AHCCCS Targeted Investments Program
Core Components and Milestones

Project: Ambulatory

Area of Concentration: Adults with Behavioral Health Needs

Provider Type: Adult Primary Care 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.

1.	**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).**	
	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 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.	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.

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<table>
<tr><td>2.</td><td colspan="2"><u>For all practices delivering primary care[1]:</u>

Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated care management. Practices should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current (Arizona Health-e Connection). Practices should prioritize members within the registry whose status may be improved or favorably affected through practice-level care management.

The registry may be maintained inside or outside of the electronic health record.</td></tr>
<tr><td></td><td>Adult members at high risk are determined by the practice, but must include members with or at risk for a behavioral health condition who are at high risk of a) near-term acute and behavioral health service utilization and b) decline in physical and/or behavioral health status.</td><td>Pediatric members at high risk are determined by the practice, but must include children/youth who a) have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and b) also require health and related services of a type or amount beyond that required by children/youth generally. This registry must also include all children/youth who have or are at risk for Autism Spectrum Disorder (ASD) and all children/youth engaged in the child welfare system.</td></tr>
<tr><td></td><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></td><td>A. By March 31, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk member members.
B. By September 30, 2018, demonstrate that the high-risk identification criteria are routinely used, and that the names and associated clinical information for members meeting the practice criteria are recorded in the registry.</td><td>By September 30, 2019, demonstrate that the care manager is utilizing the practice registry to track integrated care management activity and member progress, consistent with Core Component 3A and/or 3B.</td></tr>
</table>

[1] Practices delivering primary care means the practice assumes full responsibility for meeting all the primary care needs of a group of patients seen at the practice.

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<table>
<tr><td>3.</td><td colspan="2"><u>For adult practices delivering primary care</u>:[2]
Utilize practice care managers[3] for members included in the high-risk registry, with a case load not to exceed a ratio of 1:100. Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system), or contracted by the practice from external sources. Practice-level care management functions should include:

1) Assessing and periodically reassessing member needs.
2) Playing an active role in developing and implementing integrated care plans.
3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).
4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
5) Working with members and their families to facilitate linkages to community organizations, including social service agencies.</td></tr>
<tr><td></td><td>Milestone Measurement Period 1
(October 1, 2017–September 30, 2018*)
x 11
Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
(October 1, 2018–September 30, 2019*)
x 6
Practice Reporting Requirement to State</td></tr>
<tr><td></td><td>A. By June 30, 2018, identify at least one care manager assigned to provide integrated care management services for members listed in the practice high risk registry. Indicate the caseload per care manager full time equivalent (FTE).
B. Document that the duties of the practice care manager include the elements of care management listed in this Core Component, and document the process for prioritizing members to receive practice care management, consistent with Core Component 2.
C. By September 30, 2018, demonstrate that the care manager(s) has been trained in:</td><td>A. By March 31, 2019, document that care managers have been trained in motivational interviewing, including member activation and self-management support.
B. Based on a practice record review of a random sample of 20 members listed in the high-risk registry during the past 12 months, attest that the care manager has documented: a) completing a comprehensive assessment, b) educating members, c) conducting motivational interviewing, d) appropriately facilitating linkages to community-based organizations, and e) whether the member already received integrated care/case management from other practices and/or MCOs, at least</td></tr>
</table>

[2] Practices delivering primary care means the practice assumes full responsibility for meeting all the primary care needs of a group of patients seen at the practice.

[3] Care managers are responsible for high-risk patients at one or more defined practices where they work on an ongoing basis as a member of the care team and have relationships with practices and practice teams. Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means. A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a Bachelor's prepared licensed social worker is acceptable.

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	• Comprehensive assessment of member needs and goals;
	  • Use of integrated care plans;
	  • Member and family education; and
	  • Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10.
		85% of the time.

4.	**Implement the use of an integrated care plan[4] using established data elements[5] 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.

5.	**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** and the Accountable Health Communities Screening Tool, which can be found at: **Accountable Health Communities Screening Tool.**	
	Milestone Measurement Period 1	**Milestone Measurement Period 2**

[4] 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.
[5] 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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	(October 1, 2017-September 30, 2018*) **Practice Reporting Requirement to State**	(October 1, 2018-September 30, 2019*) **Practice Reporting Requirement to State**
	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.	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).

6.	**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**	
	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 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,	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.

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	3) Handle crises, 4) Share information, 5) Obtain consent, and 6) Engage in provider-to-provider consultation.	

7.	**For all practices delivering primary care[6]:** **Routinely screen all members at the age-appropriate time[7] for depression, drug and alcohol misuse, anxiety, developmental delays in infancy and early childhood and suicide risk using age-appropriate and standardized tools such as, but not limited to:** **1) Depression: Patient Health Questionnaire (PHQ-2 and PHQ-9).** **2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST), SBIRT.** **3) Anxiety: Generalized Anxiety Disorder (GAD 7).** **4) Developmental delays in infancy and early childhood: Parents' Evaluation of Development Status (PEDS), Ages and Stages Questionnaires (ASQ) or Modified Checklist for Autism in Toddlers (M-CHAT-R).** **5) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)** **6) Other AHCCCS approved screening tools.** **The practice must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendation. The practice must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.**	
	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 practice's policies and procedures for use of standardized screening tools to identify: 1) Depression,	Based on a practice record review of a random sample of 20 members listed in the high-risk registry in the last 12 months, attest that a reassessment if clinically necessary, occurred within the evidence-based

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[7] Practices serving children/youth should utilize the AHCCCS EPSDT Periodicity Schedule for screening of children, available at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/Exhibit430-1.docx. AHCCCS may revisit and update the periodicity schedule as needed.

	2) Drug and alcohol misuse, 3) Anxiety, 4) Developmental delays in infancy, 5) Early childhood, cognitive, emotional and behavioral problems, and 6) Suicide risk. The policies must include which standardized tool will be used. B. If the practice serves children/youth, identify the policies and procedures for routinely screening members in accordance with the AHCCCS EPSDT Periodicity Schedule for screening of children. C. Identify the practice's procedures for interventions or referrals, as the result of a positive screening. D. Attest that the results of all practice's specified screening tool assessments are documented in the electronic health record.	timeframe recommended 85% of the time.

8.	**For all practices delivering primary care[8]:** **Utilize the Arizona Opioid Prescribing Guidelines for Chronic Pain (excluding cancer, palliative and end-of-life-care) available at: http://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opiod-prescribing-guidelines.pdf**	
	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**
	By January 1, 2018, demonstrate that all providers in the practice have been trained on the AZ guidelines for opioid prescribing.	Based on a practice record review of a random sample of 20 members, who were prescribed opioids, attest that the prescriber complied with the AZ guidelines for opioid prescribing 85% of time.

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9.	**Participate in bidirectional exchange of data with Health Current, the health information exchange (i.e. 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.[9] 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.

10.	**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**

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

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	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 by both the practice and the community-based resource.	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.

11.	**For all practices that deliver primary care[10]:** **Prioritize access to appointments for all individuals listed in the high-risk registry. As applicable to the practice, specialized focus must be on:** **1) Ensuring that children/youth in the child welfare system have prioritized access to initial visits, and subsequent follow-up appointments;** **2) Ensuring that adults transitioning from the criminal justice system have same-day access to appointments on the day of release and during visits to a probation or parole office.**	
	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**
	N/A	Document the protocols used to prioritize access to members listed in the high-risk registry.

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12.	**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 hospital participation in training.	Not applicable. AHCCCS or an MCO will confirm hospital participation in training.