Clinical Performance Standards:

Federally Qualified Health Center

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C·B·H

Community Behavioral Health

A DIVISION OF DBHIDS | CBHPHILLY.ORG

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1. INTRODUCTION AND PURPOSE

Federally Qualified Health Centers (FQHC) are health centers that receive federal grant funding under Section 330 of the Public Health Service Act. FQHCs provide Philadelphia's most underserved communities with comprehensive, patient-centered, integrated, and cost-effective primary care regardless of a person's ability to pay or health insurance coverage. Services are targeted to fit a community's needs. Priorities include medical, dental, family planning, and behavioral health. Ancillary services that increase access and accommodation to care such as transportation and language interpretation assistance are also provided. FQHC governance consists of a Board comprised mostly of patients of the health center.

Community Behavioral Health (CBH) performance standards for behavioral health services at a Federally Qualified Health Center (FQHC) serves as a tool to assist in the improvement of outcomes for CBH members who present in primary care with behavioral health needs. CBH performance standards should be used as an addendum to the licensing guidelines and regulations outlined by the U.S. Department of Health and Human Services, Health Resources Administration (HRSA), and existing contractual agreements made with CBH for payment of services.

2. BHC LICENSING REQUIREMENTS

A Behavioral Health Consultant (BHC) is a licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed psychologist (PhD or PsyD), or licensed marriage and family therapist (LMFT).

3. ACCESS FOR MEMBERS

As part of the FQHC admission process for primary care services, a member signs an integrated consent to treatment. The consent includes a statement that providers, including the BHC, share information.

The consultation occurs in person or through a HIPAA compliant telehealth platform via one of the following processes:

A primary care provider (PCP) provides a "warm handoff" to the BHC: a PCP or member of the care team identifies a member who screens positive for a behavioral health condition such as anxiety, depression, substance use, or is suspected of having a behavioral condition that impedes the member's ability to follow-up with a medical treatment plan or self-manage a chronic medical condition. The PCP may ask the BHC to assist the member in making behavioral changes. The PCP may also request the BHC assess the member's readiness to engage in specific treatments or referrals to specialty medical care, including readiness for medication-assisted treatment (MAT) and tobacco use disorder treatment. BHC availability for a warm hand-off is a priority and should be accommodated in the BHC workflow.

- A PCP may also establish a standing order or defined clinical pathway in the Electronic Health Record (EHR) that would automatically trigger a BHC visit.
- Any member of the primary care team, including a nurse, medical assistant, or case manager, can initiate a referral to a BHC. In these instances, the BHC will share the result of the consultation with the PCP via the EHR.
- The BHC reviews the PCP's schedule and alerts the PCP to a member that has a need for follow-up or screening. The PCP in turn will provide the warm hand-off or the BHC will perform a "routine visit," following up on the identified need or screening.

- A member may request to meet with a BHC. The BHC can accommodate the member by either meeting as soon as there is availability or scheduling the member for a future date.

The BHC has ongoing collaboration with the member's PCP during the period of consultation. The member should engage with a PCP at least once a year. If the member does not follow up annually with the PCP, the FQHC has outreach processes to engage the member in care.

Primary Care Behavioral Health does not mirror a mental health outpatient service where there is a "discharge" from care. If a member is on the PCP's panel of patients, they are eligible for behavioral health consultation. However, the lowest frequency of consultation sessions that support the improvement of functioning and self-management of symptoms is expected. Referrals to appropriate community-based organizations, including agencies that assist with social determinants of health and access to outpatient specialty behavioral health or substance use treatment services, should be provided as needed.

Due to high rates of physical health-behavioral health morbidity in the population's served and the PCP's need for BHC assistance, it is not always possible to see every member needing behavioral health consultation upon request. The PCP and BHC together should prioritize who needs consultation. The goal should be to make sure the most needy and vulnerable members are prioritized for same day BHC service. They may include:

- Members in urgent need of behavioral health
- Members who are not connected to psychiatric care, but who are prescribed psychotropic medication by the PCP at the FQHC

Members who are in crisis should be referred to a Crisis Response Center (CRC). Situations include:

- Members experiencing acute psychotic symptoms, including hallucinations and delusions
- Members unable to care for themselves due to acute psychiatric illness
- Members presenting with active suicidal or homicidal ideation, for whom self-regulation skills and safety plan and contract is needed
- Members who are intoxicated or going through substance withdrawal
- Members who are actively a danger to self or others and require immediate treatment

It may be necessary for the BHC to facilitate the filing of a 302 if the member refuses care.

4. SERVICE DUPLICATION

Behavioral health services provided at the FQHC may be considered a duplication of services if the member is also receiving similar services from other CBH provider agencies. For example, if a BHC provides individual counseling for tobacco use disorder to a member, and the member also receives counseling during the same period from a specialty mental health provider, the BHC's intervention may be considered a duplication of services. However, members who receive treatment outside of the FQHC may continue to engage with a BHC for complimentary support services if they remain a primary care patient.

A duplication of services may also occur if a member is engaged with a therapist in an outpatient specialty mental health agency but is also engaged with a BHC in primary care for the same issue. Protocols should be implemented for inquiring about current engagement within the CBH network to prevent duplication of behavioral health services. However, when coordinating a transition of care, service overlap may be permitted to ensure the member is engaged with the community-based behavioral health provider. A member may continue to engage with a BHC if there are new episodes where medical conditions or a new psychosocial event triggers challenges with functioning or chronic condition medication adherence.

5. ENGAGEMENT

5.1. Linkages/Coordination

Care coordination in primary care is integrated and aims to help members manage chronic illness. The PCP, the BHC, and other designated members of the care team facilitate the coordination of necessary services. If the PCP and BHC determine that a higher level of behavioral health care is needed, a plan to transition the member to a community-based behavioral health provider should be detailed and documented in the electronic health record. The member will continue to be eligible for BHC support within the context of a primary health care visit for a current chronic health challenge or subsequent episodes of care. To help facilitate referrals, it is recommended that there be a Memorandum of Understanding (MOU) between the FQHC and a community-based behavioral health provider that outlines processes to facilitate bidirectional care.

5.2. Family and Client

A member's designated family, and other acknowledged supports in a member's treatment should also be included in the coordination. Information about Advance Directives may be discussed with them and assistance provided in completing an assessment.

5.3. Monitoring of Standard

To measure the effectiveness of the integration of behavioral health services into primary care the FQHC should participate in the annual Integrated Practice Assessment Tool (IPAT) review process administered by the Health Federation of Philadelphia (HFP).

The IPAT survey assesses the FQHCs degree of integration, tracks changes over time and identifies opportunities and/or barriers to process improvement. HFP provides an annual report to CBH regarding findings and improvement plans.

6. TREATMENT PROVISIONS

6.1. Evidence-Based Practices

FQHCs utilize the Primary Care Behavioral Health (PCBH) model and other models (e.g., Collaborative Care Management) as an approach to delivering integrated care that is delivered in a multidisciplinary primary care environment. The goals of the PCBH model are:

- Support primary care physicians (PCPs) in providing whole person care.
- Reduce symptoms associated with chronic illness, improve functional status, and improve quality of life.

- Reduce psychiatric distress.
- Contribute to meeting the "Quadruple Aim":
  - Enhance patient experience with care including quality, satisfaction, and the motivation to play an active role in their own care.
  - Improve population health by preventing and managing prevalent chronic diseases.
  - Reduce expenditures for care by reducing avoidable emergency room usage and hospital readmissions.
  - Improve provider and clinical staff satisfaction and sustainability.

6.2. Clinical Services

The BHC addresses a variety of needs presented in primary care that range in acuity from mild to severe disorders. This includes behavioral disturbances such as agitation or aggression, depression, anxiety, psychosis, chronic pain, sleep disorders, tobacco and other substance use disorders, challenges with chronic disease self-management, difficulty with medication management, and familial relationship challenges.

The BHC applies principles of population-based care to provide behavioral health interventions that support the primary care practice and its patient panel. As such, an independent therapy caseload that mirrors an outpatient specialty mental health model is not maintained. There are instances, however, when traditional psychotherapy may be offered for a limited duration of time until the member can be connected to the appropriate level of care.

The BHC aims to increase functioning, problem solving skills, and the overall quality of life for children, adolescents, and adults by screening and assessing for risks, strengths, and supports. Cognitive-behavioral and brief solution-focused interventions are delivered, thereby assisting the primary care team in improving targeted patient outcomes.

Group consultation is permitted for members who both the PCP and BHC identify as likely to benefit from a group dynamic. Examples include groups for members who struggle with chronic pain or unmanaged chronic illnesses such as diabetes or hypertension and have co-occurring mental health challenges that present as barriers to self-managing their chronic illness.

The following should be considered when implementing a group consultation:

- A population health perspective should be utilized, focusing on those members most in need of support to improve functioning and self-management of their chronic illness.
- A referral from the member's PCP or someone on the PCP's care team; self-referral from a member may be considered
- Priority should be given to members with symptom-severity and/or complex medication regimens.
- A pre/post assessment of symptoms to determine efficacy of the intervention(s)
- For reimbursement, if a member has both an individual and group consultation on the same day, only one claim will be reimbursed.

- All group participants must have a mental health diagnosis and must be facilitated by a licensed behavioral health consultant (i.e., LCSW, LPC, LMFT, PhD, PsyD). If there is not a mental health diagnosis, the ICD diagnostic code R69 AND a relevant Z code should be used. Allowable Z codes can be found in the CBH Provider Bulletin 19-18.
- Group participation should not exceed more than 12 patients, including CBH members.
- Documentation of the group consultation in the member's Electronic Health Record

6.3. Clinical Documentation

The primary purpose of documenting care is to facilitate interprofessional communication and support team treatment planning. In primary care, the Subjective-Objective Assessment Plan (SOAP) note format is the standard way of documenting care. To align with this, the BHC will document using the same format. The BHC will document in the primary care record all interventions and services delivered to members, demonstrating a patient-centered approach and recovery principles such as individual empowerment, utilization of evidence-based interventions, and integration of services.

The PCP is the main beneficiary of the BHC note. Given the fast pace of primary care, it is recommended that the BHC use short sentences, bullet points, and check boxes in the SOAP note utilizing language that minimizes psychological jargon, avoids stigmatization or blame, and is understandable for both members of a multidisciplinary primary care team and members themselves.

The SOAP note should provide an analysis that includes an adherence to strengths-based principles of change and recovery, including efforts toward motivation and building resiliency, and their connection to the medical challenge needing to be addressed. The treatment plan, documented in the "P" section of the SOAP note should also adhere to this. The required components of a BHC SOAP note can be found in HFP's Philadelphia Integrated Care Network Manual. Also, CBH has published General Documentation Guidelines which can be found in section 5.18 of the **CBH Provider Manual**.

6.4. Treatment Planning

HFP has developed procedures and policies for treatment planning that can also be found in its manual. Elements of a comprehensive treatment plan include:

1. Activity that indicates integration of physical and behavioral health targets
2. Specific change goals that reflect the members stage, readiness, and commitment to making the needed change
3. Measurable interventions that move the member along the continuum of change
4. Acknowledgement of barriers that may impede behavior change
5. Recommendation for what the PCP can do collaboratively to support the plan
6. An appropriate follow-up plan to be implemented at the member's next PCP visit or scheduled consultation with the BHC
7. Coordinate with social work/case management to link the member to specific supportive resources.

8. If referred to specialty mental health or substance use treatment, the name of the provider agency and appointment date will be documented in the plan.

6.5. Documentation of Group Consultation

The format for a group consultation note has elements of a SOAP note. Needed in each member's documentation is:

- Subjective – stating what the topic was for the consultation and what happened during the consultation
- Assessment – explaining specifics about the patient (how they presented and engaged and any specifics they offered during the consultation)
- Objective – measurable information, including screener results (PHQ9, GAD7, suicidal/homicidal ideation, substance use); observable behavior, including affect, appearance, and orientation; list of psychotropic medications, if any, and if there is adherence
- Plan – indicating next steps, when the member plans to return, and any assignments given in between group consultations

6.6. Medication Management

A PCP or Psychiatric Mental Health Nurse Practitioner (PMHNP) may prescribe a prescription for psych medication. If a member does not improve under their care, or additional guidance for prescribing medication would be helpful, a clinical pharmacist or psychiatrist may be consulted.

HFP has developed procedures and policies for prescribing in the FQHC environment. They can be found in the Philadelphia Integrated Care Network Manual. Treatment guidelines can be found in the Clinical Guidelines section of the CBH Provider Manual.

6.7. Medication-Assisted Treatment (MAT)

If MAT is offered, the BHC, as part of the FQHC's integrated care team, is expected to support a member receiving treatment through the medication initiation and treatment process.

7. PERFORMANCE INDICATORS

FQHCs should have policies and procedures to evaluate outcomes for the behavioral health consultation model. In addition to Uniform Data System (UDS) measures required by HRSA and Health Care Effectiveness and Data Information Set (HEDIS) measures, other recommended indicator for consideration include:

- Member satisfaction with the PCBH model
- Follow-up screening after transition to community-based behavioral health
- Abstinence from tobacco product use
- Depression and anxiety screenings