AHCCCS Targeted Investments Program
Core Components and Milestones

Project: Ambulatory

Area of Concentration: Adults with Behavioral Health Needs

Provider Type: Adult Behavioral Health Provider

Objective: To integrate primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for adults with behavioral health needs.

Unless otherwise stated, demonstration that the practice has met the criteria listed in each Milestone Measurement is due by September 30th of the respective Milestone Measurement Period.

<table>
<tr><td rowspan="3">1.</td><td colspan="2">Utilize a behavioral health integration toolkit, to develop a practice-specific course of action to improve integration, building from the self-assessment results that were included in the practice’s Targeted Investment application.

Behavioral health integration toolkit examples can be found through the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions (see www.integration.samhsa.gov/operations-administration/assessment-tools).</td></tr>
<tr><td>Milestone Measurement Period 1
(October 1, 2017–September 30, 2018*)
Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
(October 1, 2018–September 30, 2019*)
Practice Reporting Requirement to State</td></tr>
<tr><td>By December 31, 2017, identify the name of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the practice’s self-assessment, with measurable goals and timelines.</td><td>By October 31, 2018, demonstrate substantive progress has been made on the practice-specific action plan and identify barriers to, and strategies for, achieving additional progress.

By July 31, 2019, report on the progress that has been made since November 1, 2018 and identify barriers to, and strategies for, achieving additional progress.</td></tr>
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2.	**Implement the use of an integrated care plan[1] using established data elements[2], for members identified as part of Core Component 2.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	By September 30, 2018, demonstrate that the practice has begun using an integrated care plan.	Based on a practice record review of a random sample of 20 members, whom the practice has identified as having received mental health services during the past 12 months, attest that the integrated care plan, which includes established data elements, is documented in the electronic health record 85% of the time.

[1] An integrated care plan is one that prioritizes both physical and behavioral health needs, and reflects the patient and provider's shared goals for improved health. It includes actionable items and linkages to other services and should be updated continually in consultation with all members of the clinical team, the patient, the family, and when appropriate, the Child and Family Team.
[2] Established data elements may include: problem identification, risk drivers, barriers to care, medical history, medication history, etc. AHCCCS will lead a stakeholder process to identify a set of established data elements that should be included in an integrated care plan.

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<table>
<tr><td rowspan="3">3.</td><td colspan="2">Screen all members to assess the status of common social determinants of health (SDOH), and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool.

(Tool examples include the Patient–Centered Assessment Method (PCAM), which can be found at www.pcamonline.org/about-pcam.html, the Health Leads Screening Toolkit (which includes a screening tool), which can be found at: https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/), the Hennepin County Medical Center Life Style Overview which can be found at: Hennepin County Life Style Overview Tool, the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE), which can be found at: http://www.nachc.org/research-and-data/prapare.</td></tr>
<tr><td>Milestone Measurement Period 1
(October 1, 2017–September 30, 2018*)

Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
(October 1, 2018–September 30, 2019*)

Practice Reporting Requirement to State</td></tr>
<tr><td>A. Identify which SDOH screening tool is being used by the practice.
B. Develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 9, based on information obtained through the screening.</td><td>Based on a practice record review of a random sample of 20 members, attest that:
A. 85% of members were screened using the practice-identified screening tool
B. 85% of the time, results of the screening were contained within the integrated care plan
C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).</td></tr>
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<tr><td rowspan="3">4.</td><td colspan="2">A. Develop communication protocols with physical health, behavioral health, and (if appropriate) developmental pediatric providers for referring members, handling crises, sharing information, obtaining consent, and provider-to-provider consultation.
1) Behavioral health providers must also have protocols that help identify a member’s need for follow-up physical health care with his/her primary care provider, and conduct a warm-hand off if necessary.

B. Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data and to identify whether the member has practice-level care management services provided by another provider.

C. Develop protocols for communicating with MCO-level care managers to coordinate with practice-level care management activities.

An example of a protocol can be found at: Riverside Protocol Example</td></tr>
<tr><td>Milestone Period Measurement Period 1
(October 1, 2017–September 30, 2018*)
Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
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Practice Reporting Requirement to State</td></tr>
<tr><td>A. Identify the names of providers and MCOs with which the site has developed communication and care management protocols.
B. Document that the protocols cover how to:
1) Refer members,
2) Conduct warm hand-offs,
3) Handle crises,
4) Share information,
5) Obtain consent, and
6) Engage in provider-to-provider consultation.</td><td>Based on a practice record review of a random sample of 20 members whom the practice has identified as having received mental health services during the past 12 months, attest that a warm hand-off, consistent with the practice’s protocol, occurred 85% of the time.</td></tr>
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5.	**Participate in bidirectional exchange of data with Health Current, the health information exchange (that is, both sending and receiving data), which includes transmitting data on core data set for all members to Health Current.**	
	Milestone Period Measurement Period 1 **(**October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	Develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the practice's management of high-risk members.	A. Attest that the practice is transmitting data on a core data set for all members to Health Current.[3] B. Attest that longitudinal data received from Health Current are routinely accessed to inform care management of high-risk members. C. Provide a narrative description of how longitudinal data are informing the care management of high-risk members.

6.	**Identify community-based resources, at a minimum, through use lists maintained by the MCOs. Utilize the community-based resource list(s) and pre-existing practice knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources.** **At a minimum, if available, practices should establish relationships with:** **1) Community-based social service agencies.** **2) Self-help referral connections.** **3) Substance misuse treatment support services.** **4) When age appropriate, schools, the Arizona Early Intervention Program (AzEIP) and family support services (including Family Run Organizations).**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	A. Identify the sources for the practice's list of community-based resources. B. Identify the agencies and community-based organizations to which the practice has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon	Document that the practice has conducted member and family experience surveys specifically geared toward evaluating the success of referral relationships, and that the information obtained from the surveys is used to improve the referral relationships.

[3] A core data set will include a patient care summary with defined data elements.

	by both the practice and the community-based resource.	

7.	**Participate in any Targeted Investment program-offered learning collaborative, training and education that is relevant to this project and the provider population, and is not already required in other Core Components. In addition, utilize any resources developed or recommendations made during the Targeted Investments period by AHCCCS to assist in the treatment of AHCCCS-enrolled individuals.**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018*) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Practice Reporting Requirement to State**
	Not applicable. AHCCCS or an MCO will confirm practice site participation in training.	Not applicable. AHCCCS or an MCO will confirm practice site participation in training.