EVERNORTH℠
HEALTH SERVICES

Behavioral Care Group

EVERNORTH BEHAVIORAL CARE GROUP PROVIDER MANUAL

For contracted providers with the Cigna Medicare Advantage plan in Arizona conducting Guided Care for Seniors: Mental Health and Substance Use Assessments.

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Welcome to Evernorth Behavioral Care Group

Thank you for joining Evernorth Behavioral Care Group (EBCG) and partnering with us to deliver mental health and substance use disorder (SUD) assessments for pre-identified clients with the Cigna Medicare Advantage plan in Arizona.

Who is Evernorth Behavioral Care Group?

EBCG is a community of committed behavioral health clinicians grounded in the core belief that quality behavioral health care is critical to whole person health. We have secured a contract with the Cigna Medicare Advantage plan in Arizona to perform mental health and SUD assessments.

Scope of service

Your contract is limited to conducting "Guided Care for Seniors: Mental Health and Substance Use Assessments." All other services delivered to clients would be performed outside your contract with Evernorth Behavioral Care Group.

Client identification

Clients will be identified through client preparation activities, including:

- Annual health risk assessment
- Huddle
- Provider and client identification
- Clinical rules
- Analytics

Scheduling and care modality

- Once a client agrees to an assessment, EBCG will schedule the requested appointment within the Simple Practice EMR platform according to the availability listed by the provider. The appointment will be scheduled with 48 business hours' notice to the provider.
- Once appointments are scheduled, the client and assessment form will be available to the provider in EBCG's secure Simple Practice platform. All relevant client information will be in Simple Practice. The provider will be responsible for reviewing and maintaining their own availability and schedule. The provider will be notified when the client has completed their consent and notice documents.
    - If there is no evidence of patient consent or review of privacy policy in Simple Practice, the provider must review the consent form and notice of privacy practices with the client for notated, verbal consent.
- Provider will complete assessment inside Simple Practice along with any other supplemental documentation.

Providers may render appointments using the care modality that best suits their needs and the needs of their clients, whether it's via:

- In-person
- Virtual
- Telephone

Guidelines

Action	Required time frame
Provider lists availability within Simple Practice	**Must be maintained and updated as needed**
Conduct assessment	**Within 5 business days of outreach**
Complete "Guided Care for Seniors: Mental Health and Substance Use Assessment"	**Within 2 business days of date of service**

Note: EBCG does *not* offer a no-show or cancelation payment at this time as the Medicare Advantage plan will only provide compensation when an assessment is completed.

Key contacts

To help us work together most effectively, below is key contact information, including phone, email, and mailing addresses:

Team	Need	Contact information
Provider Services	Questions or concerns about contracts, credentialing, and the onboarding process if their recruiter is unavailable.	**Email:** ECBGProviderservices@evernorth.com.
		General Phone: 877.501.7991
	Mailing address	Evernorth Behavioral Care Group 6625 West 78th Street Bloomington, MN 55439
Scheduling	Schedule clients for assessments and/or assistance related to scheduling/no show appointments.	**Email:** EBCGscheduling@evernorth.com
Practice Administration	Questions or concerns for contracted providers.	**Email:** EBCGpracticeadmin@evernorth.com
		General Phone: 877.501.7991

Guided Care for Seniors Program

Assessment Documentation Expectations

Required Forms

- **Verbal Consent for Treatment** and **Verbal Notice of Privacy Practices**
  Consent for Treatment and Notice of Privacy Practices are provided to patients via email or US mail based on patient preference. Simple Practice will be updated to show if the Provider must review the verbal version of the Consent for Treatment and Notice of Privacy Practices with the patient and attest to receiving verbal consent.

- **Guided Care for Seniors Assessment Form**
  You are expected to fully complete all mandatory fields on the assessment, and if you choose to use supplemental screening tools, these also must be completed in Simple Practice (see Appendix A).

  1. Assessment summary: Provide assessment date and time, place of service, length of time in assessment, assessment completion by.
  2. Patient Information: Name, age, gender, contact information, and relevant demographic details.
  3. Presenting Problem: A clear description of the current issues the patient is facing, including the nature, duration, and severity of symptoms.
  4. History of Present Illness: A chronological account of how the symptoms have evolved, any triggering events, and their impact on the patient's life.
  5. Past Psychiatric History: Previous diagnoses, treatments, hospitalizations, and responses to interventions.
  6. Medical History: Relevant medical conditions, medications, allergies, and any physical health factors influencing mental health.
  7. Family History: Information about psychiatric disorders or other relevant medical conditions in the patient's family.
  8. Social History: Details about the patient's living situation, SDOH, relationships, occupation, education, substance use, and any recent changes.

9. Mental Status Examination (MSE): A concise assessment of the patient's appearance, behavior, mood, affect, thought content, thought process, perception, cognition, insight, and judgment.
10. Risk Assessment: Evaluation of any potential harm the patient may pose to themselves or others, including suicidal or homicidal thoughts.
11. Diagnosis: A preliminary or working diagnosis based on the assessment findings and applicable diagnostic criteria.
12. Treatment Plan: Recommendations for further assessments, monitoring, or interventions, including a suggested timeline.
13. Include any scales administered, i.e., PHQ-9, GAD, MMSE, etc.

Clinical Oversight Process

Behavioral health documentation is a priority for Evernorth Behavioral Care Group as it ensures that patients receive high-quality and evidence-based care.

- Our physicians will be conducting randomized reviews of completed assessments. These reviews are designed to achieve two primary objectives: documentation expectations and continuous improvement. If any issues are uncovered during a review, our team will promptly reach out to the respective provider to discuss and address them. This feedback loop is vital in maintaining transparency and fostering a culture of improvement within our organization.
- Assessments will be reviewed regularly to make sure we have proper documentation aimed to maintain best clinical standards and promote effective care delivery.
- Accurate documentation is crucial for continuity of care and communication among healthcare providers. It also provides transparency to patients, families, and regulatory bodies, demonstrating that Evernorth Behavioral Care Group is committed to maintaining high standards of care.

Getting paid

Providers are only required to complete the assessment form and document the appropriate diagnosis required for claim submission. Providers will not be involved with the billing or claims processing. In addition, the use of a third-party biller or EMR clearing house will not be required and providers will not be required to check eligibility or benefits. There is no patient cost share for Medicare Advantage assessments. EBCG will manage all the claims processing once a completed assessment has been submitted.

Completed assessment submission

Submit completed “Guided Care for Seniors: Mental Health and Substance Use Assessment” in Simple Practice with appropriate care management recommendations. To learn more about using Simple Practice, see Appendix A.

Provider payment

Providers will be paid their contracted amount for each assessment that is fully completed, documented and approved by Practice Admin. Providers will receive contracted payment amounts within 15 business days upon approval of a completed assessment document by EBCG Practice Admin. Payment will be made via electronic funds transfer (EFT).

Continuation of care

If you are a contracted provider for the Cigna Medicare Advantage plan, you can offer ongoing clinical services to clients as appropriate. It is not a requirement to see clients for ongoing care. Care provided beyond the assessment will *not* be billed through EBCG If you are not willing or able to deliver ongoing care, EBCG will assist in connecting the client to the recommended services.

Appendix A: Accessing Simple Practice

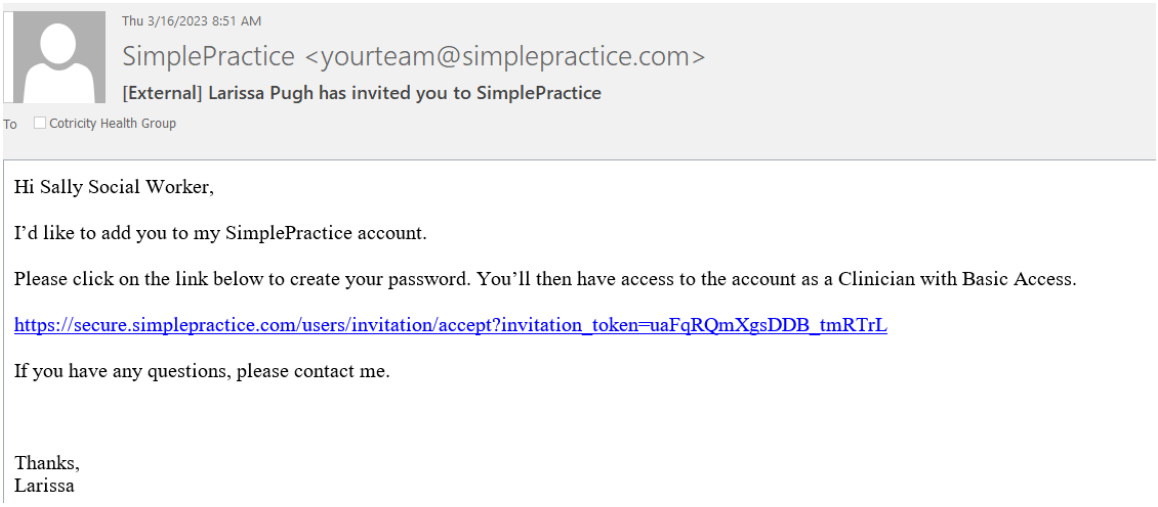
Launch browser	Enter https://www.simplepractice.com/ and click **sign in** at the top right of the screen
Enter your UserID & Password	Your UserID is the registered email address on file and your password is case sensitive

If you forget your username or password, click ***Forgot your userID?*** or ***Forgot your password?*** on the Registered Users Login screen.

- If you continue to experience technical difficulties, email EBCGpracticeadmin@evernorth.com for assistance or click *Get Help* on the sign in page.

How to set-up user access

1. The provider will receive an email to set up their access.


Thu 3/16/2023 8:51 AM

SimplePractice <yourteam@simplepractice.com>

[External] Larissa Pugh has invited you to SimplePractice

To Cotricity Health Group

Hi Sally Social Worker,

I'd like to add you to my SimplePractice account.

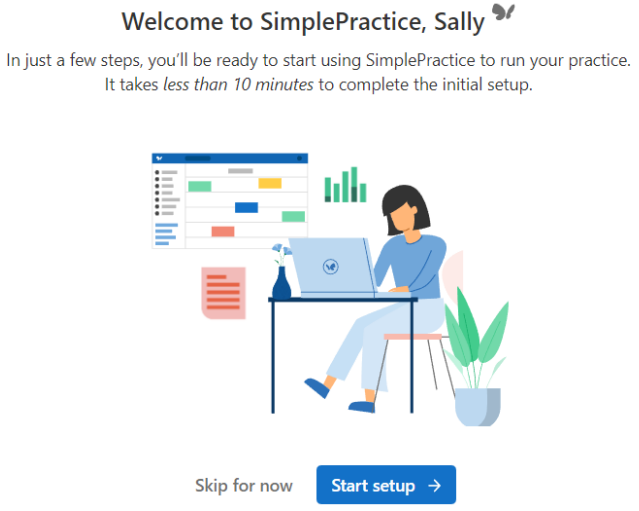
Please click on the link below to create your password. You'll then have access to the account as a Clinician with Basic Access.

https://secure.simplepractice.com/users/invitation/accept?invitation_token=uaFqRQmXgsDDB_tmRTrL

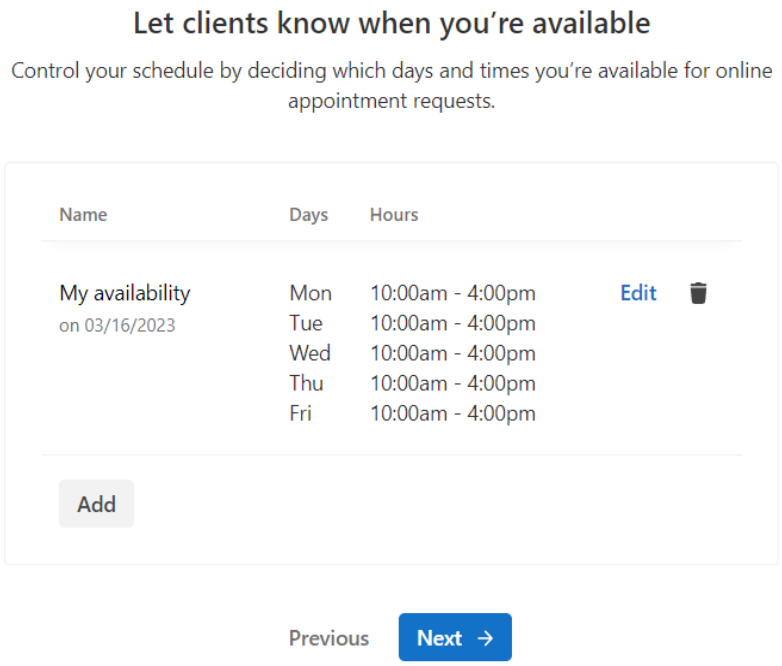
If you have any questions, please contact me.

Thanks,
Larissa

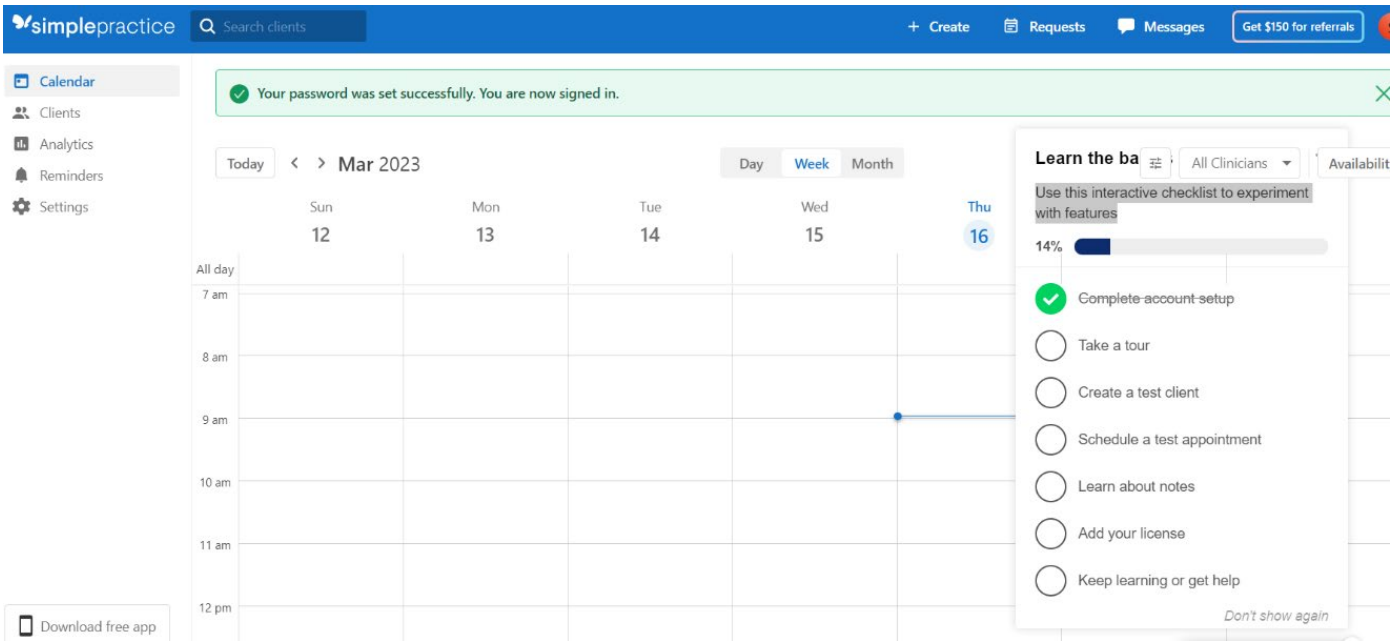
2. Follow the link and complete the account access request (password and mobile number to confirm access).



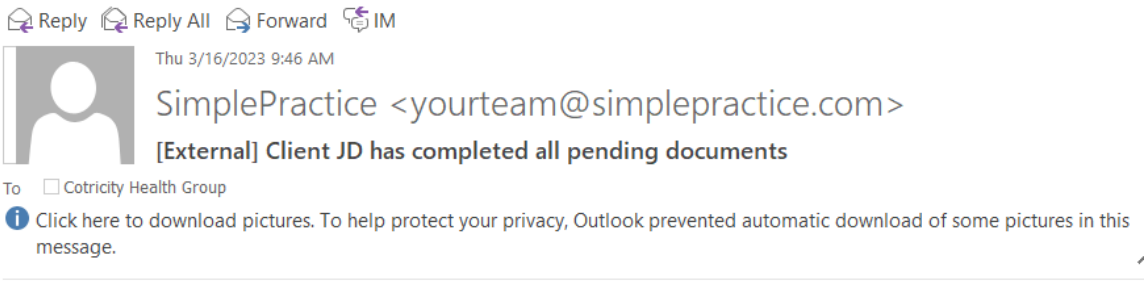
3. Click **Start setup** and set availability (can be changed later).



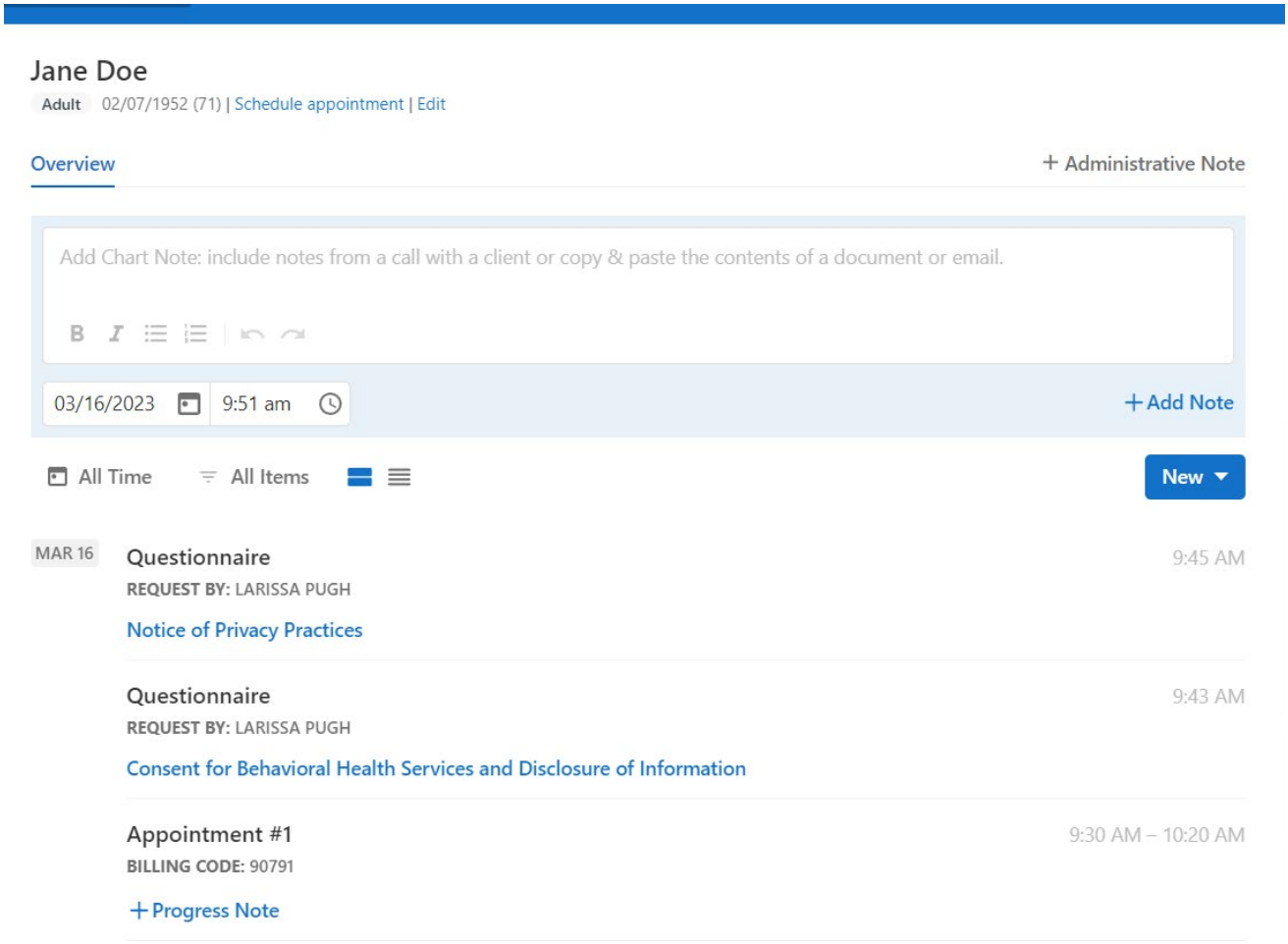
4. A **Learn the basics** menu will populate for tutorials.



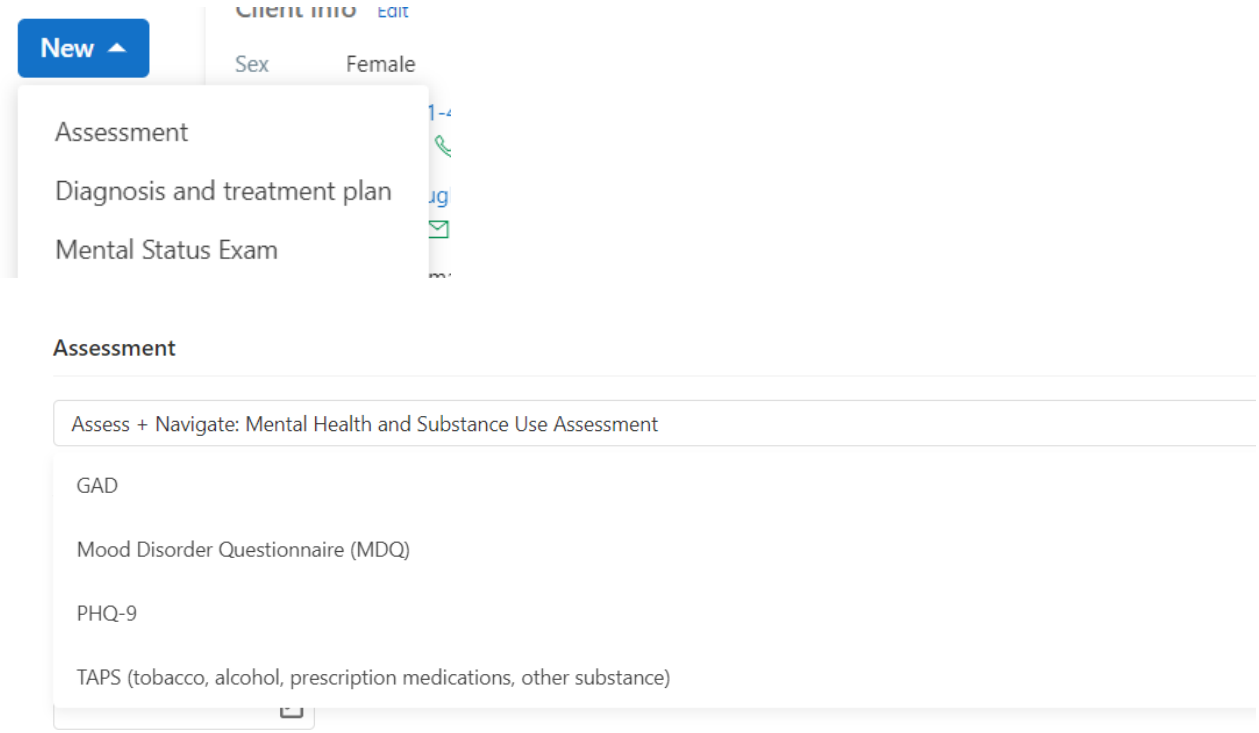
5. The provider will be notified that all documents have been completed by the client.



6. By clicking the link, the provider will be taken to their view of the client - the client can also be viewed within the system by clicking **Clients** and choosing the appropriate patient.

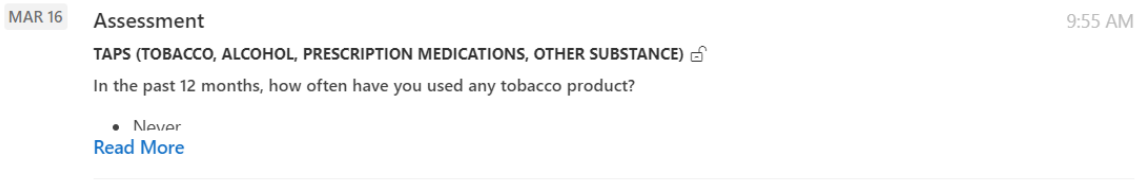


7. During the appointment, the provider should choose the appropriate forms from the **New** drop down menu under assessment.



8. Once the form is complete, it will be loaded to the patient profile.

9. Supplemental forms are available for use. If there is a chart note indicating that verbal consent is required, please also complete the Consent for Treatment and Notice of Privacy Practices documents under Assessment.



10. At this point the provider can make edits as needed or add more information. This can be repeated for all forms.

If the client is a “no show” for their appointment, please update the appointment in Simple Practice to “no show.”

You can edit you profile information, including appointment availability, as needed.

- From the **Simple Practice landing page click on your profile initials on the top right corner**
- Click **Edit**
- Make desired changes
- Click **Save Information**

Appendix B: Administrative requirements for Evernorth Behavioral Care Group

Purpose

To identify minimum necessary processes to perform the administrative functions critical to the management of the Evernorth Behavioral Care Group (EBCG) practice. These services may be provided by Evernorth Care Solutions (ECS) as specified in the Management Services Agreement. Major topics include:

- Privacy Policy, Permitted and Required Uses and Disclosures of Personal Health Information (PHI)
- Patient Rights and Roles
- Patient Consent for Treatment
- Provider Services Functions

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Policy

Privacy Policy, Permitted and Required Uses and Disclosures of PHI

EBCG's Privacy Policy (HIPAA-related) is provided to patients at the beginning of a treatment episode. This Privacy Policy will give patients insight into their rights regarding their personal health information. EBCG values patient privacy. As such, EBCG staff may not use or disclose protected health information without a valid authorization in any way that is not required for the purposes of fulfilling administrative requirements for the provision of health care services. Failure to comply with documented Privacy Policies and Procedures will result in appropriate sanctions, which may include disciplinary action, up to and including termination; applicable to 1099 contract and full time employed care team members.

Required uses and disclosures of PHI:

- To the individual who is the subject of the PHI, upon request.
- To the Secretary of the Department of Health and Human Services.
- As required by law.

Permitted uses of PHI:

- EBCG may use an individual's PHI to carry out its own treatment, payment, and healthcare operations activities.

Permitted disclosures of PHI:

- To the individual who is the subject of the PHI.
- To another Covered Entity (CE) for its treatment or payment activities.
- To another CE for its healthcare operation activities, as described below, provided that both the CE and EBCG have or had a relationship with the individual and only the minimum PHI necessary to complete the intended activity is shared.
    - Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
    - Reviewing the competence or qualifications of health care professionals, evaluating qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing or credentialing activities.
- To detect fraud and abuse or comply with related mandates.
- To an authorized individual pursuant to an authorization signed by the individual or his or her Personal or Legal Representative.
- To a Business Associate (BA), pursuant to the BAA in place with the BA.
- Conduct public health activities as defined by HIPAA (e.g., communicable disease reporting, abuse reporting, or regarding quality, safety or effectiveness of products regulated by the FDA, etc.).
- Report victims of abuse, neglect or domestic violence per state and licensure requirements.

- To a health oversight agency for oversight activities authorized by law.
- In response to a Court order as outlined by HIPAA.
- To law enforcement officials for purposes of identifying or locating a suspect or victim of a crime or to report a crime on EBCG premises. This includes disclosure of limited identifying information about the suspected perpetrator of a crime to law enforcement by an employee who is the victim of the crime.
- Coroners or medical examiners for the purpose of identifying a deceased person or determining cause of death or for other duties as authorized by law.
- Funeral directors to allow them to carry out their duties.
- For research purposes in which EBCG or its clinician(s) is participating, provided the requirements outlined in HIPAA are met.
- To avert a serious threat to health or safety.
- For specialized government functions, including national security and intelligence activities.
- To comply with laws relating to Workers' Compensation or similar programs established by law providing benefits for work-related injuries. Please note, PHI is limited to only the information related to a reported work-related injury.
- Disclosures to government agencies, law enforcement or regulatory agencies, as mandated by law.
- For disaster relief efforts, subject to specific conditions. Contact the EBCG Privacy Office or EPO for guidance.
- An employee who, in good faith, believes that the CE has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that care, services or conditions provided by the CE are potentially dangerous, may disclose PHI to:
    - A health oversight agency or public health authority, to investigate or otherwise oversee the relevant conduct or condition. Disclosures may also be made to an attorney retained by the employee or BA for purposes of determining legal options associated with the oversight and accreditation disclosures; or
    - An appropriate health care accreditation organization for purpose of reporting the allegation of failure to meet professional standards or misconduct; or
    - An attorney retained by or on behalf of the employee for the purpose of determining the legal options of the employee.

In accordance with applicable State and federal law, uses or disclosures that are not specifically addressed by EBCG Privacy Policies may be permitted upon review of the EBCG Privacy Office.

Definitions

Business Associate – is a person or entity which performs activities or provides services, involving the use or disclosure of PHI, to a Covered Entity.

Business Associate activities and services may include claims processing, data analysis, utilization review, and billing. Business associate services to a covered entity are limited to legal, actuarial, accounting, and consulting, data aggregation, management, administrative, accreditation, or financial services.

Business Associate Agreement ("BAA") – a HIPAA Privacy Rule mandated agreement between a Covered Entity and a Business Associate the Business Associate assures that it will appropriately use and safeguard PHI it receives or creates on behalf of the Covered Entity.

Covered Entity (CE) – is a health plan, a health care provider or a health care clearinghouse.

Designated Record Set (DRS, as defined in 45 CFR 164.501) means a group of records maintained by or for a covered entity that is:

- The medical records and billing records about individuals maintained by or for a covered health care provider; or
- Used, in whole or in part, by or for the covered entity to make decisions about individuals.

Exclusions

Psychotherapy notes, meaning notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. See 45 CFR 164.524(a)(1)(i-ii).

Electronic Health Information (EHI, as defined in 45 CFR 160.103 and 171.102) - means protected health information (PHI) transmitted by and maintained in electronic media, to the extent that it would be included in a designated record set. Exclusions to this are psychotherapy notes (as defined in 45 CFR 164.501) and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

- Until at least October 2022, EHI for purposes of the information blocking definition is limited to the EHI identified by the data elements represented in the USCDI standard adopted in § 170.213. See policy 600.42 – Interoperability and Patient Access.

HIPAA Privacy Rule - establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patient's rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Individual - means the person who is the subject of protected health information.

Information Blocking - The practice of restricting the access, exchange and use of Electronic Health Information (EHI).

Machine-Readable – means EHI in a data format that can be automatically read and processed by a computer, such as CSV, JSON, XML, etc. Machine-readable data must be structured data. Not all records maintained electronically are machine-readable; for example, a scanned document in the EHR is maintained electronically, but is not considered machine-readable.

Protected Health Information ("PHI") – individually identifiable information held or transmitted by Evernorth Behavioral Care Group in relation to that individual's past, present or future health care, condition, payments or provisions, in any form (e.g., electronic, paper or oral). The following are examples of PHI: name or partial name, address, Social Security number, ZIP code, birth date, phone number, email address, diagnosis or mental health status, IP address, employer, relatives, billing information, Alternate Member ID ("AMI"), enrollment information and/or any other combination of information that can be used to identify an individual.

Patient rights and roles, and patient consent for treatment

It is the policy of Evernorth Behavioral Care Group (EBCG) that patient rights are critical to developing a successful therapeutic alliance and treatment experience. Further the patient should be actively included in the establishment of treatment goals and plan.

Provider Services

A variety of provider services are arranged through a management relationship with Evernorth Care Solutions. Administrative services include, but are not limited to:

- Credentialing
- Appointment scheduling
- Claims submission
- Banking and Accounting

Procedure

Information sharing

Evernorth Behavioral Care Group (EBCG) clinicians and staff should consult with appropriate counsel re the release of any Personal Health Information.

1. A treatment record should be established for a new patient at the onset of a treatment episode. At the start of an episode, and every 12 months thereafter, treatment record should be updated with required forms. EBCG staff (i.e., provider or provider services according to treatment relationship) will request that the patient review and sign the Privacy Policy (HIPAA requirements). The signed document must be preserved within the treatment record. Alternatively, the document may be verbally reviewed with the patient and consent documented in the treatment record. Subsequently, the document should be mailed.

2. As the Privacy Policy is presented to the patient, the Patient Rights and Responsibilities should be provided to the patient to sign as well. The signed document must be preserved within the treatment record as noted above.
3. Before making any permitted disclosures of Personal Health Information, EBCG staff must determine who the request for release of information is for, the requestor, and content being requested.
4. With this information EBCG staff should consult disclosure allowances to determine if the disclosure is likely indicated or contraindicated.
5. The completed request will be reviewed with appropriate counsel for determination on if request can be made and how.

Consent for treatment

It is critical for patients to have ownership and clarity on treatment goals and modalities. This is achieved through a behavioral component of EBCG's Consent for Assessment and Treatment.

1. As noted in Policy & Procedure, 200.00, the patient and provider should complete the Consent for Treatment at the end of the conclusion of the initial session. The provider must complete the consent with the patient.
2. The signed document must be preserved within the treatment record. Alternatively, the document may be verbally reviewed with the patient and consent documented in the treatment record. Subsequently, the document should be mailed.

Attachments *To be provided separately.*

- Consent for Release of Confidential Information Patient
- Rights and Responsibilities
- Privacy Policy
- Consent for Assessment/Treatment

Appendix C: Specialty behavioral health practice administration

Purpose

Evernorth Behavioral Care Group (EBCG) is a community of committed behavioral health clinicians, grounded in the core belief that high quality behavioral health is critical to whole person health. We enable clinicians to focus on their patients by alleviating administrative burdens and we encourage patients to work with us to find the right provider match to achieve health and life goals. We are committed to measurable outcomes to support patients and providers in the health care journey.

EBCG is established as a specialty behavioral practice for the provision of mental health and substance use treatment and associated clinical services. EBCG is committed to behavioral health and wellbeing as a critical element of whole person health. As such, the clinical model emphasizes a wide range of services to promote behavioral well-being and treatment while having a strong commitment to navigation across the health care ecosystem.

Clinicians contracted by EBCG (clinicians) are intended to be an independent treatment resource while having the capability of collaborating with other members of EBCG as well as the extended treatment and care coordination teams available to our patients. The processes documented for EBCG clinicians will be specific to licensure and function to promote top of license interactions between care team, patients, and the health care community.

Measurement is a critical consideration for the group in support of the patient/provider alliance, clinical excellence, and optimal experience for patients, providers, and purchasers of care.

Policy

A core group of individuals are at the center of EBCG's clinical operations.

- Individuals seeking behavioral health services are patients of EBCG. While different terms may be fairly applied in day-to-day clinical practice, EBCG recognizes the import of mental health and substance use illness on health and will use the term patient in response.
- Rendering/treating providers are those with a contractual relationship with EBCG. Providers may offer services according to licensure and certification as well as associated EBCG guidelines.

Purchasers are those entities funding care which could include, but are not limited to, payers, health systems, etc. Patients may choose to access services through a network relationship with a payer or through a direct contract with a purchaser. Patients may also choose to access EBCG on a self-pay basis. In all instances, EBCG will adhere to the clinical guidelines applicable to a rendering provider's license type. Further, clinical recommendations from nationally acknowledged authorities, (i.e., American Psychiatric Association, American Psychological Association, and the National Association of Social Workers). The most up to date Diagnostic and Statistical Manual of Mental Disorders will be the reference for provision of diagnosis. Further, rules of the state in which services are provided will be adhered to.

Clinical documentation, from rendering providers, is the property of Evernorth Behavioral Care Group and will be made available to EBCG administration upon request.

Administrative services, detailed in Appendix B: Administrative requirements for Evernorth Behavioral Care Group, are provided through a management company on behalf of EBCG.

Procedure

1. A patient can be self-referred to EBCG or identified through a program deployed by a purchaser. The initial contact with EBCG will be primarily administrative in nature in order to establish a treatment record and review policies of the practice. Importantly though, the initial contact between patient and clinician will include a thorough discussion regarding patient goals and the provider's services in order to establish treatment goals. These goals may be time limited or longitudinal based on the terms and goals of engagement.

2. The provider performs an assessment of a patient including, but not limited to, history of present complaint, family and social history, drug use, behavioral health treatment history, socioeconomic issues, legal/court history and current symptoms. The provider shares conclusions from the assessment with the patient and confirms the patient's understanding of recommendations for treatment including the treatment plan, documented in the consent for treatment. The recommendation will be thoroughly documented in the treatment record.

3. The provider will inquire with the patient about other treating providers who may benefit from knowledge of diagnosis and treatment recommendations. This could include existing providers, like a primary care provider, or new providers needed to facilitate the treatment plan. The provider will route treatment recommendations accordingly after obtaining required consents. Coordinating providers will be thoroughly documented in the treatment record.

4. The treatment record will be maintained at each patient contact including in-person, virtual, telephonic, or written contact. In order to release information from the treatment record, outside of coordination of care with established treating providers, a separate release of information is required.

5. Any documentation, such as screenings, assessment, and questionnaires should be documented within the treatment record. If any tool is not completed within the treatment record, they will be scanned into the record. Summary findings are included in the note. All clinical documentation should be validated and signed within 48 hours (preferably 24) by the initiating care team member.

6. Progress toward treatment goals is determined at every visit and documented. A visit summary is provided to the patient at the close of each visit. The plan of care, including number and frequency of visits, is included in the discharge summary.

7. If the patient's behavioral health issues are outside of the expertise of the treating provider, the provider may request a clinical consultation from EBCG's medical staff. If a transition to a different service provider is required, the treating provider will support the patient through transition.

8. Patient progress towards goals, and other critical patent and provider experience measures will be monitored throughout an episode of care and communicated appropriately according to the measure.

9. If the patient discontinues treatment or no shows, the provider will attempt to re-engage the patient. If care is not resumed, the behavioral health service is discontinued, and the patient is discharged from behavioral health. Discharge is documented in the patient's treatment record.

10. Any request for psychotherapy records requires a specific authorization from the patient/legal representative. Upon receipt of a valid authorization, the EBCG Custodian of Records/designee will reach out to the authoring provider to review and approve or deny the request prior to any disclosure.

Attachments *To be provided separately.*

- Consent for Assessment/Treatment
- Behavioral Health Emergency Supports

Related policies and procedures

Administrative requirements for Evernorth Behavioral Care Group, including:

- Permitted and Required Uses and Disclosures of PHI
- Client Rights and Roles
- Informed Consent
- Professional License and/or Certification Verification
- Suspected Abuse Neglect Exploitation and Non-Accidental Injury Reporting and Documentation

Appendix D: Behavioral health emergency process

Emergency circumstances

Engage resources to support client experiencing a crisis, as defined by the following signs or symptoms:

- Client states clear intention and plan to harm him/herself or someone else; especially if the client has the means to carry out the plan.
- If PHQ is conducted, the 9th question on the PHQ screener indicates thoughts of being 'better off dead, or of hurting yourself' and the client verbalizes intent and plan to complete suicide.
    - Note: Presence of a plan and ability to carry out the plan may differentiate an emergent need as opposed to an urgent referral to behavioral health treatment
- Client is gravely disabled meaning he/she lacks judgment to the extent that he/she is a risk to personal safety or that of others, for example:
    - Due to auditory hallucinations, client wanders into traffic and does not understand it is not safe.
    - Due to paranoia about others, client refuses to wash or eat.

Follow appropriate steps based on if emergency help is needed or if there is an imminent risk to safety.

Imminent risk to safety

If a client is actively dangerous, physically threatening the safety of him/herself or others:

1. Call 988 for emergency behavioral services; 911 may be used for immediate risk of harm to self or others.

2. Stay with the individual, if possible, whether in person or on the phone, while waiting for emergency services to arrive.

3. Avoid confronting or arguing with the individual.

Note: Engaging emergency services could exacerbate the situation and should only be used in the event of an immediate safety risk.

Emergency help needed, but no imminent risk to safety

1. Have a discussion with client regarding next steps if possible.
    - Leverage the ED Safe (ESS-6) screening tool to determine the immediate level of risk and recommendation: ED-SAFE Secondary Screener and Tip Sheet.pdf (sprc.org)

2. Determine if the client would benefit from an evaluation for a higher level of care.

If	Then	
Yes	Contact Evernorth Behavioral Care Group Provider Services to confirm in-network resources as needed	Go To: Step 3
No	>>>	Go To: Step 3

3. Consider if a safety plan should be developed with the client prior to ending the appointment.
    - Stanley Brown Safety Plan is the preferred tool: Stanley-Brown-Safety-Plan.pdf (finalsite.net)

4. Provide client instructions to support safety:
    - If you have any suicidal or homicidal ideations, go to your nearest emergency room or call **911**.
    - Behavioral health emergencies: 988
    - Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
    - Crisis Text Line: Text HELLO to 741741 from anywhere in the United States, 24/7. We will text about whatever is a crisis to you - addiction, anxiety, assault, bullying, depression, eating disorders, self-harm, and suicide.

Appendix E: External resources

- **HIPAA Privacy Regulation,** 45 CFR Part 164, Subpart E, §164.502 – Uses and Disclosures of PHI HIPAA Privacy Regulation, 45 CFR Part 164, Subpart E, §164.512(b) – Disclosures for Public Health Activities
- **21st Century Cures Act:** Interoperability, Information Blocking (Section 4004), and the ONC Health IT Certification Program 85 FR 25642 pages 25642-25961 45 CFR 170, 171