *Am J Manag Care*. 2012;18:e398-404.
		Standardize the information in referral requests and consultation reports to ensure it meets agreed upon expectations.	Berta W, Barnsley J, Bloom J, et al. Enhancing continuity of information: essential components of a referral document. *Can Fam Physician*. 2008;54(10):1432-1433, 1433 e1431-1436.
			Berta W, Barnsley J, Bloom J, et al. Enhancing continuity of information: essential components of consultation reports. *Can Fam Physician*. 2009;55(6):624-625 e621-625.
			Reichman M. Optimizing referrals & consults with a standardized process. *Fam Pract Manag*. 2007;14(10):38-42.

Design Element	Major Changes	Activities	Tools and Resources
Connectivity	6. Develop and implement an information transfer system.	Investigate the potential of shared EHR or web-based e-referral systems; if not available, set up another standardized information flow process.	Case Studies of Humboldt County, San Francisco, and Oklahoma e-Referral systems.
			Horner K, Wagner E, Tufano J. Electronic Consultations Between Primary and Specialty Care Clinicians: Early Insights. The Commonwealth Fund. October 2011.
			Metzger J, Zywiak W. Bridging the Care Gap: Using Web Technology for Patient Referrals: California HealthCare Foundation; September 2008.
			O'Malley AS, Grossman JM, Cohen GR, Kemper NM, Pham HH. Are electronic medical records helpful for care coordination? *J Gen Internal Med.* 2009 [Epub], Journal print copy March 2010.

Considerations when developing referral and transitions workflows:

- **Types of patients/clients referred**. Many specialists have developed criteria for the patients/clients they prefer to see. For instance, it is important to understand the levels of care when referring to mental/behavioral health providers
- **Information provided** at time of referral
- **Event notification**
- **Testing to be completed prior to referral**. If PCPs complete a specialist's preferred laboratory testing prior to the referral, it increases the value of the consultation and reduces possible duplicate testing
- **Availability for "curbside consults"**
- **Consultation report content and timeliness**
- **Post-consultation care expectations** need discussion to prevent unhappiness among providers because expectations weren't met (e.g., specialist assumes care when PCP only wanted advice, or specialist returns patient and advice when PCP wanted to transfer care)
- P**ost-ED / hospitalization *[N4H recommends considering all care transitions, including prison]* care expectations**
- **Specialist-to-specialist referrals.** Many PCPs do not want specialists to refer their patients/clients to other specialists without first consulting with the PCP
- Source: **http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf**

The Joint Commission enterprise transitions of care initiative include the following important elements:

Multidisciplinary communication, collaboration and coordination	Including patient/caregiver education – from admission through transition. A care team – including a physician, nurse, pharmacist, social worker, and others as

	appropriate – communicates, collaborates and coordinates effectively; these steps include actively teaching patient and family/friend caregivers to learn and practice self-care and to follow the care plan, including how to self-manage medications.
Clinician involvement and shared accountability during all points of transition	Both sending and receiving clinicians are involved in and accountable for a successful transition. They are identified by name and exchange information electronically or by fax or telephone during the time of transition. At every point during the transition, the responsible coordinating clinician (such as a primary care physician or nurse practitioner) is identified for the patient
Comprehensive planning and risk assessment	Patients/clients are assessed for risk factors that may limit their ability to perform necessary aspects of self-care. Such risk factors include low literacy, recent hospital admissions, multiple chronic conditions or medications, and poor self-health ratings. Also, clinicians begin to assess risks that may be present at the receiving setting. For example, the clinician should confirm that the patient will have access to medications he or she needs at the next setting, as the pharmacy formulary there may not have the medications, or the ability to compound medications as ordered.
Standardized transition plans, procedures and forms	The following components are included in a written transition plan or discharge summary: active issues, diagnosis, medications, required services, warning signs of a worsening condition, and whom to contact 24/7 in case of emergency. Plans are provided in the patient's preferred language and use pictures for patients/clients having low literacy.
Standardized training	The organization begins by defining what constitutes a successful transition. Staff are taught the necessary steps to complete a successful transition and are engaged in real-time performance feedback. Successful transitions are made an organizational priority and performance expectation.
Timely follow-up, support and coordination	Organizations develop a process that provides for timely post-referral/discharge follow-up with patients/clients .
If a patient is readmitted within 30 days, gain an understanding of why	Readmissions within 30 days of discharge can often be prevented by providing a safe and effective transition of care from the hospital to home or another setting. Convene a meeting of the multi-disciplinary care team, including the attending physician and other key staff, and the patient and family members. Ask the patient questions about what happened after discharge. Find out if there were financial or transportation barriers, and whether or not home caregivers were unavailable.12 This important information can be used by organizations to improve care transitions for

	patients/clients and family/friend caregivers.
Evaluation of transitions of care measures	Monitor compliance with standardized forms, tools, and methods for transitions of care. Use surveys and data collection to find root causes of ineffective transitions and to identify patient and caregiver satisfaction with transitions and their understanding of the care plan. For example, this three-item survey queries patients/clients about key aspects of a care transition: The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital. 2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. 3. When I left the hospital, I clearly understood the purpose for taking each of my medications

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

Referral Tools

Develop a referral/transition tracking system

An effective referral/transition tracking system can be pencil and paper, a function of an e-referral system or EHRs, or developed on readily available software such as Microsoft® Excel or Access. The American College of Physicians Center for Practice Improvement & Innovation has a practical guide to tracking referrals on its website: **http://www.improvingchroniccare.org/downloads/3_referral_tracking_guide.pdf**

Sample Referral Forms Templates from Community Care North Carolina (CCNC)

CCNC, in partnership with other stakeholders, developed the following set of three referral forms for primary care and behavioral health providers to facilitate easier consultation and communication… A summary of revisions to the forms are available **here** and instructions for using the forms are available **here**.

Form #1 – Behavioral Health Request for Information is for behavioral health providers who begin working with a new consumer or identify a potential medical need, and wish to make contact with the primary care provider (PCP).

Form #2 – Referral to Behavioral Health Services Section I is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

Form #3 – Behavioral Health Feedback to Primary Care Section II is to be used in conjunction with the second form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

https://www.communitycarenc.org/what-we-do/clinical-programs/behavioral-health-integration/referral-forms

SAMHSA-HRSA Center for Integrated Health Solutions Sample Scripts for Warm Handoffs

Warm Handoff from Primary Care to Behavioral Health
Source: Warm Handoff Scripts and Procedures (.doc)

Warm hand-off scripts and procedures from primary care to behavioral health

Primary Care Providers (PCPs) have their own style of communicating, and will have different relationships with different patients/clients. These and other factors (especially cultural considerations) will tailor each 'warm hand off' so it best helps the patient overcome any barriers to seeing a Behavioral Health (BH) provider. However, some general principles can be articulated:

- The referral to a BH provider should be as directive as a PCP would normally make a referral to any other service. There should not be a discernible difference in content or tone between a referral to a BH provider and a referral to a cardiologist. Patients/clients will pick up the importance a provider implies regarding a referral, and respond accordingly.
- Unless a patient has used a diagnostic term themselves ("I feel depressed"; "I had a panic attack"; "I'm addicted"), it is more effective to use general terms like 'stress' to refer to behavioral health problems. BH providers have the time and the skill to assess patients/clients readiness to identify themselves as having particular problems, and can work with patients/clients on de-stigmatizing these terms when necessary.
- Similarly, it is more effective to use general terms such as 'colleague' or 'someone who specializes' instead of 'counselor' or 'therapist' or 'social worker'. For many patients/clients these terms evoke stigma, fear, and misunderstanding, and may keep a patient from seeing the BH provider. Skilled BH providers can identify themselves and intervene to address any of these apparent issues. Along the same lines, a PCP asking or offering a patient 'counseling' is less effective than offering them 'education' or 'ideas' or even 'support'.

> Example 1, medical provider: It sounds like you might be having a lot of stress right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you. Is it all right with you if I introduce you to her/him?
>
> Example 2, medical assistant: From some of your answers on this questionnaire, it looks as if you may be feeling down lately. We have someone here who can give you some ideas of ways to help with this. Her/his office is just down the hall. Is it okay with you if I see if he/she is available to meet you?

Referral to a psychiatrist: The following are two sample scripts for referring to a psychiatrist. Both address the major barriers in psychiatric consultation, which are stigma and fear regarding the implications of seeing a psychiatrist, and misunderstanding about the role of a psychiatrist. Because of their history, and an almost archetypical stereotype, patients/clients commonly assume a psychiatrist is a super competent, specialized analyst, who will engage them in intensive therapy. Some patients/clients feel disgruntled, ignored, and even angry by very competent and kind psychiatrists, because they 'only' received an assessment and a prescription.

Example 1, medical provider: We have already tried three medications that have not worked for you, and I know that has been frustrating for you. We have a specialist here who is a doctor for anxiety/depression/voices, who may be able to change your medicine and find something that works for you. He/she is right here, and could see you next week. Is that okay?

Example 2 (previous history with mental health services), medical provider: You have a long history of struggles with this problem, and since you are a new patient to me, I am wondering if you would be willing to see our specialist to make some recommendations about medicine. She/he is a medical doctor, so he/she doesn't do counseling. However, we do have a counselor that I think could be helpful to you. Is it okay with you for me to make you two appointments, one for medications, and one for counseling? I will follow up with you in two weeks.

Warm Handoff from Behavioral Health to Primary Care

Source: Warm Handoff Scripts (.doc)
Scripts for behavioral health clinicians to refer to primary care clinicians within a primary care clinic

In many integrated health care settings, behavioral health (BH) services are only available to patients/clients who also receive primary care from the organization. There are rarely enough behavioral health resources for existing clinic patients/clients, let alone those who are not currently receiving medical care there. In addition, many clinicians feel that when clients receive behavioral and medical services under the same roof, the quality of care is higher due to the ease of communication (electronic and otherwise) and convenience for the patient. Sometimes in these systems the patient's first and sometimes primary contact is with a behavioral health provider. In this case, it becomes the BH clinician's responsibility to successfully refer the patient to a primary care provider (PCP), either to establish care or for a consult. The following sample scripts were developed for BH providers and front office staff.

- **Script 1**, BH clinician, to establish care with PCP: (towards the end of session): Can we change course for a minute so I can give you some important information? (wait for agreement). I know the call center/receptionist let you know that all clients who obtain BH services here also receive medical care here. I wanted to ask you if you have thoughts about your preferences for doctors. I can make some recommendations. (wait for information about gender or age preferences, location or specialties). Thank you for telling me that. I will walk you up to reception and they can help you make an appointment with a PCP who works at (this clinic). They will have access to my notes, and I will make sure to write what you and I talked about - that you (need refills for your medications/need an EKG to make sure no heart problems/follow up to recent ER visit, etc.).
- **Script 2**, BH clinician, client already established, referral back to PCP indicated: (towards the end of session, unless an appropriate opening is shown earlier in the visit). Can we change course just for a minute so we can talk about our plan for next steps? (wait for agreement). You shared with me that [reiterate the medical problems the client expressed, such as the medication not being effective or producing unwanted side effects, etc.]. It sounds like you would like to discuss this with your physician, and in that case we can make an appointment today when you leave here to see your him/her. How does that sound?
- **Alternate reason for referring to PCP:** When I look at your health record it looks like it has been over six months since you have seen your PCP. As we continue to work together on your [whatever their issues are], I would recommend that you see your PCP for a regular physical, just to make sure your problem [specify] is not being caused by another medical condition. What are your thoughts about this?

- **Script 3**, Front office/reception/call center, to establish care with PCP: I would be happy to make you an appointment with one of our BH clinicians. What have you heard about also receiving medical care at our clinic? (wait for what client already knows). Can I give you some information about this? (wait for agreement). At our organization, in order to see our BH clinicians, clients also need to receive their medical care here. What are your thoughts about this? (wait for agreement). Great! I would be happy to make an appointment with one of our medical providers as well so you can establish care with them too.

Warm Handoff from Others Staff/Departments- Sample Scripts

Source: Five Scripts For Great Handoffs (.doc)

NURSE – Handing off patient and companion to physician

GREAT Behaviors	**GREAT Words**
If the physician is not there: Use words that prepare the patient for your departure and for what will happen next. Walk with patient and gesture with your arm to show the way. Once in the room, invite them to make themselves comfortable. Overestimate the amount of time they can expect to wait and tell them what to expect if the wait time is longer. Build the patient's confidence in the doctor. Tell them that you are leaving, but offer to help or answer questions first. Give a gracious goodbye in which you address patient and companion by name.	*"Great, Mr. Hampton! I've got all I need. Thank you!"* *"Now, if you'll come with me, I'll show you to the room where Dr. Clark will see you."* *"Please make yourself comfortable.* *"Dr. Clark should be here within 10 minutes. If for some reason, she can't get here by then, I'll be back to give you an update."* *If patient is new: "Mr. Hampton, you'll be in great hands with Dr. Clark. She's a wonderful doctor."* *If patient already knows the doctor: "I know Dr. Clark will be very glad to see you again…"* *"Before I go, is there anything you need or any questions you have?* *"I hope all goes well, Mr. Hampton, and I hope to see you on your way out.*
If physician is there: Use words that prepare the patient for the transition. Explain what will happen next.	*"Great, Mr. Hampton! I've got all I need. Thank you!"* *"Now, if you'll come with me, I'll show you to the exam room where Dr. Clark will see you."*
Along the way, walk close to the patient and stay connected. Make small talk.	*"Isn't it a nice day? I'm so glad the rain finally let up."*
If first visit with the doctor: Introduce the patient to the doctor. Say the patient's full name first. If patient has seen this doctor before, remind the doctor of this.	*"Oh hi, Dr. Clark, I'm glad you're here. Mr. Hampton, this is Dr. Clark. You'll be in good hands with her."* *"Dr. Clark, Benjamin Hamilton is here to see you again."*
Introduce the doctor to the patient.	*"Dr. Clark, this is Mr. Hampton."* *Dr. Clark: "Nice meeting you Mr. Hampton. I was expecting you. Come right in." (Turning to nurse: "Thanks Peg. I'll take good care of him."*
Smile and make eye contact. Share a good intention.	*"Okay, Mr. Hampton, you're all set. I hope all goes well for you!"*

RECEPTIONIST — passing a patient with a billing question on to a billing person

GREAT Behaviors	GREAT Words
• Make eye contact and address the person by name. • Explain what and who. • Share the good intentions behind the request. • Build customer's confidence in your co-worker. • Solicit the person's agreement. • Gesture enthusiastically and walk with the patient to your coworker's desk.	• *"Ms. Hamilton, before we schedule your follow-up appointment, Katy, the person who handles all our insurance and billing, would like to ask you a question regarding your insurance."* • *"Katy's here to make sure everything goes smoothly so you can continue to get the care you need."* • *“Can you speak with Katy for a few moments?”*
• Introduce your coworker by full name and position. • Then introduce the patient to your coworker. • Say something to remind coworker of why the patient is here.	• *"Ms. Hamilton, this is Katy Hammond our Financial Accounts Representative. Katy helps all of our patients/clients with their insurance and payment."* • *"Katy, this is Ms. Hamilton, here to discuss your insurance question."*
• Before you go, clarify when and if they will see you the person again.	• *“Ms. Hamilton, when you and Katy have finished talking, you can come back out to the front desk and I’ll help you schedule your next appointment.”*

Transferring a Phone Call

GREAT Behaviors	GREAT Words
• Keep in mind that the caller may have been transferred to several other offices before reaching yours. • If the caller reached you by mistake when trying to reach someone else, tell the caller which office he or she has reached and offer to transfer the call to the proper office. • Take the time to understand what the caller needs and to figure out who he or she should actually be calling. • If you do not have the correct extension at your fingertips, take the time to look it up. • Be sure to give the caller the correct number for future use and for use if transfer is disconnected. When you transfer the call, stay on the line to make sure you've connected the person to the place they want to reach.	• *"Can I have your name please?* • *"I'm sorry, Mr. Mancini. This is Martin Internal Medicine, and it sounds like you want the pharmacy. I'll be glad to transfer your call."* • *"In case we get disconnected or you get a busy signal, would you want to write down the number? Is a pencil handy?"* • *"Their number is XXX-XXXX. Can I repeat that for you?"* • *"Please hold while I transfer your call."* • *"And thank you for calling."*

Receptionist – Passing a patient with a complaint to the office manager

GREAT Behaviors	GREAT Words
Call the person by name and thank the person for speaking up. Express empathy without judging, agreeing, or disagreeing. Tell patient that you want to help. Handle the issue or draw in the right person who can. Build up your colleague in the patient's mind. Express confidence that this colleague cares and will help. Give the person options. Follow through on the option they choose. Make sure you close the loop. Make sure the person connects with the office manager before you let go.	Receptionist: *"I'm glad you spoke up about this, Mrs. Jones. It sounds very frustrating. I want to connect you to the right person. I think Marla Roberts, our office manager, is the person who can best help you. I know she'll be very concerned. Would you like me to see if Marla's available now or would you prefer that I have her call you later today?"* To Marla: *"Marla, I'm glad you're here. You know Mrs. Jones? She has a concern that I know you'll want to know about. Do you have a few minutes to talk with Mrs. Jones? I know you can help."* To Mrs. Jones: *"You'll be in good hands with Marla. Thanks for waiting."*

Taking and delivering a phone message

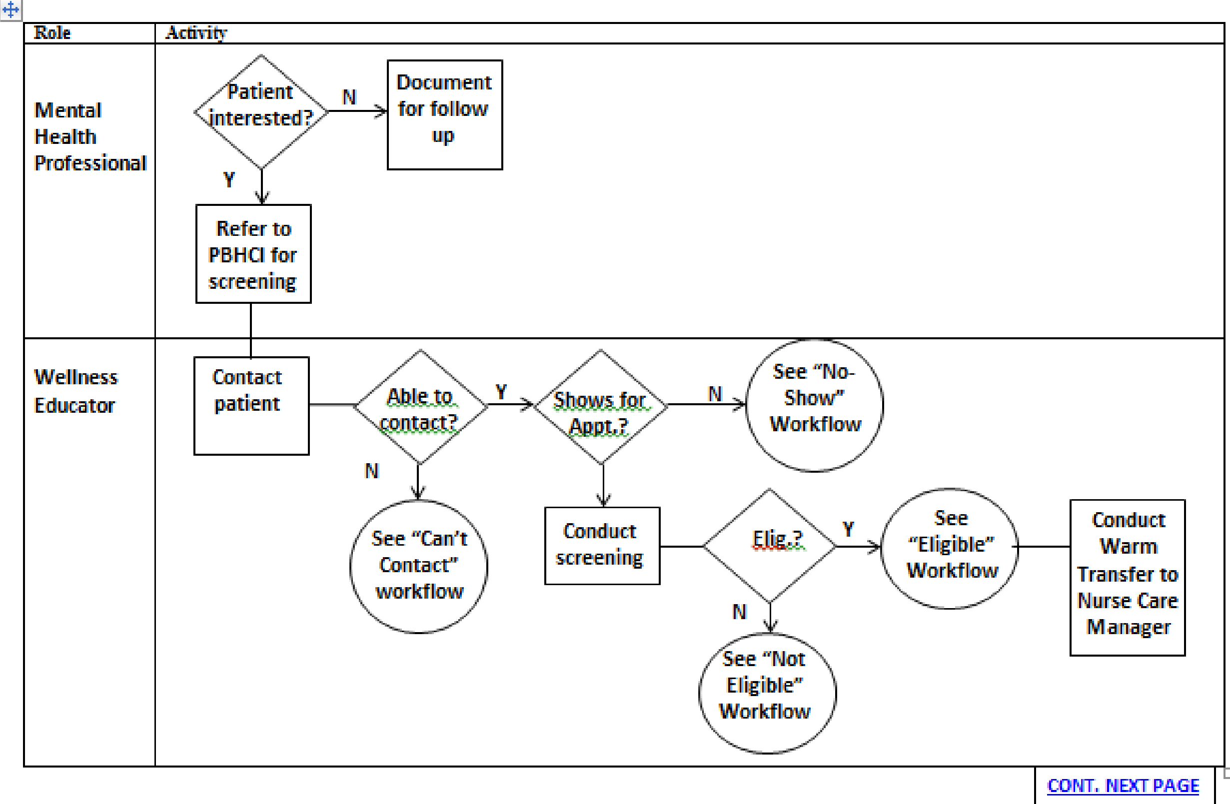
DO's	DON'T's
"I'm sorry, he's not available right now" "She's out of the office at the moment. I expect her back at 4:00. May I take a message?" "He's in a conference right now but I'll be happy to take a message."	*"She's impossible to find or reach, but as soon as I can, I'll give her your message."* *"She's working at home."* *"She's always off somewhere. It's a real challenge to get her."*

	"He's taken the afternoon off for personal business."
ACTIONS	
Write down the caller's name and phone number. Include other identifying information (e.g., name of patient the caller is associated with). Don't be shy about asking the caller to spell out a difficult name when necessary. Make note of the date and time of the call and the subject if you can tactfully find that out. This will help your coworker prioritize. If you can, locate any information your coworker will need when returning the call and provide it to him or her with the message. Be sure to put your initials at an appropriate place on the message so that your coworker will know who took the call in the event of questions. Sometimes you may have to take a message for someone who is in and nearby but who is on the phone or involved in some other work requiring immediate attention. You have a caller on the line and you need to get your coworker's attention in order to complete the call. To attempt this, place a written note in front of your coworker explaining the situation. Wait for a response. Your co-workers will appreciate your courtesy and thoughtfulness as much as patients/clients do.	

https://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

Sample Referral /Transition Workflows

ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER



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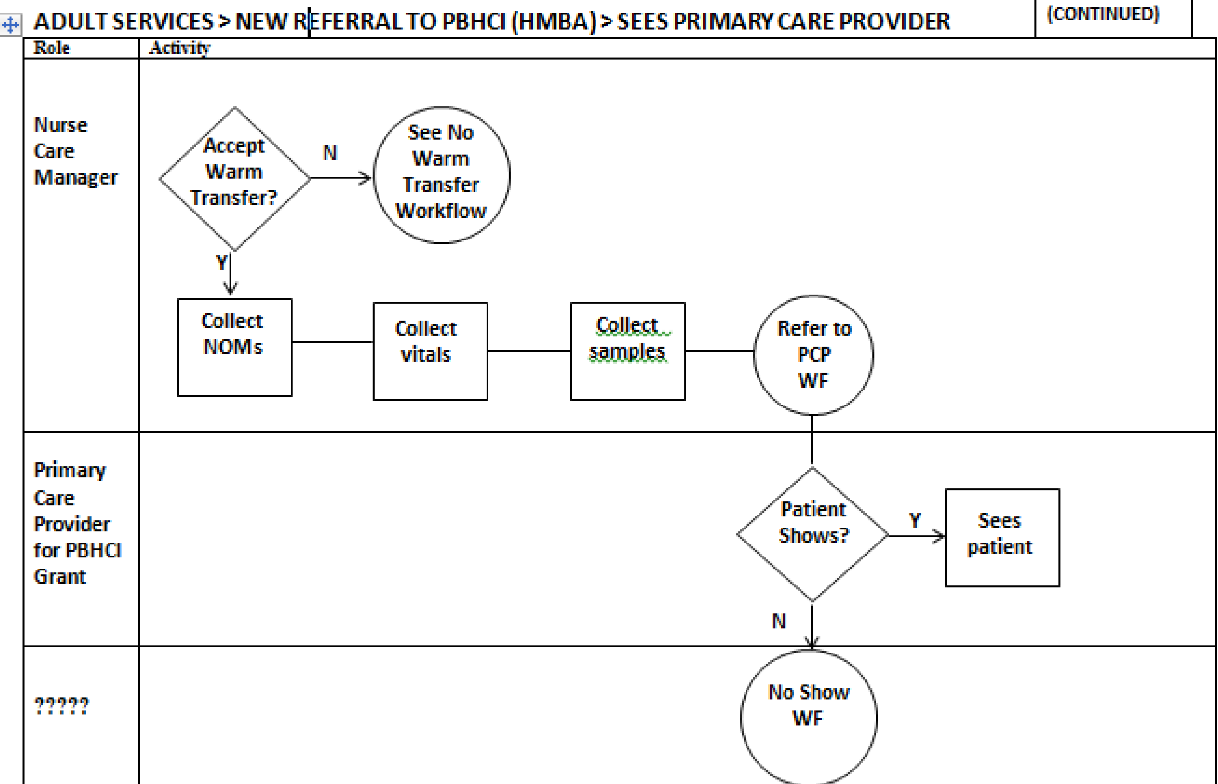
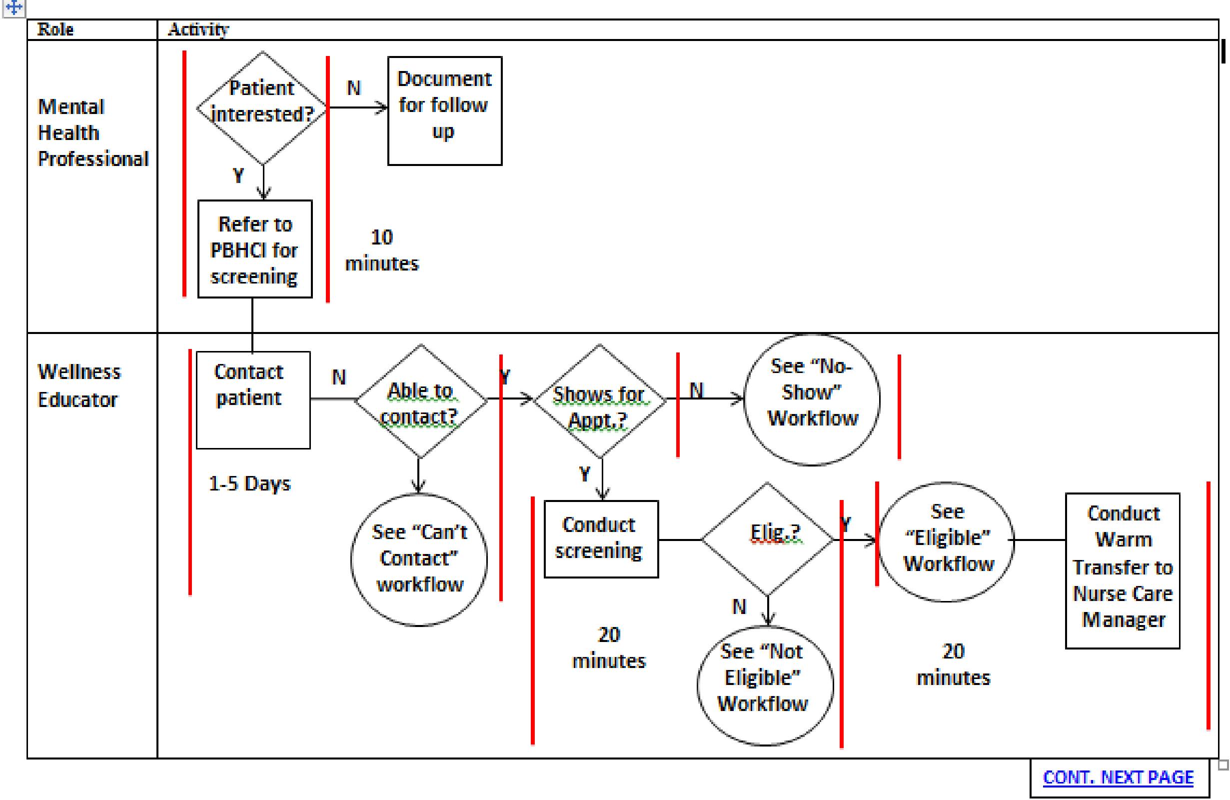
NETWORK 4 HEALTH


ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER
(CONTINUED)
Role
Activity
Nurse Care Manager
Accept Warm Transfer?
N
See No Warm Transfer Workflow
Y
Collect NOMs
Collect vitals
Collect samples
Refer to PCP WF
Primary Care Provider for PBHCI Grant
Patient Shows?
Y
Sees patient
N
?????
No Show WF

ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER



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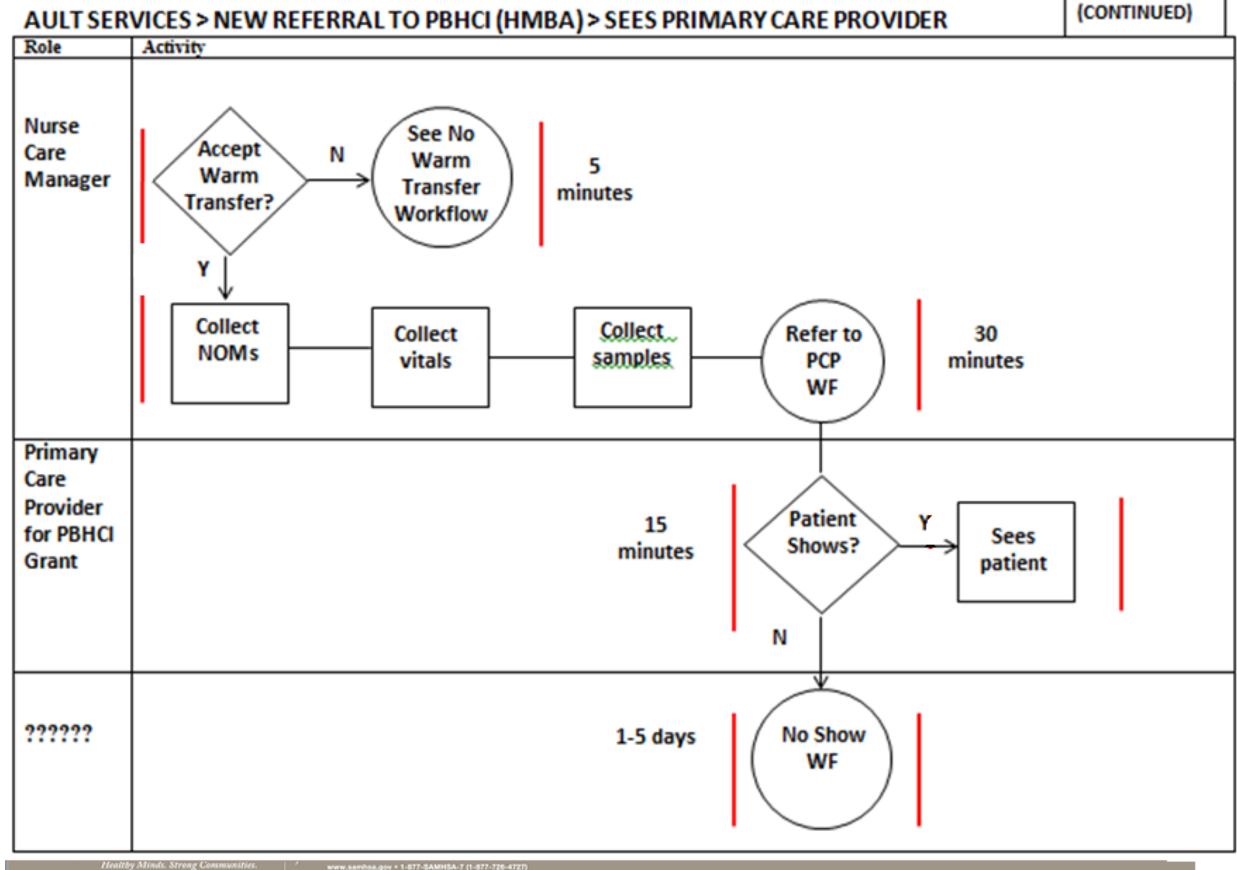

Templates to create workflow diagram and business process analysis

See SAMHSA Business Process Analysis Workbook:
https://www.integration.samhsa.gov/search?q=closed+loop+referral

Sample Care Compact / Memorandum of Understanding (MOU)

Co-created by PCP and Mental Health provider - to be completed in writing prior to the start of the collaborative to gain agreement regarding referral types and definitions, role expectations, and communication expectations.

Sample Collaborative Care Compact Co-created PCP - MH Provider Shared Care Compact

The primary care practice of ________ and the mental health practice of ________ have developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

Collaborative Guidelines

Aim Statement: Our aim is to improve the coordination of patient/client care between our offices. Specifically, we aim to ensure:

- Patients/clients are seen in an appropriate time frame;
- Clinical questions and responses are clearly stated and effectively communicated from one office to another;
- Patients/clients understand the reason for their referral and are satisfied with the referral process.

Principles

• Safe, effective and timely patient/client care is the central goal.

• Effective communication between mental health and primary care providers is key to providing optimal integrated care.

• Mutual respect is essential to building and sustaining a professional relationship and working collaboration.

• A high functioning integrated health system of care provides patients/clients with access to the 'right care at the right time in the right place.'

Timely Referral 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

Person Centered Care - Informed, Involved Patient/Client in Closing the Loop

Key to "closing the loop" on referrals is not only ensuring patients/clients have a good understanding of their health conditions, understand the importance of following through with referrals, but also feel empowered to do so. Address any health literacy barriers identified. The following are excellent health literacy resources:

Learn about Health Literacy, CDC: http://www.cdc.gov/healthliteracy/learn/
Quick Guide to Health Literacy: Fact Sheet https://health.gov/communication/literacy/quickguide/factsbasic.htm
Health Resources and Services Administration: http://www.hrsa.gov/publichealth/healthliteracy/

Referral Specialist

A team member in the office who is responsible for receiving the referral request, overseeing the referral process in the office, and sending the referral document with the clinical question to the primary care or mental health provider, as appropriate.

Reporting

Structured reports, to be simple but meaningful for both sides**: Referral Summary of Care Record**

- **Referral** - A new patient is referred between primary, mental health care, and SUD providers. Provider sends Summary of Care Record with Referral that includes:
  - Plan of Care field (Patient/client centered goals and instructions)
  - Care team (other providers)
  - Reason for Referral – Clinical Issue/Information
  - Current problem list
  - Current medication list
  - Current allergy list

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

Adherence to NH Board of Medicine Opioid Protocols

N4H integrated healthcare partners are expected to be in adherence with the New Hampshire Board of Medicine's Opioid protocols. "According to the NH Board of Medicine, the rules, codified in the Med 502 series of the NH Administrative Regulations, are divided into rules governing treatment of acute pain and rules governing treatment of chronic pain. Notably, the rules do not apply to physicians treating cancer or palliative care patients/clients."

Source: https://www.oplc.nh.gov/medicine/opioid-prescribing.htm

The NH Board of Medicine Rules

(a) Use of written treatment agreements;

(b) Provision of information to patients/clients on topics such as risk of addiction and overdose, and safe storage and disposal;

(c) Use and documentation of opioid risk assessments;

(d) Prescription of the lowest effective dose;

(e) Use of informed consent forms;

(f) Periodic review of treatment plans;

(g) Required clinical coverage; and

(h) Use of random and periodic urine drug testing for patients/clients using opioids long term.

Treating Acute Pain	• Conduct and document a physical examination and history.
	• Consider the patient's risk for opioid misuse, abuse, or diversion.
	• Prescribe for the lowest effective dose for a limited duration.
	• Document the prescription and rationale for prescribing.
	• Provide the patient with information on all of the following topics:
	    • Risk of side effects including addiction and overdose resulting in death.
	    • Risks of keeping unused medication.
	    • Options for safely securing and disposing of unused medication.
	    • Danger in operating a motor vehicle or heavy machinery while under the influence of opioids.
	• Comply with all federal and state controlled substances laws, rules, and regulations.
	• Adhere to the principles outlined in the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015).	

	With regard to the patient information requirement, the NH Board of Medicine has published a notice that, while not required, can be used to satisfy this requirement. The information sheet can be found at **https://www.nh.gov/medicine/documents/acutepainpatientinfo.pdf**	

Treating Chronic Pain	• Conduct and document a history and physical examination.
	• Conduct and document a risk assessment, including, but not limited to the use of an evidence-based screening tool such as the Screener and Opioid Assessment for patients/clients with Pain (SOAPP).
	• Document the prescription and rationale for all opioids.
	• Prescribe the lowest effective dose for a limited duration.
	• Comply with all federal and state controlled substances laws, rules, and regulations.
	• Utilize a written informed consent that explains the following risks associated with opiates:
	    • Addiction
	    • Overdose and death
	    • Physical dependence
	    • Physical side effects
	    • Hyperalgesia
	    • Tolerance
	    • Crime victimization
	• Create and discuss a treatment plan with the patient, which addresses issues such as goals of treatment in terms of pain management, restoration of function, safety, and time course for treatment.
	• Utilize a written treatment agreement that is contained in the patient's medical record and addresses, at a minimum, the following:
	    • Safe medication use and storage.
	    • Requirement to obtain opioids from only one prescriber or practice.
	    • Consent to periodic and random drug testing.
	    • Prescriber's responsibility to have clinical coverage available.
	    • Conduct that will trigger the discontinuation or tapering of opioids.
	• Document the consideration of a consultation with an appropriate specialist in the following circumstances:
	    • When the patient receives a 100 mg morphine equivalent	

	dose daily for longer than 90 days. • When a patient is at high risk for abuse or addiction. • When a patient has a co-morbid psychiatric disorder. • Require periodic review of the treatment plan and patient follow-up every four months. • Require random and periodic urine drug testing *at least annually* for all patients/clients using opioids for longer than 90 days. • Have clinical coverage available 24 hours per day, 7 days per week. • Adhere to the principles outlined in the American Society of Addiction Medicine's *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (2015). Please note that physicians treating chronic pain may forego written treatment agreements and periodic testing for those patients/clients: (a) who are residents in a long-term, non-rehabilitative nursing home where medications are administered by licensed staff, or (b) who are being treated for episodic pain and will receive no more than 50 dose units of opioids in a three-month period. The NH Medical Society has made various opioid prescribing tools and sample forms such as a pain evaluation, risk assessment, written consent form, and opioid treatment agreement available on its website at **http://nhms.org/resources/opioid**.	

The NH Medical Society has made a checklist for the Prescribing of Opioids for the Management or Treatment of Pain, **https://www.oplc.nh.gov/medicine/documents/opioid-patient-checklist.pdf** and various opioid prescribing tools and sample forms such as a pain evaluation, risk assessment, written consent form, and opioid treatment agreement available on its website at **http://nhms.org/resources/opioid**. Physicians should also consult with legal counsel or the NH Board of Medicine if they do not understand any aspect of these rules.

Board-Approved Risk Assessment Tools

- Screener and Opioid Assessment for patients/clients with Pain-Revised (SOAPP®-R)
- Screener and Opioid Assessment for patients/clients with Pain (SOAPP)® Version 1.0 - 14Q
- Opioid Risk Tool (ORT)
- Drug Abuse Screening Test, DAST-10
- Venebio Opioid Advisor At the present time, any provider wishing to use the tool will need to contact Venebio via a form at http://voa.venebio.com/contact/

REFERENCES

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 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