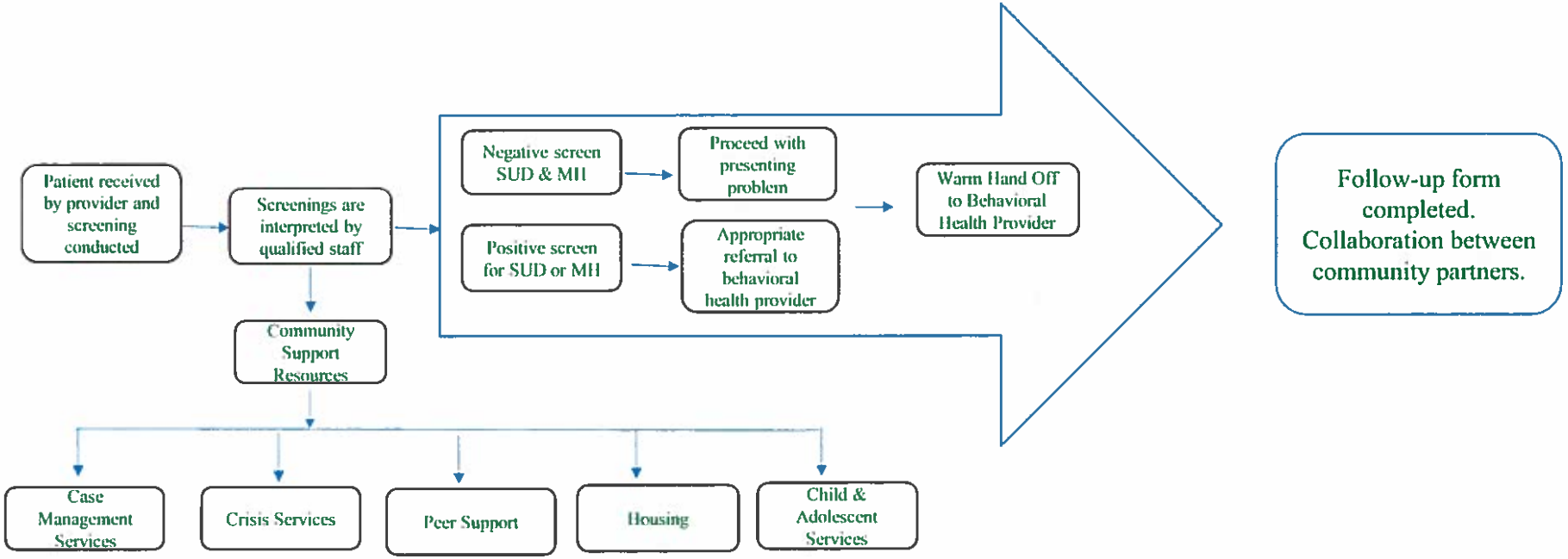
MID-SHORE WARM HAND-OFF RESOURCE GUIDE

MID SHORE
BEHAVIORAL HEALTH
RESOURCES, GUIDANCE, WHOLENESS, & HOPE

FLOW CHART

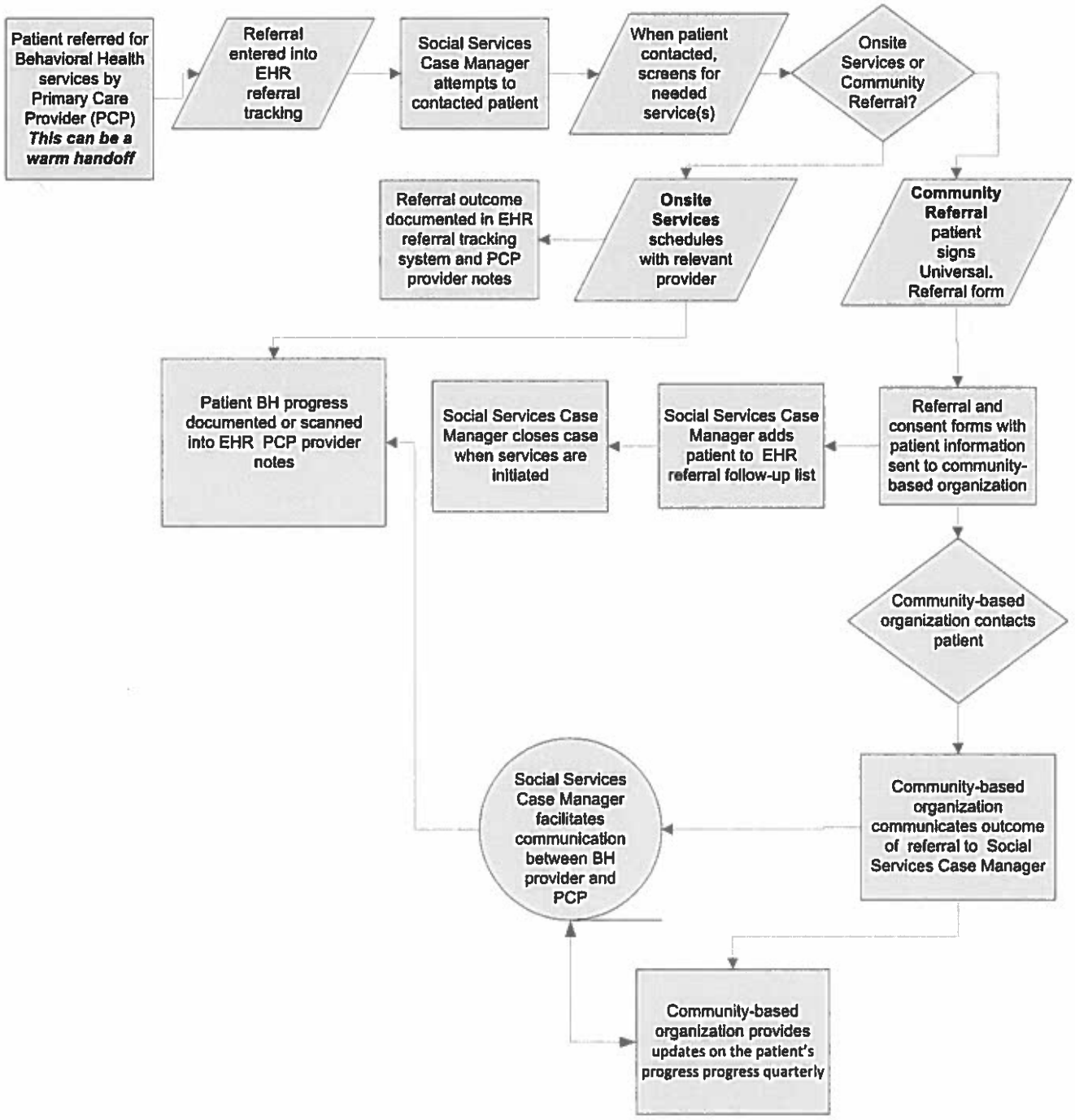
Warm Hand Off Flow Chart



Florida Department of Health In Sarasota County

Community Health Centers of Sarasota County

BEHAVIORAL HEALTH REFERRAL FLOWCHART



EXAMPLE MOU

MEMO OF UNDERSTANDING/SCOPE OF SERVICES
University of Wisconsin Department of Family Medicine, and the Wisconsin Medical Society
Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL)
Contract Year 5: September 15, 2010 - May 14, 2011

I. Agreement Purpose:
To enable the Wisconsin Department of Health Services (DHS), the University of Wisconsin Department of Family Medicine (UW-DFM), and the Wisconsin Medical Society (the Society) to implement the five year federal Substance Abuse and Mental Health Services Administration (SAMHSA) Screening, Brief Intervention and Referral to Treatment (SBIRT) Grant.

The Society is entering into this agreement with **(Site)** to pay for patient services, provision of a Health Educator for screening, brief intervention and referral to treatment activities, and to manage **(site)** fiscal resources to support these activities in contract year five. The continued funding for program contract year five (September 15, 2010 to May 14, 2011) is contingent upon satisfactory performance of grant requirements and state and federal approval.

II. Primary Objectives of SBIRT Grant:
The DHS, the UW-DFM, and the Society will collaborate throughout the grant, and will work with **(site)** and with SAMHSA, under terms of the cooperative agreement Notice of Grant Award and the Wisconsin SBIRT/WIPHL grant proposal.

A. Purpose, Goals, and Major Objectives - Statewide:
The purpose of the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) is to improve the health of the people of Wisconsin by reducing drug use and at-risk, problem, and dependent alcohol use. The goal of this project is to sustainably enhance delivery of SBIRT services to all Wisconsin residents.

Major objectives of WIPHL statewide over the five years are:
1) WIPHL will assemble the organizational infrastructure to support SBIRT implementation, ongoing improvement, evaluation, and policy change.

2) Clinical staff at **(site)** will demonstrate knowledge and competence to administer the brief substance abuse screening, using prompts by telephone or written questionnaire.

3) Health Educators will demonstrate knowledge and competence to deliver computer-prompted, protocol-driven, culturally competent, standardized SBIRT services. The delivery of Health Education services will be based on the principles of motivational interviewing.

4) WIPHL will implement substance abuse brief screening and SBIRT services at primary care, emergency care, and inpatient medical settings (represented in this document by "**(site)**") in urban, suburban, and rural Wisconsin for the following numbers of individuals statewide within five years:

- Brief Screening 88,425
- Screening 21,372
- Referral to Treatment 1,111
- Brief Treatment 1,304
- Brief Intervention 18,957

5) WIPHL will finance conventional, specialty-based substance abuse treatment for up to 1,111 patients (statewide) who are referred by WIPHL Health Educators from general medical settings.

6) **(Site)**, the WIPHL Health Educator group, and the WIPHL Cultural Competence Steering Committee will participate in efforts to continually improve SBIRT service delivery.

7) Patients who receive referral to treatment, brief treatment, and brief intervention services will manifest a 25% decrease in days of risky alcohol use or illicit drug use.

8) WIPHL will generate policy-relevant data on penetration, volume, and effectiveness of SBIRT services.

9) WIPHL will elicit commitment from major private and public health care providers and financers to systematically provide SBIRT services to its patients and subscribers by 2011.

10) WIPHL will develop, maintain, and continually improve systems that will dependably and sustainably deliver culturally competent SBIRT services.

11) WIPHL will support **(site)** in delivery of services at a sufficient volume, and with sufficiently documented quality, that payers will reimburse for clinical service provision when such reimbursement is available.

III. Expected Outcomes:

A. Clinical Site:

1) Institutional Arrangements - The clinical site will work within their organization and with the WIPHL Coordinating Center to establish institutional arrangements prior to the launch or delivery of services for this contract period.

a) **(Site)** will work with WIPHL staff to ensure that Business Associate Agreements are in place for the duration of the project with the clinical site and the UW-DFM, and the clinical site and Symphony Corporation. If the clinical site or umbrella organization elects to have translation resources provided through the grant, a Business Associate Agreement must be in place with Pacific Interpreters, the clinical site using the translation resources, and the UW-DFM.

b) **(Site)** will work with WIPHL staff to ensure that a signed Memorandum of Understanding (MOU) has been returned to the WIPHL Coordinating Center.

c) If required, **(site)** will apply to the appropriate Institutional Review Board (IRB) for exempt status as needed. The UW Health Sciences IRB has declared this project exempt from IRB oversight, because it is a service project and does not fit the federal definition of research. The IRB number is M-2007-1011 issued in the name of D. Paul Moberg for the University of Wisconsin Population Health.

d) **(Site)** will provide private office space, office equipment, materials, supplies, high speed internet access, and a cell phone/private phone line required by the Health Educator to provide confidential substance abuse screening, brief intervention and referral services.

e) **(Site)** will provide medical and other appropriate liability insurance for the Health Educator.

f) **(Site)** will work with WIPHL through WIPHL's IS staff to assure network compatibility and appropriate security between the WIPHL tablet and the clinical site. Health Educators will have access to high speed internet connections and comply with practices to regularly transfer data from the tablets to the central server as instructed by WIPHL staff.

g) **(Site)** will work with WIPHL staff in efforts focused on quality improvement for the clinical site's SBIRT services, as needed.

2) Evidence-Based Service Delivery - Clinical site will continue providing screening, brief interventions and referral to treatment to individuals throughout the grant year.

a) Each month, **(site)** will aim to administer WIPHL brief screens to all eligible patients (as defined by mutual agreement between WIPHL and the clinical site). A minimum quality assurance goal is to administer the brief screen to 75% of eligible patients.

b) Each month, the Health Educator will aim to conduct full screens and provide additional brief intervention, extended intervention or referral services, as indicated, to at least 75% of patients with positive WIPHL brief alcohol and drug screens. This percentage is based on the number of patients with a positive brief screen who are seen by the Health Educator for a full screen.

FORMULA:

$$\frac{100 * \text{\# of patients seen for full screen after positive brief screen}}{\text{Total number of patients with positive brief screens}}$$

c) 75% of services must be delivered face-to-face or telemedicine, rather than via telephone.

d) The minimum service delivery targets, beginning **September 15, 2010 through May 14, 2011**, for all clinical sites receiving funding for 1.0 FTE for Health Educator staffing for this period are as follows. The Health Educator is expected to deliver 180 full screens* in the first quarter (September 15, 2010 - December 14, 2010) and second quarter (December 15, 2010 - March 14, 2011) of the contract year. From March 15, 2011 - May 14, 2011, the Health Educator is expected to deliver 120* full screens.

WIPHL will allow for slight variations from monthly and quarterly targets as long as each clinical site with a full time, full contract year Health Educator delivers SBIRT full screens to a minimum of 480** patients in contract year 5.

*Targets are proportional to the Health Educator FTE funded by WIPHL. For clinical sites with .50 FTE funding, the targets for service delivery are ½ of the service delivery target.

** All completed full screens will count towards this deliverable regardless of a previous positive brief screen.

3) Site Operations/Quality Improvement:

a) The **(site)** Health Educator will participate in weekly conference calls, monthly check-in calls, retreat attendance, and continuing education with the WIPHL Site Operations Team.

b) The **(site)** Health Educator will participate in individual telephone calls with the WIPHL Associate Director of Cultural Competence once per quarter.

c) The **(site)** Health Educator will submit plans by October 14, 2010, to complete a cultural competence immersion process with a clinic patient population that they are not familiar with, using the Cultural Competence in Process and Practice (Part III-Workbook Framework) or The California Brief Multicultural Competence Scale (CBMCS) Modules. The WIPHL Associate Director of Cultural Competence will provide technical assistance for this process.

d) Each month, the **(site)** Health Educator will submit, for review by the WIPHL Senior Manager of Site Operations or her designee, an audiotape of a session with a patient and collaborate on strategies to improve services to patients. Those Health Educators who

repeatedly demonstrate a high level of competence will be asked to submit tapes less frequently per the Site Operations Team.

e) **(Site)'s** Health Educator will synchronize his/her tablet every day that the Health Educator delivers SBIRT services.

f) **(Site)'s** Health Educator will have no more than 3 unexcused absences from scheduled weekly conference calls. Excused absences can only be arranged before each call. Absences will only be excused if the Health Educator is not working that day or in the event of unforeseen circumstances.

g) **(Site)'s** SBIRT team will work with the WIPHL Site Operations Team to conduct QI efforts and Plan-Do-Study-Act (PDSA) cycles that the **(site)** SBIRT team can use to address service delivery objectives as needed when targets are not being met.

h) A key administrator or manager from **(site)** will attend the designated day of the fall semi-annual statewide project meeting and one teleconference. Up to a total of four administrators and other key site SBIRT staff may attend the final statewide meeting in April 2011; attendance is encouraged but not required. Travel may be required the evening before the meeting is to take place, in which case WIPHL will fully reimburse travel expenses. The meetings for 2010/2011 contract year are:
   - October 1, 2010 in Green Lake
   - February 11, 2011 two hour teleconference, 12:00pm - 2:00pm
   - April 7, 2011 in Madison

i) **(Site)'s** Health Educator will attend each quarterly retreat and semi-annual statewide project meetings in their entirety. The meetings required for 2010/2011 contract year are:
   - September 30 - October 1, 2010 in Green Lake
   - February 9, 2011 in Madison
   - February 11, 2011 two hour teleconference, 12:00pm - 2:00pm
   - April 5 - 6, 2011 in Madison

j) **(Site)** will work with the Associate Director of Cultural Competence to address any disparities in processes or outcomes of care that may arise among cultural or demographic groups participating in WIPHL.

k) **(Site)'s** Health Educator will invite all patients with a social security number that ends with 30-39 to participate in a 6-month follow-up for quality improvement and evaluation purposes, as required by SAMHSA. The Health Educator will obtain written consent from all patients who agree to be contacted for follow-up. Health Educators who fail to get consent from all eligible subjects will be required to work with the Site Operations Team and the Evaluation Team on processes that will assure 100% compliance.

4) **Sustainability Efforts:**

a) **(Site)** will submit to WIPHL a quarterly worksheet, to be provided by WIPHL, summarizing revenue generated from billing for SBIRT services and costs of SBIRT service delivery and barriers to enhancing revenue generation as necessary for sustaining SBIRT services after the termination of grant funding. This worksheet will be due at the end of each quarter.

5) **Reporting:**

a) Each month, the **(site)** Health Educator will accurately complete discharge documentation on all cases according to posted/published policies about discharge procedures.

b) Each month, with the assistance of clinical staff, the **(site)** Health Educator will report the number of patients who are eligible to participate in WIPHL brief screening, the number of patients who refused brief screening, the number of patients who refused full screening, and the number of patients who are seen face-to-face. These numbers will be reported on a WIPHL-generated, month specific worksheet. The worksheet will be

completed and returned via email to the Site Operations Team by noon on the first business day after the 14th of each month.

c) **(Site)** will work with WIPHL staff to document changes in WIPHL implementation plans as requested.

d) **(Site)** will provide information as necessary to assist their umbrella organization and the WIPHL Coordinating Center in complying with DHS reporting requirements.

B. WIPHL Project Staff:

1) Will work with **(site)** to recruit and hire the Health Educator and provide clinical supervision to the Health Educator. The WIPHL Coordinating Center will provide feedback to the clinical site on Health Educator performance and collaborate on any HR issues that may arise.

2) Will train the Health Educator in WIPHL protocols prior to providing services.

3) Will provide a tablet computer to the Health Educator with pre-programmed software necessary for delivering WIPHL services. The tablet computer will remain the property of WIPHL.

4) Will work with **(site)** to assure the Health Educator receives appropriate training on WIPHL protocols, best practices and WIPHL Health Educator responsibilities.

5) Will provide opportunities through weekly Health Educator meetings, continuing education/quarterly retreats, technical assistance clinical site visits as needed and semi-annual meetings for ongoing learning and quality improvement.

6) Will provide policy updates through www.wiphl.com, the WIPHL Word electronic newsletter, project listservs, and other forms of written and verbal communication.

7) Will provide a translation line with a WIPHL code for the Health Educator to use with patients who are non-English speaking.

8) Will provide treatment liaison services and necessary sponsorship to assist patients in navigating treatment systems.

9) Will work with **(site)** to develop and implement quality improvement plans and to monitor planned changes, as needed to assist and assure Health Educator and **(site)** achieve efficiency targets, clinical site screening volume, intervention targets, cultural competence and protocol requirements for **(site)**.

C. The Society:

1) Compensation:

The Society will reimburse **(site)** for Health Educator salary and benefits, not to exceed $40,000 for the contract period (September 15, 2010 through May 14, 2011) for 1.0 FTE. Contingent on **(site)'s** full participation in key WIPHL activities and completion of obligations as listed in Section III.A., the Society will also provide **(site)** with up to $3,335 for administrative activities, space, and/or general support, as **(site)** deems appropriate. Of this amount, $1,250 will be distributed after each quarter (prorated to $835 for March 15 - May 14, 2011) provided the obligations listed in Section III are met in their entirety by **(site)**.

IV. Non-compliance, Corrective Action, and Termination of Agreement:

A. **Compliance/Non-compliance:**
WIPHL will provide each clinical site with monthly progress reports about their implementation, service delivery, QI efforts and sustainability benchmarks in comparison with expectations as outlined in Section III. If quarterly service deliverables are not met, the areas of non-compliance will be identified and **(site)** will work in collaboration with the WIPHL Site Operations Team and DHS on a corrective action plan that outlines concrete and specific actions and benchmarks that must be met. If demonstrable progress is not made toward achieving service delivery goals and sustainability benchmarks, a 30 day notice will be issued and funding will be terminated.

B. **Termination:**
This agreement may be terminated:
1) At any time by mutual agreement of the Society, WIPHL Program and **(site).**
2) Immediately by the Society or **(site)** for just cause.
3) By the Society or **(site)** with 30 days notice.

V. Signatures:

Signature Date	Signature Date
Print Name	Print Name
Wisconsin Medical Society	**(Clinical Site, Location)**

MEMO OF UNDERSTANDING
BETWEEN
AGENCY 1
AND
THE AGENCY 2

The AGENCY 2 and Agency 1 intend by this agreement to set forth the mutual goals, objectives, and scope of the integrated health project. The parties agree as follows:

I. DEFINITIONS

Agency 2: The Community Mental Health Services Provider, a program operated under contract with the (Insert State Name) Department of Community Health.
Serious and Persistently Mentally Ill (SPMI): State term for Medicaid and indigent recipients who meet established criteria that entitles them to public mental health services.

II. MUTUAL GOALS AND OBJECTIVES

1. Identify public mental health consumers who are Agency 1 patients and who might be appropriate to use Agency 1 as their "medical home".
2. Improve the overall health of consumers involved in the project.
3. Enhance Agency 1 service capacity by having on-site substance abuse and mental health screening and regular ongoing therapy services located at the primary clinic.
4. Enhance Agency 1 service capacity via ready access to adult psychiatric consultation for the public SPMI patient.

III. IDENTIFIED PARTNERS

Identified partners in this project include the following:

- AGENCY 2, providing funding and project oversight;
- Agency 1, a primary healthcare provider for vulnerable citizens.

IV. TARGET POPULATION

The target population will be public mental health consumers who are already patients at Agency 1, as well as other vulnerable patients with mental health or substance abuse issues served by Agency 1 who are not currently consumers of public mental health services.

The number of public mental health consumers served at Agency 1 is unknown at this time, but is expected to be at least fifty (50).

V. EXPECTED OUTCOMES, MEASURES, AND BENEFITS

1. Demonstration of an effective public-private as evidenced by:

- Improved health care for the mutual consumer/patient as a result of one integrated team communicating regularly about patient care, and a medical home for the consumer/patient;
- Enhanced services for vulnerable populations at Agency 1;
- Expansion of Agency 1 on-site services for vulnerable populations.

2. A blueprint for integrated treatment in (insert State Name).

3. Specific clinical outcomes to be determined, but may include:
    - Increased ability by primary care staff to manage mental health and substance abuse disorders in a primary health care setting;
    - Prevention of medical and psychiatric deterioration via early identification and direct, on-site treatment of at-risk consumers and families;
    - Improved health by increasing medication adherence via psychosocial interventions;
    - Reduction in poverty-related destabilizing events, such as eviction prevention.

4. Agreement indicator
    - The identification of common consumers/patients and the inclusion of those individuals in the project to determine if Agency 1 could become their medical home. This presumes that the staffing provided by AGENCY 2 would remain in place.

Review: A regular review by all stakeholders shall occur regarding the progress of the project.

VI. FINANCING PLAN

Funding: AGENCY 2 shall provide funds for mental health staffing as agreed between the parties with the goal that the project will be sustainable over time.

Staffing: Mental health staff located at Agency 1 shall be CMHC employees

Billing: CMHC will bill and collect for mental health services provided by the CMHC employees located at Agency 1. Billable services and capitation offsets will apply towards AGENCY 2 costs.

Annual Report: AGENCY 2 will prepare an annual report, which will be shared with Agency 1. It is the hope and expectation that results will support a continuing partnership.

VII. POLICIES AND PROCEDURES

Agency 1 agrees to follow those polices, procedures, and administrative directives or other documents as specified by the AGENCY 2. During the term of this Agreement, AGENCY 2 shall advise Agency 1 of any applicable modifications to the Mental Health

Code or any changes in the AGENCY 2 Policies and Procedures or the MDCH Administrative Rules promulgated according to the (Insert State Name) which have a bearing on this Agreement or Agency 1. Agency 1 shall expressly acknowledge receipt of any such changes.

VIII. HIPAA COMPLIANCE AND CONFIDENTIALITY

HIPAA Compliance: Agency 1 shall be in compliance with all applicable aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Administrative Simplification Section, Title II, Subtitle F, regarding standards for privacy and security of PHI (protected health information) as outlined in the Act.

Agency 1 Requirements. Agency 1, as a business associate of AGENCY 2, must agree to appropriately safeguard any protected health information received from, or created or received by the Agency 1 on behalf of AGENCY 2 in accordance with AGENCY 2 policies and applicable state and federal laws.

A. Appropriate Uses and Disclosures of PHI. Agency 1 may use or disclosure such information:
   - for the proper management and administration of its business;
   - for purposes of treatment, payment (if allowed by law), or healthcare operations;
   - for the purpose of providing data aggregation services relating to the health care operations of AGENCY 2 ("data aggregation" means combining protected health information created or received by the provider to permit data analyses that relate to the health care operations of a covered entity); or
   - for purposes set forth in AGENCY 2 policies or required by law.

Agency 1 will not use or further disclose the information other than as permitted or required by this Agreement, or as required by law. Any other use or disclosure of protected health information must be made pursuant to a properly executed Release of Information.

B. Subcontractors. Agency 1 will ensure that any agents, including any subcontractors, to whom it provides protected health information received from, or created or received by Agency 1 on behalf of AGENCY 2 agrees to the same restrictions and conditions that apply to Agency 1 with respect to such information.

C. Consumer Requests to Review Record. Since AGENCY 2 is the holder of the mental health record for public mental health consumers, AGENCY 2 will respond to any consumer request to review such records. Agency 1 should notify AGENCY 2 immediately of the receipt of any such request.

D. Cooperation with the Secretary of Health and Human Services. Agency 1 will make its internal practices, books, and records relating to the use and disclosures of protected health information received from, or created or received by Agency 1 on behalf of AGENCY 2 available to the Secretary of Health and Human Services, or its designee,

for the purpose of determining AGENCY 2's compliance with the Health Insurance Portability and Accountability Act of 1996.

E. Agreement Termination. At termination of this Agreement, Agency 1 will return all protected health information received from, or created or received by Agency 1 on behalf of AGENCY 2 that Agency 1 still maintains in any form, and will retain no copies of such information. If such return is not feasible, Agency 1 must extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. Breaches of Confidentiality. If Agency 1 becomes aware of a material breach or any violation of its obligation to protect the confidentiality and security of consumers' protected health information, Agency 1 must immediately take reasonable steps to cure the breach or end the violation, and must report the breach or violation to the AGENCY 2 Privacy Officer. The alleged breach or violation will be investigated and an appropriate sanction issued. AGENCY 2 reserves the right to terminate this Agreement if it determines that the Agency 1 has violated a material term of the Agreement.

G. Additional Confidentiality Requirements: Agency 1 acknowledges that consumers of public mental health services are entitled to additional confidentiality protections awarded under the (Insert State Name) Mental Health Code, which may supercede the confidentiality protections provided by HIPAA. Furthermore, consumers of substance abuse treatment services are entitled to additional confidentiality protections awarded under 42 CFR, Part 2, which may supercede the confidentiality protections provided by HIPAA. When serving public mental health consumers or when providing substance abuse treatment services at its site, Agency 1 will comply with the confidentiality requirements of these and any other applicable state or federal laws, rules, or regulations.

IX. STAFF SUPERVISION

Agency 1 will participate in the oversight and supervision of CMHC staff working on site at Agency 1.

X. NOTICE

Any notice substantially affecting the terms or conditions of this Agreement shall be directed to:

AGENCY 2: Executive Director
Insert Address

PACKARD CLINIC: Executive Director
Insert Address

XI. INDEMNIFICATION

The parties shall protect, defend, and indemnify one another, one another's Board members, officers, agents, volunteers, and employees from any and all liabilities,

claims, liens, demands, costs, and judgments, including court costs, costs of administrative proceedings, and attorney's fees, which arise out of the occupancy, use, service, operations, performance or nonperformance of work, or failure to comply with federal, state, or local laws, ordinances, codes, rules and regulations, or court or administrative decisions, negligent acts, intentional wrongdoing, or omissions by either party, its officers, employees, agents, representatives, or subcontractors in connection with this Agreement. Nothing herein shall be construed as a waiver of any public or governmental immunity granted to AGENCY 2 and/or any representative of AGENCY 2 as provided in statute or court decisions.

XII. TERMINATION

Termination Without Cause. Either party may terminate this agreement by giving thirty (30) days written notice to the other party.

Termination Effective Immediately Upon Delivery of Notice. The above notwithstanding, either party may immediately terminate this agreement if upon reasonable investigation it concludes:

1. That the other party's Board of Directors, Director/CEO, or other officer or employee has engaged in malfeasance;
2. That the other party lost its state licensing (if applicable);
3. That the other party lost its eligibility to receive federal funds;
4. That the other party cannot maintain fiscal solvency.

XIII. AUTHORITY TO SIGN

The persons signing below certify by their signatures that they are authorized to sign this Agreement on behalf of the party they represent, and that this Agreement has been authorized by said party.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written below.

Agency 2 AGENCY 1

_____

_____

Date

Date

Executive Director Executive Director

EXAMPLE REFERRAL FORMS

BEHAVIORAL HEALTH AGENCY REQUEST FOR INFORMATION

Date: _____ MID: _____

Patient's name: _____ DOB: _____

This patient is currently receiving Behavioral Health Services at our agency and identifies you/your practice _____ as being their primary care provider.

☐ ***If this patient is no longer receiving services in your practice, please check this box and fax back to our agency.***

Requesting Agency name: _____

Address: _____

_____

Phone: _____ Fax: _____ Email: _____

Please fax the following Medical Information to:

_____ **Fax number:** _____

(Name of Contact)

- ☐ Most Recent Physical Exam
- ☐ Medical Diagnosis(es)
- ☐ Medication list
- ☐ Recent lab work
- ☐ Pain Agreement (if applicable)
- ☐ Other _____

Once we have confirmation that the above-named individual is your patient, we will share the following Behavioral Health Information.

- ☐ Diagnosis(es): Axis I and Axis II
- ☐ Current Clinical Issues
- ☐ Medication List
- ☐ Recent Lab work
- ☐ Pain Agreement (if applicable)
- ☐ Other _____

Thank you,

_____

Name of requesting provider/ credentials (Psychiatrist, Physician Assistant, Nurse Practitioner, PhD, LCSW, LPC, etc.)

Developed by: Community Care of North Carolina

REFERRAL TO BEHAVIORAL HEALTH SERVICES **SECTION I**

Date: _____ MID _____

Patient's name: _____ DOB: _____ Phone: _____
County: _____
Payer Source: ___Medicaid ___Medicare ___Health Choice ___Private ___Self Pay
Legal Guardian: _____ Phone: _____

This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment from you/your agency

Referring Primary Care Provider's Name: _____

Practice Name: _____
Address: _____

Phone: _____ Fax: _____ Email: _____

Carolina Access Referral NPI # (if applicable) _____

Referral Request

Specific concerns/requests/recommendations:

The following patient information is attached:

- ☐ Medical Diagnosis(es)
- ☐ Most Recent History and Physical
- ☐ Current Medication List
- ☐ Recent Lab work
- ☐ Pain Agreement (if applicable)
- ☐ Other _____

Signature: _____
(Physician/Physician Assistant/Nurse Practitioner)

Thank you for agreeing to evaluate this patient.

***** Please fax Section II to the Primary Care Provider listed above. *****

Developed by: Community Care of North Carolina

BEHAVIORAL HEALTH FEEDBACK TO PRIMARY CARE SECTION II

Referral back to Primary Care Provider/Practice: _____

Date: _____ MID: _____

Patient's name: _____ DOB: _____

Behavioral Health Agency: _____ Name of Contact: _____

Phone: _____ Fax: _____ Email: _____

Mark all that apply

- ☐ Patient did not schedule an appointment.
- ☐ Patient did not keep the scheduled appointment on _____
- ☐ Patient kept appointment on _____
- ☐ Behavioral Health Assessment was completed on _____
- ☐ Patient was seen, but refuses to give consent for sharing information at this time.
- ☐ Other: _____

Initial Diagnosis(es)/ Diagnostic Impression: (Axis I/ Axis II):

- ☐ Medications were prescribed by _____ and list is attached.
- ☐ Labs ordered _____
- ☐ Other information/documents attached _____

Follow up plan:

Patient:

- ☐ Declined behavioral health services.
- ☐ Was referred to another agency.

Agency name: _____ Phone: _____

- ☐ Agrees to continue behavioral health services with our agency.

Date of next appointment: _____ Type of Service _____

- ☐ Medications to be managed by our agency.
- ☐ Medications to be managed by another provider.

Provider name: _____ Phone: _____

- ☐ Pain Agreement is recommended.
- ☐ Other:

Clinician completing this assessment: _____

Thank you for the opportunity to assess this patient

Developed by: Community Care of North Carolina

Referral Form between Primary Care Physician Office and Behavioral Health Provider

Name of person being referred_____

Contact Information for person being referred_____

_____

Name of referring source_____

Contact information of referring source_____

Presenting Complaint_____

_____

_____

_____

_____

Screening Tool used and the results_____

_____

_____

_____

_____

_____

Current diagnosis_____

_____

_____

_____

Status of referral:

Apt needs to be scheduled
Apt was scheduled, list the date _____
Follow up requested, please respond by date _____

EXAMPLE RELEASE OF INFORMATION

Appendix B: Blue Shield Consent Form

Blue Shield Transition Pilot

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

THE FOLLOWING ORGANIZATIONS ARE AUTHORIZED TO RELEASE and/or RECEIVE INFORMATON:

☐ UCSD/Gifford Clinic ☐ Council of Community Clinics	☐ Family Health Centers of San Diego ☐ La Maestra Community Health Center ☐ San Diego Family Care

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☐ Most recent Behavioral Health Assessment or most recent Behavioral Health Update
☐ Psychiatric assessment
☐ Information about medication regime over the last six months, history of keeping appointments, stability over the last six months, current living arrangement and insurance status

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax: I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulafons section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

VALIDATE IDENTIFICATION

SIGNATURE OF STAFF PERSON:	DATE:

Mid-Shore Mental Health Systems, Inc.

Authorization for Release of Confidential Information

Please fax requested materials to 410-770-4809

Name: _____ **Date of Birth:** _____

Address: _____

Release of Information

I hereby authorize: □ _____ or □ Mid-Shore Mental Health System, Inc.

_____ and

_____ _____

To release health information, including psychiatric and substance abuse records, from the medical records of the above-named person for the following purpose: clarify diagnosis, formulate a treatment plan and aftercare.

Release information to:

□ Mid-Shore Mental Health System, Inc. or □ _____

and _____

_____ _____

For treatment date(s): _____ or □ Any/all previous treatment dates at your facility

Type of information requested:

□ Discharge Summary □ Social Work Summary □ Day Treatment Records □ Lab reports

□ Admission Summary □ Drug Treatment □ Medication History □IEP

□ Psychological testing □ Other_____

This authorization will expire one year from the date signed below unless specific expiration date or condition is named here: _____. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for Release of Confidential Information and authorizing the disclosure is voluntary. I understand I may inspect the information to be used or disclosed, as provided in CFR 186.524.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been take in reliance upon it. I acknowledge that the material authorized for release may contain, alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts. 160 and 164. This entity is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Confidential Information."

Date_____ Signature_____

Date_____ Witness_____

The Bay Pediatric Center

606 Dutchmans Lane
Easton, MD 21601

410-763-8272
(Fax) 410-763-6014

Authorization to Obtain Protected Health Information

_____ _____
Patient Last Name, First Name, MI DOB:

As the Parent/Guardian of the above child, I hereby authorize the school and BHIPP counselor to share information as it relates to my child's well being. I am voluntarily signing this authorization which will expire in 90 days. I also authorize that a photocopy of this request shall be considered as valid as the original.

Date: _____ Signature: _____

Printed Name of Parent/Guardian: _____

Date: _____ Signature of Witness: _____

BEHAVIORAL HEALTH RESOURCES

Transportation

- Transportation Links

https://www.dcsdct.org/transportation--mobility.html

https://www.dcsdct.org/uploads/2/5/0/4/25044487/finalmustschedulenov2014.pdf

- Local Transportation

MUST 866-330-6878
Delmarva Community Transit 410-221-1910
Dorchester County 410-479-3867
Caroline County 410-778-5187
Kent County 410-822-4155
Talbot County 1-866-645-7111
Queen Anne's County, County Ride 410-758-2357
Shore Transit 443-260-2300
MD Relay #711
MTA Commuter Bus 800-543-9809
Annapolis Transit 410-269-0674
Key Lime Taxi of Elkton, Chestertown, Easton
https://www.elktontaxi.com/mobile/taxi_cabs.html

**CALL A TRAVEL TRAINER OR ONE STOP NEAR YOU Toll Free 1-866-645-7111, Dorchester 410-221-1910, Talbot 410-822-4155, Caroline 410-479-3867, Kent 410-778-5187, Spanish 1-410-490-1696

**24 hour notice for door to door service for the elderly and disabled population

**Deviated Routes can drive ¾ mile outside of designated route with a 2 hour notice.

- Eligibility Determination:

To determine if you are eligible for the Medical Assistance (MA) Transportation Program, you must answer "YES" to each of the following questions:

Do you have a current (Red & White Medicaid card) Medicaid number? Do you require transportation to your medical appointments? Is this your only source of transportation? Have you completed an application?

- Points of Contact for Transportation in Each County

Talbot County contracts with DCT:
https://healthytalbot.org/resources/medical-assistance-transportation-health-department/
Caroline County MA Transportation
https://www.carolinehd.org/ma-transportation
Kent County MA Transportation
http://kenthd.org/adult-health/medical-assistance-transportation/
QAC MA Transportation
https://health.maryland.gov/qahealth/community-health/Pages/Medical_Transportation_Services.aspx
Dorchester County MA Transportation
http://www.dorchesterhealth.org/index.php?page=medical-assistance-transportation

Resources for consumers released from detention

- Provide them a Pocket Resource Guide (found on MSBH website)
- Communication between the service provider (substance use/mental health/somatic) in the detention center and provider in the community. For example, if a client is at Caroline Detention and has Choptank as PCP, staff from the mental health program within the Detention could contact Choptank re care received inside and transitioning back home.
- Access the BHA list of Recovery Houses. https://bha.health.maryland.gov/pages/index.aspx
- SOAR as a resource for those who need income (Referral found on MSBH website).
- Forensic Case Manager (referral found on MSBH website)

Cultural Competence/Language barriers

- the National Center for Cultural Competency at Georgetown University Center for Child and Human Development is a great resource. https://nccc.georgetown.edu/
- Provide a training for front desk staff re cultural competency? At minimum, front desk can learn "Hello"
- Utilize Language Link.
- Agency literate/documents available in other languages. Display sign with various languages

Child and Adolescent School Based Services Points of Contact

- Caroline, Dr. Derek Simmons, Director of Student Services 410-479-3253 ext.111 simmons.derek@ccpsstaff.org
- Dorchester, Dr. James Bell, Supervisor of Student Services 410-228-4747 ext. 1066 bellj@dcpsmd.org
- Kent, Dr. Angela Holocker, Supervisor of Student Services 410-810-3170 aholocker@kent.k12.md.us
- Queen Anne's, Stirling Ward, Clinical Resource Specialist 410-758-2403 stirling.ward@qacps.org
- Talbot, Dr. Robert Schmidt, Mental Health Services Coordinator 410-822-0330 rschmidt@tcps.k12.md.us

Peer Support

- Chesapeake Voyagers, Inc.

Chesapeake Voyagers Inc. (CVI) is a Peer Support Wellness & Recovery Center which is a place where adults experiencing difficulty with mental health and/or addiction can connect with others who have similar life experiences, learn about wellness and recovery, receive one on one and group peer support and have fun – all for free! CVI serves residents in all five Mid-Shore counties at various locations. They offer a safe and comfortable environment where you can make friends who will become like family to you. They are open to EVERYONE! No referral, insurance or specific diagnosis is needed to attend. Stop by or call to learn more.
Main address: 342-C North Aurora St. Easton, MD 21601 and phone number 410-822-1601
Hours of Operation: Monday – Friday 11am – 6pm, Saturday 9am – 4pm
Website: www.chesapeakevoyagers.org
Payment Types Accepted: Free Services

- DRI-Dock Recovery and Wellness Center

The Dorchester Recovery Initiative (DRI), in conjunction with Chesapeake Voyagers, Inc., promotes personal recovery for all, no matter what path one takes to recovery. They also help to strengthen the recovery community and the services and structures that help folks get and stay in recovery worldwide! We are here for those seeking help for mental health, co-occurring, and addictions concerns.
Address: 206 Sunburst Highway Cambridge, MD 21613
Phone: 410-228-3230
Email: www.dri-dock.org
Hours of Operation: Monday – Friday 8am to 6pm
Payment Types Accepted: Free Services

- HALOS Support Group – Compass Regional Hospice

The HALOS (Healing After A Loved One's Suicide) Support Group is open to adults 18 and over. For more information, please contact Rhonda Knotts,443-262-4109, rknotts@compassregionalhospice.org, or Wayne Larrimore, 443-262-4108, .
Address: 255 Comet Drive Centreville, MD 21617
Phone: 443-262-4109 or 410-643-7674
Website: www.compassregionalhospice.org
Hours of Operation: 2nd Wednesday of each month, 6:30 PM to 8:30 PM
Payment Types Accepted: Free Services

- Maryland Coalition of Families

Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers, youth and other loved ones, we connect, support and empower Maryland's families. Our staff provide one-to-one support to parents and caregivers of young

people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue. To connect to MCF in your community, call 410-730-8267, press 1 or email referral@mdcoalition.org
Address: 9 S. Third Street Denton, MD 21629
Phone: 410-730-8267
Website: www.mdcoalition.org
Payment Types Accepted: Free Services

- Parents, Families, and Friends of Lesbian, Gay, and Transgender Communities (PFLAG) Chestertown & Mid-Shore

PFLAG promotes the health and well-being of lesbian, gay, bisexual, and transgender persons, their families and friends through: support, to cope with an adverse society; education, to enlighten an ill-informed public; and advocacy, to end discrimination and to secure equal civil rights. Parents, Families, and Friends of Lesbians and Gays provides opportunity for dialogue about sexual orientation and gender identity, and acts to create a society that is healthy and respectful of human diversity.
We are a national support, education, and advocacy organization for lesbian, gay, bisexual, and transgender (LGBT) people, their families, friends and allies. With 200,000 members and supporters, and local affiliates in more than 350 communities across the U.S. and abroad, PFLAG is the largest grassroots-based family organization of its kind. PFLAG is a non-profit organization and is not affiliated with any religious or political institutions. Case Management services are provided to assist participants in gaining access to needed
Address: 914 Gateway Drive Chestertown, MD 21620
Phone: 301-938-0868
Website: www.pflagchestertown.com
Hours of Operation: Meetings are the 1st and 3rd Thursdays of the month at 7:00PM, locations vary

- Recovery in Motion – Kent County Health Department

Address: 300 Scheeler Road Chestertown, MD 21620
Phone: 410-778-5895
Website: www.kenthd.org
Hours of Operation: Mon. and Fri. by appt., walk-ins Tues. and Thurs.
Payment Types Accepted: Free Services

Crisis Services

- Affiliated Santé Group

Eastern Shore Crisis Response Services: 408 Byrn Street Cambridge, MD 21613
Phone: 1-888-407-8018
Website: www.thesantegroup.org
Hours of Operation: 7 days a week, 9am to midnight
Payment Types Accepted: Grant Funds, Free Services Providers:
Affiliated Sante is the largest provider of crisis services in Maryland. Mobile Crisis Teams services are dispatched vi the Eastern Shore Operations Center (ESOC) 888-407-8018. Mobile Crisis teams operate 7 days a week 9am to midnight serving Cecil, Kent, Queen Anne, Talbot, Caroline, Dorchester, Wicomico, and Somerset Counties. ESOC operates 24/7 and serves all 9 counties on the Eastern Shore

SANTÉ

"Discover Your Options"

EASTERN SHORE CRISIS RESPONSE SERVICES (ESCRS)

1-888-407-8018

CRISIS RESPONSE & RESOURCE HELPLINE

Available 24/7/365

Serves all 9 counties of Eastern Shore

Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico & Worcester Counties

MOBILE CRISIS TEAMS

Available 9am to midnight 7/365

Teams serve Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, & Wicomico Counties

What is ESCRS able to do?

- Respond to calls from or regarding consumers who are experiencing an emergent or urgent behavioral health crisis – mental health, substance use, or co-occurring – assisting by phone or mobile crisis team
- Serve consumers across the lifespan; need parental consent for children and adolescents unless there is a safety issue
- Perform clinical assessments
- Triage calls
- Provide linkages to community resources
- Follow-up with consumer
- Main goal is to divert from emergency department and incarceration when possible

What is ESCRS not able to do?

- Transportation
- Medication
- Medical advice
- Legal advice
- "Clear" children and adolescents for return to school
- See children and adolescents without parental consent unless there is a safety issue
- Ongoing counseling

How can ESCRS assist?

- We can be *part* of crisis and/or well-being plans
- Ideas that could be included in clients' crisis and/or well-being plans *prior* to contacting ESCRS
    1. Natural supports
    2. Coping tools already identified in therapy
    3. Contact OMHC (office during hours OMHC is open; on-call number after hours)
    4. Contact ESCRS
- ESCRS would be the *last* option on the crisis and/or well-being plan continuum and would be contacted only after all other steps have been exhausted
- **Crisis plans should be prefaced with something like: If life threatening behavior is already occurring, i.e., suicide attempt in process, weapon engaged, etc., *call 911 immediately.***

1-888-407-8018

Rev 04/19/18

SCREENING TOOLS

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire" *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

 This instrument is designed for screening purposes only and is not to be used as a diagnostic tool

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med*. 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

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

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.

CAGE-AID - Overview

The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include alcohol and other drugs.

Clinical Utility

Potential advantage is to screen for alcohol and drug problems conjointly rather than separately.

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited[1]:	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

1. Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wisconsin Medical Journal. 1995;94(3) 135-140.

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

SBQ-R - Scoring

Item 1: taps into *lifetime* suicide ideation and/or suicide attempts			
Selected response 1	Non-Suicidal subgroup	1 point	
Selected response 2	Suicide Risk Ideation subgroup	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 points	
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	**Total Points**

Item 2: assesses the *frequency* of suicidal *ideation* over the past 12 months			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	
	Very Often (5 or more times)	5 points	**Total Points**

Item 3: taps into the *threat of* suicide *attempt*		
Selected response 1	1 point	
Selected response 2a or 2b	2 points	
Selected response 3a or 3b	3 points	**Total Points**

Item 4: evaluates *self-reported likelihood* of suicidal behavior in the future			
Selected Response:	Never	0 points	
	No chance at all	1 point	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather Likely	5 points	
	Very Likely	6 points	**Total Points**

Sum all the scores circled/checked by the respondents.
The total score should range from 3-18.

Total Score

AUC = Area Under the Receiver Operating Characteristic Curve; the area measures discrimination, that is, the ability of the test to correctly classify those with and without the risk. [.90-1.0 = Excellent; .80-.90 = Good; .70-.80 = Fair; .60-.70 = Poor]

	Sensitivity	Specificity	PPV	AUC
Item 1: a cutoff score of ≥ 2				
• Validation Reference: Adult Inpatient	0.80	0.97	.95	0.92
• Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R : a cutoff score of ≥7				
• Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: a cutoff score of ≥ 8				
• Validation Reference: Adult Inpatient	0.80	0.91	0.87	0.89

The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:[1]

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]

	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	93%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

1. *Osman A, Bagge CL, Guitierrez PM, Konick LC, Kooper BA, Barrios FX., The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical and nonclinical samples, Assessment, 2001, (5), 443-454.*

DETERMINE YOUR NUTRITIONAL HEALTH

The Warning Signs of poor nutritional health are often overlooked. Use this Checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's –

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this Checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn the page to learn more about the Warnings Signs of poor nutritional health.

These materials are developed and distributed by the Nutrition Screening Initiative, a project of:

AMERICAN ACADEMY OF FAMILY PHYSICIANS
THE AMERICAN DIETETIC ASSOCIATION
THE NATIONAL COUNCIL ON THE AGING, INC.

The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well, or cause mouth sores, make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or choosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals, when taken in large doses, act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/GAIN

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

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