

Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee
Meeting Minutes
November 20, 2015, 9:00 AM – 12:00 PM
410 SW Oak, Transformation Center Meeting Room
Portland, OR

Present

Mitchell Anderson (co-chair)
Carolyn Anderson
Seth Bernstein, PhD
Patty Black
Chris Bouneff
Kevin Campbell
Scott Fields, MD
Robin Henderson, PsyD
Kris Keith
Susan King
Helen Kurre, MBA
Lynnea Lindsey-Pengelly, PhD
Doug Lincoln, MD (co-chair)
Barbara Martin, PA
Charlotte Navarre
Jorge Ramirez Garcia, PhD
Bruin Rugge, MD
Evan Saulino, MD
Kathy Savicki
Christine Seals, MD
Barb Seatter
Colleen Smith
Megan Viehmann, PharmD

OHA Staff

Nicole Merrithew
Megan Bowen
Chris Carrera
Amy Harris
Deepti Shinde
Dan Reece
Michael Morris
Rita Moore

Joining by phone

Colleen Reuland
Joe Hromco, PhD

Absent

Tammy Alexander, MED
Carrie Baldwin-Sayre, ND
Maggie Bennington Davis, MD
Kristin Dillon, MD
David Dorr, MD
Meg Portwood, FNP

Introduction and Overview of Committee Meeting

Co-chair Mitch Anderson convened the meeting at 9:10 AM and reviewed the agenda. Nicole Merrithew noted a change in the agenda: the tier structure will be discussed at the end of the meeting.

Staff Summary from Last Meeting and Survey Results

Following the last meeting committee members were surveyed by email about which population the Behavioral Health Home model should apply and should the standards focus on physical health, behavioral health or both. (see meeting summary). Mitch shared the survey results. Committee responses favored a targeted population based model with an emphasis on physical health measures.

Behavioral Health Criteria Discussion: Comprehensive Whole-Person Care; Continuity; Coordination & Integration; Person & Family Centered Care.

Based on the conceptual conversations in prior meetings, PCPCH Program staff drafted a proposed BHH model for the committee to review. The model was based on the current PCPCH model and the Certified Community Behavioral Health Clinic Standards, and was informed by the SAMHSA-HRSA Center for Integrated Health Solutions Behavioral Health Home model. (see meeting materials). PCPCH Staff revised the proposed model based on feedback from the November 3 meeting (see meeting minutes and summary).

The committee met in small groups to discuss the last three attributes of the proposed BHH model. The committee was directed to consider the model as it would apply to a population with a Serious and Persistent Mental Illness (SPMI) and individuals who need continuous behavioral or mental health care. This reflected the committee survey results. Written feedback and notes on the attributes were submitted to PCPCH Program staff. This feedback will be incorporated into an updated version of the model that will be presented at the next meeting.

Tier Structure

Nicole presented two options for revising the current tier structure (see meeting materials). Committee members were asked to submit comments and feedback by email, however most members felt the options needed further discussion so this topic will be included in the next meeting's agenda.

Public Comment

Mitch opened the meeting to public testimony at 11:50 A.M. Patrick Moony, Ph.D. provided a statement on behalf of the Oregon Independent Mental Health Professionals (OIMHP) requesting the committee consider a broad and inclusive definition of BHH in the development of standards that would focus on integrative care functions without requiring both primary care and behavioral health services be located in the same building. Dr. Mooney referenced several sections of SB832 that emphasized the concepts of "team work" without specifying services be provided in the same physical location. He further described OIMHP commitment as a professional association to facilitate coordination with primary care and support the Triple Aim through the organization's Connecting Care practice model.

Adjourned 12:00 P.M.

PCPCH SAC Meeting Summary – November 20, 2015

Summary and Survey Results

Following the last meeting committee members were surveyed by email about which population the Behavioral Health Home model should apply and should the standards focus on physical health, behavioral health or both. The committee was asked:

1. “Be our partner over time” is the patient-centered language that describes PCPCH Core Attribute of Continuity. Consider this language when answering the following question: Which population should the BHH model apply to:
 - a. General population
 - b. SPMI population
 - c. Population with a longevity of engagement with BH/MH clinic
 - d. Both b and c

2. Should the BHH Standard focus on:
 - a. Physical health services in a behavioral health setting
 - b. Behavioral health services in a behavioral health setting
 - c. Both a. and b.

Committee responses favored a targeted population based model with an emphasis on physical health measures.

BHH Core Attribute Discussion

Based on committee feedback at the last meeting, PCPCH Program staff drafted a revised proposed BHH model for the committee to review. (see meeting materials)

The committee met in small groups to discuss the last three attributes of the proposed BHH model. The committee was directed to consider the model as it would apply to a population with a Serious and Persistent Mental Illness (SPMI) and individuals who need continuous behavioral or mental health care. This reflected the committee survey results. Written feedback and notes on the attributes were submitted to PCPCH Program staff. Overall the following concepts were identified as needing further discussion and revisions from the committee:

- **Coordination & Integration with Primary Care.** Committee members are divided in their opinion about integration with primary care. Some feel coordination with primary care services is too low a standard for any behavioral health home and only integration should be part of the model. Others feel coordination would create a more stepped model of care that would encourage a continuum of transformation toward improved care.

- **Specialized Care Setting Transitions.** There is debate over whether the BHH model should adopt the PCPCH standard of requiring a written hospital agreement or adopt the CCBHC requirements which do not require a written agreement but are more prescriptive.

- **Planning for Continuity** demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available. Some committee

members feel this should be a “must pass” measures in the BHH model. It is currently not a must pass measure for PCPCHs.

- Population. Although the majority of committee members feel the BHH model should apply to a targeted population, some committee members have presented a rationale for a broader application of the model.

These concepts will be discussed further at the next committee meeting.

Tier Structure

Based on committee and stakeholder feedback from a previously proposed tier structure revision, Nicole presented two options for revising the current tier structure (see meeting materials).

- Option 1:
Expand on the current model to create five tiers as opposed to three. The additional tiers would segment the current Tier 3 clinics to better distinguish clinic capability without causing clinics to “drop a tier.” Maintain a proposed implementation date of January 1, 2016 as clinics would not be at risk of having their status lowered upon application renewal.
- Option 2:
Keep the previously proposed 3 tier model adjustment in place, but move the implementation date back to January 1, 2017 in order to provide advance notice of the proposed changes. This would allow providers to implement workflows necessary to achieve higher tier level recognition and also not conflict with ICD-10 implementation.

Committee members we asked to submit comments and feedback by email, however most members felt the options needed further discussion specially surrounding the proposed implementation timelines. This topic will be included in the next meeting’s agenda.

Staff Summary of Proposed Tier Structure Changes and Revised Recommendations

Staff Summary of Proposed Tier Structure Changes

At the September 1, 2015 PCPCH Standards Advisory Committee meeting PCPCH staff proposed recommended changes to the PCPCH model tier structure.

The PCPCH model was developed and implemented on foundational principles of provider and stakeholder engagement. The intention, as clearly stated during implementation in 2011, was to meet providers where they were, engage them through technical assistance, and incrementally refine the model over time to promote continued transformation.

94% of clinics recognized under the current PCPCH model are Tier 3, the highest level in the model. Achieving Tier 3 PCPCH recognition was intended for clinics that had implemented more advanced primary care home functions. Informal feedback from payers and providers indicate that the current tier structure does not hold significant meaning since it does not accurately reflect the level of transformation occurring in a clinic. Citing this same reason, commercial payers have been hesitant to move forward with provider incentive payments based on PCPCH recognition. This may be warranted in cases where providers have not made significant change in practice; however, it leaves some providers without the resources necessary to operate a highly transformational model of care.

Current Tier Structure:

Tier	Current Thresholds	Additional Requirements	% of Clinics
Tier 1	30 - 60 points	+ 10 must-pass standards	0%
Tier 2	65-125 points	+ 10 must-pass standards	6%
Tier 3	130 – 380 points	+ 10 must-pass standards	94%
3 STAR Designation	255 – 380 points	+ 10 must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit	NA

Proposed Recommendation to Tier Structure:

Tier	Proposed Threshold	Additional Requirements	% of Clinics
Tier 1	60 - 145 points	+ 10 must-pass standards	11%
Tier 2	150 - 250 points	+ 10 must-pass standards	51%
Tier 3	255 - 380 points	+ 10 must-pass standards	34%
3 STAR Designation	255 - 380 points	+ 10 must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit	NA

PCPCH Standards Advisory Committee Discussion Summary

The committee discussed the proposed tier structure changes noting both the positive and negative aspects of the recommendation. The following is a summary of committee member comments.

Positive Aspects:

- The proposed changes highlight true transformation and make the recognition more meaningful.
- More meaningful differentiation between the Tiers would better support alternative payment methodology (APM) work in this area.

- Clinics are competitive by nature and would likely rise to the challenge of increasing performance to maintain their Tier 3 status.

Negative Aspects:

- The current proposal may seem punitive to providers since they could ‘move down’ a tier; it could have a psychological impact on provider’s perceptions of performance.
- A January 2016 implementation date may not be good timing given ICD-10 implementation as well as short notice to practices.
- This change could be viewed as ‘changing the game mid-practice.’
- CCO incentive pool payments may be impacted since this change could affect the PCPCH incentive metric.
- CCOs and other payers may need to potentially renegotiate their arrangements with PCPCH providers if those providers are currently receiving tier-based incentives.

Revised Tier Structure Change Recommendation:

Committee feedback and feedback received from other stakeholders have informed a revision to the proposed tier change structure. PCPCH staff recommend the following options:

- Option 1:
Expand on the current model to create five tiers as opposed to three. The additional tiers would segment the current Tier 3 clinics to better distinguish clinic capability without causing clinics to “drop a tier.” Maintain a proposed implementation date of January 1, 2016 as clinics would not be at risk of having their status lowered upon application renewal.

Tier	Thresholds	Additional Requirements
Tier 1	30 - 60 points	+ 10 must-pass standards
Tier 2	65-125 points	+ 10 must-pass standards
Tier 3	130 – 190 points	+ 10 must-pass standards
Tier 4	190 -250 points	+ 10 must-pass standards
Tier 5 (Current 3 STAR Designation)	255 – 380 points	+ 10 must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

Note: total points for Tier 3 in current model were divided in half to create Tier 3 and Tier 4 point thresholds.

- Option 2:
Keep the previously proposed 3 tier model adjustment in place, but move the implementation date back to January 1, 2017 in order to provide advance notice of the proposed changes. This would allow providers to implement workflows necessary to achieve higher tier level recognition and also not conflict with ICD-10 implementation.

1. Access to Care

1.A In-Person Access	1.B After Hours Access	1.C Telephone & Electronic Access	1.D Same Day Access	1.E Electronic Access	1.F Prescription Refills	1.G. Timely Access (New)	1.H Access even if unable to pay (New)
1.A.1 BHH surveys a sample of its population on satisfaction with in-person access to care.	1.B.1 BHH offers access to in-person care for bh services at least 4 hours weekly outside traditional business hours.	1.C.0 BHH provides continuous access to behavioral health advice by telephone that is then documented in the client's medical record. (Must-pass)	1.D.1 BHH provides same-day and walk-in appointments for BHH services.	1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the BHH provides clients with an electronic copy of their health information upon request.	1.F.1 BHH tracks the time to completion for prescription refills.	CCBHC: 1. All new consumers requesting or being referred for bh services will, at the time of first contact, receive a preliminary screening & risk assessment to determine acuity of needs. 2. The preliminary screening will be followed by: (1) initial evaluation, (2) a comprehensive person-centered & family-centered diagnostic & treatment planning evaluation.	CCBHC: 1. The CCBHC ensures no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services. 2. The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria
1.A.2 BHH surveys a sample of its population using the Experience of Care & Health Outcomes (ECHO) or CAHPS survey tools on client satisfaction with access to care	1.B.3 (New) BHH offers access to in-person care for primary care services at least 4 hours weekly outside traditional business hours.	1.C.3 (New) BHH provides continuous access to primary care advice by telephone that is then documented in the client's medical record	1.D.3 (New) BHH provides on-site same day appointments for primary care services.			(cont.) 3. Outpatient clinical services for established CCBHC consumers seeking an appt for routine needs must be provided within 10 bus. days of requested date for service.	(cont.) 3. The CCBHC ensures no individual is denied bh care services because of place of residence or homelessness or lack of a permanent address.
1.A.3 BHH surveys a sample of its population using the Experience of Care & Health Outcomes (ECHO) or CAHPS survey tools, and meets a benchmark on client satisfaction with access to care.	CCBHC: The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.					(cont.) 4. The CCBHC provides crisis management services that are available & accessible 24/7 & delivered within 3 hrs. 5. Following a psychiatric emergency or crisis involving a CCBHC consumer, the CCBHC creates, maintains, & follows a crisis plan to prevent & de-escalate future crisis situations, w/ goal of preventing future crises.	
https://cahps.ahrq.gov/Surveys-Guidance/ECHO/index.html							

2. Accountability

2.A Performance & Clinical Quality	2.B Public Reporting	2.C Patient/Family Involvement in QI	2.D Quality Improvement	2.E Ambulatory Sensitive	2.F Care Team Involvement (New)	2.G Evidence-based Data-Driven Care (New)
2.A.0 BHH tracks one quality metric from the core or menu set of BHH Quality Measures. (Must-pass)	2.B.1 BHH participates in a public reporting program for performance indicators.	2.C.1 BHH involves clients, caregivers, and client-defined families as advisors on at least one quality or safety initiative per year.	2.D.1 BHH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and client experience.	2.E.1- BHH tracks selected utilization measures most relevant to their overall or an at-risk patient population.	2.F.1 BHH uses an interdisciplinary team including peer supports & involves client/family in treatment planning & care coordination activities. A care coordination agreement is developed that helps establish which provider is reasonable for what aspects of care & its coordination.	2.G.1 BHH uses data-driven, evidence-based care to guide treatment decisions and delivery of care including use of validated assessment tools, information systems like registries to track data over time.
2.A.2 BHH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH/BHH Quality Measures.	2.B.2 Data collected for public reporting programs is shared within the BHH (with providers & staff) for improvement purposes.	2.C.2 BHH has established formal mechanism to integrate client/caregiver/client-defined family advisors as key members of quality, safety, prog. Dev. &/or ed. imp. activities.	2.D.2 BHH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.		CCBHC: The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and familycentered	2.G.2 BHH embeds clinical guidelines into routine delivery of care.
2.A.3 BHH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH/BHH Quality Measures		2.C.3 Client, caregiver, and client-defined family advisors are integrated into the BHH and function in peer support or in training roles.	2.D.3 BHH has doc. clinic-wide imp. strategy w/ performance goals derived from community, client family, caregiver, & other team feedback, publicly reported measures, & areas for clinical & operational imp. identified by practice. The strategy includes a QI methodology, multiple imp. related projects, & feedback loops for spread of best practice.		CCBHC: The CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers.	
CCBHC: has capacity to collect, report, & track encounter, outcome, & quality data, inc. but not limited to data capturing: consumer char.; staffing; access to services; use of services; screening, prevention, & treatment; care coordination other processes of care; costs; & consumer outcomes			CCBHC: The CCBHC develops, implements, & maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinicalservices and clinical management.			

3. Comprehensive Whole-Person Care

3.A Preventive Services	3.B Provision of Services	3C Coordination & Integration with Primary Care (New) (See separate sheet)	3.D Comprehensive Health Assessment & Intervention	3.E Preventive Services Reminders
3.A.1 BHH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	3.B.0 BHH reports that it routinely offers all of the following categories of PC services <i>as well as screening/referral for necessary primary care prevention & treatment for common health conditions & risk factors like glucose/lipid levels, BP, weight, BMI, HIV, Hep C, Htn. (Must-pass)</i>	3.C.1 BHH conducts screenings, links clients to PCPs and coordinates primary care with PCP. BHH has designated staff that serves as bridge between client, bh providers and primary care provider. BHH has a cooperative referral process with primary care providers . Both BHH and primary care staff receive cross training. BHH must assist client identify medical provider who will provide continued care.	3.D.1 BHH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	3.E.1 BHH uses client information, clinical data, and evidence-based guidelines to generate lists of clients who need reminders and to proactively advise clients/families/caregivers and clinicians of needed services.
3.A.2 BHH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the BHH client population	3.B.2 (new) BHH incorporates prevention and wellness support services including nutrition consultation, health ed & literacy, peer specialists & self-help/management programs into individualized wellness plans.	3.C.2 BHH is co-located with primary care and provides access to primary care services during at least 50% of hours that clinic is open. (or some minimum number of hours)		3.E.2 BHH tracks the number of unique clients who were sent appropriate reminders.
3.A.3 BHH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	3.C.3 (New) BHHs offer or coordinate 24/7 access to crisis management services	3.C.3 BHH is integrated with primary care and provides access to primary care services during all clinic hours of operation. BHHs have a nurse case manager.		3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the BHH sends reminders to clients for preventative/follow-up care.
	CCBHC: CCBHCs are responsible for the provision of all care specified in PAMA, including crisis services; screening, assessment & diagnosis; person-centered treatment planning; outpatient bh services; outpatient pc screening & monitoring; targeted case management; psychiatric rehabilitation; peer & family supports; & intensive community-based outpatient bh care fo Armed Forces & veterans. May be provided either directly by the CCBHC or through formal relationships w/ other providers that are DCOs but either way the CCBHC is ultimately clinically responsible for all care provided.	CCBHC: The CCBHC has an agreement establishing care coordination expectations with FQHCs & as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For consumers who are served by other PCPs, the CCBHC has established protocols to ensure adequate care coordination.		

4. Continuity

4.A Personal BHH Clinician Assigned	4.B Personal BHH Clinician Continuity	4.C Organization of BHH Info	4.D Clinical Info Exchange	4.E Specialized Care Setting Transitions (See separate sheet for options)	4.F Planning for Continuity (See separate sheet for options)	4.G Medication Reconciliation
<p>4.A.0 BHH reports the percentage of active clients assigned to a personal PC clinician and/or BHH team. (Must-pass) Note: All of 4A and 4B refers to the person/team responsible for client's primary care needs.</p>	<p>4.B.0 BHH reports the percent of clients visits with assigned PC clinician and/or BHH team. (Must-pass). Note: All of 4A and 4B refers to the person/team responsible for client's primary care needs.</p>	<p>4.C.0 BHH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit. Health record is integrated to include both BH and PC information. (Must-pass)</p>	<p>4.D.3 BHH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).</p>	<p>4.E.0 BHH has a written agreement with its usual hospital providers or directly provides routine hospital care. (Must-pass)</p>	<p>4.F.1 BHH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.</p>	<p>4.G.1 Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation.</p>
<p>4.A.3 PCPCH meets a benchmark in the percentage of active clients assigned to a personal PC clinician and/or BHH team. (D)</p>	<p>4.B.2 BHH tracks and improves the percent of client visits with assigned PCP clinician and/or BHH team. (D)</p>			<p>CCBHC: 1. CCBHCs maintain a working relationship w/ local EDs & agreements in place with inpatient acute-care hospitals, including EDs, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities & ambulatory detoxification providers 2. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs. 3 The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. 4. inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, med detox inpatient facilities and ambulatory detox providers. 5. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge.</p>		<p>4.G.2 PCPCH tracks the percentage of patients whose medication regimen is reconciled.</p>

Continuity (continued)

	<p>4.B.3 BHH meets a benchmark in the percent of client visits with assigned PCP clinician and/or BHH team. (D)</p>			<p>CCBHC: The CCBHC has an agreement establishing care coordination expectations w/ programs that can provide inpatient psychiatric treatment, w/ ambulatory & medical detox, post-detox step-down services, & residential programs to provide those services for CCBHC consumers. The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting.</p>		<p>4.G.3 Adopt CCBHC standard as the new Tier 3 for this standard. The BHH makes and documents reasonable attempts to determine any medications prescribed by other providers for BHH consumers and to provide such information to other providers not affiliated with the BHH to the extent necessary for safe and quality care.</p>

5. Coordination and Integration

5.A Population Data Management (Check all that apply)	5.B Electronic Health Record	5.C Care Coordination (New Must-Pass, 5.C.1, 5.C.2 and 5.C.3 all combined into 5.C.0)	5.D Test & Result Tracking	5.E Referral & Speciality Care Coordination	5.F End of Life Planning
5.A.1a BHH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its client population.	5.B.3 Replaced 5.B.3 with the CCBHC standard. The BHH establishes or maintains a HIT system that includes EHRs. The HIT system has the capability to capture structured info in consumer records (including demographic information, diagnoses, & med lists), provide clinical decision support, & electronically transmit prescriptions to pharmacy. Uses HIT system to conduct activities such as pop. health management, QI, reducing disparities, & for research & outreach.	5.C.0 BHH assigns individual responsibility for care coordination and tells each client or family the name of the team member responsible for coordinating his or her care. BHH describes and demonstrates its process for identifying and coordinating the care of clients with complex care needs. 5.C.3 BHH develops an individualized written care plan with clients & families. This care plan should include at least the following: self management goals; goals of preventive & chronic illness care; & action plan for exacerbations of chronic illness. BHH uses single shared care plan that whole team uses & that addresses all phy, beh, wellness needs of client. Care plan is developed collaboratively w/ client/family. Must document specific services and supports to be provided, arranged or coordinated to assist the client/family to achieve intended outcomes.	5.D.1 BHH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to clients and families with interpretation, as well as to ordering clinicians.	5.E.1 BHH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to clients and/or caregivers and clinicians.	5.F.0 BHH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (Must-pass)
5.A.1b BHH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its clients using up-to-date information			5.D.3 (NEW) BHH tracks outcomes related to tests and results. le what % of clients got into treatment and recovery	5.E.2 BHH demonstrates active involvement and coordination of care when its clients receive care in specialized settings (hospital, SNF, long term care facility).	
				5.E.3 BHH tracks referrals and cooperates with community service providers outside the BHH such as social services, housing, ed systems, & employment opportunities as necessary to facilitate wellness and recovery of the whole person. (Replaced w/ lanugage from CCBHC standard)	
				CCBHC: The CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute & chronic) & bh care, as well as social services, housing, ed systems, & employment opportunities as necessary to facilitate wellness and recovery of the whole person. 2. The CCBHC assists consumers and families of children & youth, referred to ext. providers or resources, in obtaining an appt & confirms appt was kept	

6. Person and Family Centered

6.A Language / Cultural Interpretation	6.B Education & Self-Management Support	6.C Experience of Care (Will be changed to reflect new language for this standard related to	6.D Communication of Rights, Roles & Responsibilities
<p>6.A.0 BHH offers and/or uses either providers who speak a client's and family's language at time of service in-person or telephonic trained interpreters to communicate with clients and families in their language of choice. (Must-pass)</p>	<p>6.B.1 BHH has a process for identifying client-specific educational resources and providing those resources to clients when appropriate.</p>	<p>6.C.1 BHH surveys a sample of its clients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended client experience of care survey is the ECHO or CAHPS survey tools</p>	<p>6.D.1 BHH has a written document or other educational materials that outlines BHH and client/family rights, roles, and responsibilities and has a system to ensure that each client or family receives this information at the onset of the care relationship.</p>
<p>6.A.1 BHH translates written client materials into all languages spoken by more than 30 households or 5% of the practice's client population.</p>	<p>6.B.2 More than 10% of unique clients are provided client-specific education resources. BHH tracks usage of these resources and outcomes that occur as a result of usage.</p>	<p>6.C.2 BHH surveys a sample of its population at least annually on their experience of care using the ECHO or CAHPS survey tools. The client survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.</p>	
<p>CCBHC: 1. Auxiliary aids & services are readily available , ADA compliant & responsive to the needs of consumers w/ disabilities. 2. Documents or messages vital to a consumer's ability to access CCBHC services are available in languages common in community served, taking account of literacy levels & alternative formats. Such materials are provided in a timely manner at intake</p>	<p>6.B.3 More than 25% of unique clients are provided client-specific education resources and self-management services. BHH tracks usage of these resources and outcomes that occur as a result of usage. (Changed from 10% to 25%)</p>	<p>6.C.3 BHH surveys a sample of its population at least annually on their experience of care using the ECHO or CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.</p>	

CCBHC

Staffing Requirements	Outreach and Engagement	Other
1. CEO, with management team including psychiatrist as medical director. Exceptions made for HRSA shortage areas	The CCBHC engages in outreach and engagement activities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs	Is a non-profit organization, Is part of a local government behavioral health authority; Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service

2. The CCBHC must have staff, either employed or available through formal arrangements, who are credentialed substance abuse specialists.

Providers must include individuals with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI) and those with substance use disorders.

3. Training must address cultural competence, person-centered and family-centered, recovery oriented, evidencebased and trauma informed care; and primary care/behavioral health integration

1. Coordination & Integration with Primary Care (3.C)

Option 1:

Keep as is in matrix (3.C.1 would be must-pass for Tier 1 BHH, 3.C.2 a must-pass for Tier 2 BHH, 3.C.3 a must-pass for Tier 3 BHH)

3.C.1 BHH conducts screenings, links clients to PCPs and coordinates primary care with PCP. BHH has designated staff that serves as bridge between client, bh providers and primary care provider. BHH has a cooperative referral process with primary care providers . Both BHH and primary care staff receive cross training. BHH must assist client identify medical provider who will provide continued care. (MUST-PASS)

3.C.2 BHH is co-located with primary care and provides access to primary care services during at least 50% of hours that clinic is open. (or some minimum number of hours)

3.C.3 BHH is integrated with primary care and provides access to primary care services during all clinic hours of operation. BHHs have a nurse case manager.

Option 2:

Screening and Coordination with primary care is not enough to meet the minimum to be a BHH. Make Co-location and integration a must-pass. Must pass: BHH is co-located and integrated with primary care and provides access to primary care services that is appropriate to client population. The BHH has established protocols to ensure care coordination with primary care.

Option 3:

Includes all of option 2 plus the addition of 3.C.3 measure – BHH provides services to address psycho-social aspects of care (like having a bh consultant). 3.C.3 would not be a must-pass measure.

2. Specialized Care Setting Transitions (MUST-PASS) (4.E)

Option 1: Keep what is currently in PCPCH model except for BHH instead of PCPCH

4.E.0 BHH has a written agreement with its usual hospital providers or directly provides routine hospital care. (Must-pass)

Option 2: Make the entire CCBHC standard a must-pass for the BHH.

CCBHC:

1. CCBHCs maintain a working relationship w/ local EDs & agreements in place with inpatient acute-care hospitals, including EDs, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities & ambulatory detoxification providers

2. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs.

3. The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Also with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, med detox inpatient facilities and ambulatory detox providers.

4.. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge.

5. The CCBHC has an agreement establishing care coordination expectations w/ programs that can provide inpatient psychiatric treatment, w/ ambulatory & medical detox, post-detox step-down services, & residential programs to provide those services for CCBHC consumers. The

CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting.

Option 3: Expand current 4.E.O to include key parts of the CCBHC standard.

3. Planning for Continuity (4.F)

4.F.1 BHH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.

Option 1: Keep as is

Option 2: Make a must-pass standard in the BHH model (not currently a must-pass in the PCPCH model)

4. Population for BHH

A majority of committee members (15 out of 24 or 63%) answered that the BHH model should apply to both 1) A population with a SPMI (Serious and Persistent Mental Illness) **AND** 2) A population with a longevity of engagement with a behavioral/mental health clinic but not a SPMI. For example, an individual with a personality disorder who needs ongoing care (includes people with mental/behavioral health needs or substance use disorders).

In order to more clearly define this population are there any additional considerations for the committee and PCPCH program staff to consider?