Provider Type: Primary Care Provider
Area of Concentration: Adults with Behavioral Health Needs

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.

Adult PCP Ambulatory Project		
Core Component	**Milestone**	**Due Date**
1	Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare	12/31/18 7/31/19 9/30/19
2	Identify members who are high-risk and develop electronic registry; Demonstrate use of identification criteria and document members in registry	9/30/19
3	Utilize care managers for members in high-risk registry; Demonstrate that care manager(s) are trained in integrated care	3/31/19 9/30/19
4	Implement integrated care plan	9/30/19
5	Screen all members to assess SDOH	9/30/19
6	Develop communication protocols with physical health and behavioral health providers for referring members	9/30/19
7	Screen all members for behavioral health disorders	9/30/19
8	Utilize the Arizona Opioid Prescribing Guidelines for acute and chronic pain	9/30/19
9	Participate in the health information exchange with Health Current	9/30/19
10	Identify community-based resources	9/30/19
11	Prioritize access to appointments for all individuals listed in high-risk registry	9/30/19
12	Participate in any TI program-offered training	N/A

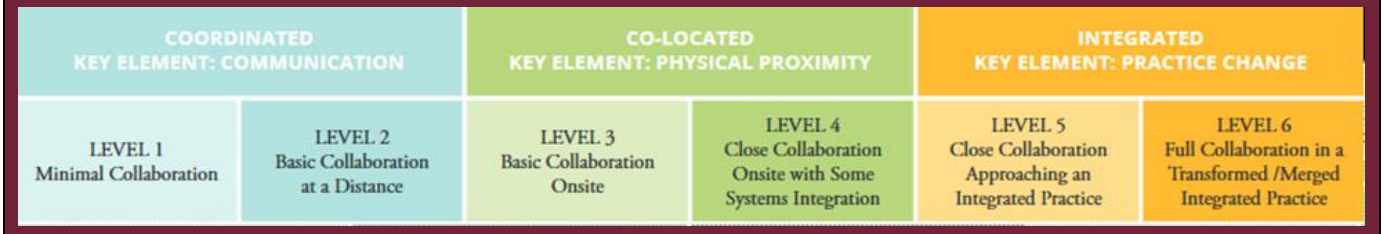
Provider Type: Primary Care Provider
Area of Concentration: Adults with Behavioral Health Needs

1.

1. Utilize a behavioral health integration toolkit, to develop a practice-specific action plan to improve integration, building from the self-assessment results that were included in the practice's Targeted Investment application.

One of the three toolkits listed here [Organizational Assessment Toolkit (OATI) ; Massachusetts Behavioral Health Integration Toolkit (PCMHI) and PCBH Implementation Kit]may be used to inform the development of a practice action plan to improve integration. Practices are welcome to use a behavioral health integration toolkit with which they may have already been working, or find one that fits their needs and practice profile.

2. Identify where along the *Levels of Integrated Healthcare* continuum the practice falls (see table below). To do so, please complete the Integrated Practice Assessment Tool (IPAT).



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 May 31, 2018, 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, **AND** By May 31, 2018, report the practice site's level of integration using the results of the IPAT level of integration tool to AHCCCS and submitting your **IPAT results here.**	By December 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 updating the practice action plan, **AND** By July 31, 2019, report on the progress that has been made since January 1, 2019 and identify barriers to, and strategies for, achieving additional progress, **AND** Complete and submit an updated IPAT score between August 1, 2019 and Sept 30, 2019 and report the practice site's level of integration using the results of the IPAT level of integration tool to AHCCCS.

2. **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.[1]**

The registry may be maintained inside or outside of the electronic health record.

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.

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**
A. By August 31, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members, **AND** 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.	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.

[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.

3. **Utilize practice care managers[2] 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.**

Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) x 11 **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) x 6 **Practice Reporting Requirement to State**
A. By September 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), **AND** B. By September 30, 2018, 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, **AND** C. By September 30, 2018, demonstrate that the care manager(s) has been trained in: • 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.	A. By March 31, 2019, document that care managers have been trained in motivational interviewing, including member activation and self-management support, **AND** B. By September 30, 2019, based on a practice record review of a random sample of at least 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 85% of the time.

[2] 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 bachelors or an advanced degree in the behavioral health or social services field plus one year of relevant experience in clinical care management, care coordination, or case management are also acceptable.

4.	**Implement the use of an integrated care plan[3] using established data elements[4] 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.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members, whom the practice has identified as having received behavioral 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 but are not limited to: the Patient–Centered Assessment Method (PCAM) , the Health Leads Screening Toolkit , the Hennepin County Medical Center Life Style Overview and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)**	
	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**
	A. By September 30, 2018, identify which SDOH screening tool is being used by the practice, **AND** B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members, attest that: A. 85% of members were screened using the practice-identified screening tool, **AND** B. 85% of the time, results of the screening were contained within the integrated care plan, **AND** C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).

[3] 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.
[4] Established data elements may include: problem identification, risk drivers, barriers to care, medical history, medication history, etc.

6.

A. Develop communication protocols with physical health and behavioral health 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 managed care organization-(MCO) level care managers to coordinate with practice-level care management activities.

An example of a protocol can be found at: Riverside Protocol Example
Riverside Protocol Example (Word Version)

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. By September 30, 2018, identify the names of providers and MCOs with which the site has developed communication and care management protocols, **AND** B. By September 30, 2018, 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.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members whom the practice has identified as having received behavioral health services during the past 12 months, attest that a warm hand-off, consistent with the practice's protocol, occurred 85% of the time.

7.	**Routinely screen all members for at least one of the following or as clinically indicated based on an affirmative response to triggers or general questions for depression, drug and alcohol misuse, anxiety, 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) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)** **5) Other MCO provided 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. By September 30, 2018, identify the practice's policies and procedures for use of standardized screening tools to identify: 1) Depression, 2) Drug and alcohol misuse, 3) Anxiety, 4) Suicide risk. The policies must include which standardized tools will be used, **AND** B. By September 30, 2018, identify the practice's procedures for interventions or referrals, as the result of a positive screening, **AND** C. By September 30, 2018, attest that the result of all practice's specified screening tool assessments are documented in the patients'' electronic health record.	By September 30, 2019, based on a practice record review of a random sample of at least 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 timeframe recommended 85% of the time.

8.	**Utilize the Arizona Opioid Prescribing Guidelines for acute and chronic pain (excluding cancer, palliative and end-of-life-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**
	By May 31, 2018, demonstrate that all providers in the practice have been trained on the AZ Guidelines for Opioid Prescribing.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members, who were prescribed opioids, attest that the prescriber complied with the AZ guidelines for opioid prescribing 85% of time.

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[5].**	
	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 September 30, 2018, 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.	By September 30, 2019, A. Attest that the practice is transmitting data on a core data set for all members to Health Current.[6] **AND** B. Attest that longitudinal data received from Health Current are routinely accessed and used to inform 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 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. By September 30, 2018, identify the sources for the practice's list of community-based resources, **AND** B. By September 30, 2018, 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.	By September 30, 2019, document that the practice's member and family experience survey includes questions specifically geared toward evaluating the success of referral relationships, and document that the information obtained from the surveys is used to improve the referral relationships.

11.	**Prioritize access to appointments for all individuals listed in the high-risk registry.**	
	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	By September 30, 2019, document the protocols used to prioritize access to members listed in the high-risk registry.

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

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

Resource Links

Core Component #1:

Organizational Assessment Toolkit (OATI)

Massachusetts Behavioral Health Integration Toolkit (PCMH)

PCBH Implementation Kit

Integrated Practice Assessment Tool (IPAT)

IPAT Assessment to Identify Level of Integration

Core component #5:

Patient–Centered Assessment Method (PCAM)

The Health Leads Screening Toolkit

Hennepin County Medical Center Life Style Overview

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).

Core Component #6:

Riverside Protocol Example

Riverside Protocol Example (Word Version)

Core Component #8:

Arizona Opioid Prescribing Guidelines for acute and chronic pain