Provider Type: Hospital Providers
Area of Concentration: Adults with Behavioral Health Needs

Project: Hospitals

Area of Concentration: Adults with Behavioral Health Needs

Provider Type: Hospital Providers

Objective: To more effectively coordinate the care for adults with a primary discharge diagnosis of behavioral health and persons with serious mental illness designation, who are being discharged from an inpatient stay.

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.

Hospital Project		
Core Component	**Milestone**	**Due Date**
1	Develop protocols to identify members' primary care physicians and to obtain members health history	9/30/19
2	Make direct connections to community behavioral health providers	9/30/19
3	Schedule follow-up with behavioral health provider within 7 days of patient discharge	9/30/19
4	Conduct a review within 48 hours of discharge	9/30/19
5	Provides priority medications in sufficient amounts for patients	9/30/19
6	Participate in relevant TI program-offered training	N/A

Provider Type: Hospital Providers
Area of Concentration: Adults with Behavioral Health Needs

1.	**A. Develop and implement written protocols used to identify member's primary care provider (PCP) and community behavioral health providers. The protocols must include utilizing Health Current, the health information exchange, AHCCCS managed care organizations (MCOs), including regional behavioral health authorities (RBHAs), and hospital-based electronic medical records.** **B. Develop and implement written protocols with high volume community behavioral health providers and PCPs to solicit and receive their input into their member's health history upon admission, seven days per week.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Hospital Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Hospital Reporting Requirement to State**
	A. By September 30, 2018, document and attest to the implementation of hospital protocols used to identify patient PCP and behavioral health providers, **AND** B. By September 30, 2018, list the names of the community behavioral health and PCPs with whom written protocols have been established for soliciting and receiving relevant clinical information about the patient upon admission.	By September 30, 2019, based on a hospital record review of a random sample of at least 20 discharged members with a primary discharge diagnosis of mental health and persons with serious mental illness designation, attest that, 85% of the time, the patient's community behavioral health or PCP was asked about the patient's behavioral and medical health history upon admission.

2.	**The hospital must make direct connection to the PCP provider and/or community behavioral health provider to discuss the member's clinical and discharge disposition *prior* to discharge and to obtain input into the discharge planning process.** **In its communication, the hospital must include information regarding any social determinants of health that may impact the member's ability to transition out of the hospital. (Specific social determinants of health shall include but not be limited to housing, safety, food insecurity and access to support systems.)**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Hospital Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Hospital Reporting Requirement to State**
	A. By September 30, 2018, document and attest to the implementation of protocols to directly contact the PCP and/or community behavioral health provider(s), on a priority basis and through an acceptable means[1], in addition to providing the discharge summary, **AND** B. By September 30, 2018, document a protocol for identifying[2] the social determinants of health (SDOH) that may impact the member's ability to transition from the hospital and documenting	By September 30, 2019, based on a hospital record review of a random sample of at least 20 discharged members with a primary discharge diagnosis of behavioral health and persons with serious mental illness designation, attest that, 85% of the time, the inpatient provider made a direct connection to the members community behavioral health provider (s) to: 1) Discuss the patient's clinical and discharge disposition prior to discharge, obtain input into the discharge planning process, and

[1] This may include face-to-face, phone or secure electronic communication.
[2] One approach to identify social determinants of health is by administering a screening tool like, the Patient Centered Assessment Method (PCAM), which can be found at https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Practice%20Centered%20Assessment%20Model%20(PCAM).pdf or 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 https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Hennepin%20Health%20Life%20Style%20Overview.pdf,theProtocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE), which can be found at: https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/PRAPARE - NACHC.mht and the Accountable Health Communities Screening Tool which can be found at https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

	those SDOH in the electronic medical record.	2) Convey any identified social determinants of health.
3.	**For patients with a primary diagnosis of mental illness, the hospital must, with input from the patient, schedule a follow-up appointment with the patient's community behavioral health provider to occur within seven days of discharge.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Hospital Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Hospital Reporting Requirement to State**
	By September 30, 2018, document the protocol for setting up follow-up appointments to occur within seven days of discharge with the patient's community behavioral health provider.	By September 30, 2019, based on a hospital record review of a random sample of at least 20 discharged members with a primary discharge diagnosis of behavioral health and persons with serious mental illness designation, attest that, 85% of the time, the hospital scheduled a follow-up appointment to occur within seven days of discharge with the patient's community behavioral health provider.

4.	**Conduct a community-based, post-discharge medication review within 48 hours of discharge, for members with a primary diagnosis of mental illness and for members with complex medication regimens. Protocols developed by the hospital should identify for which members in home reviews will be conducted and for which members telephonic or telehealth-enabled review will be conducted. Any medication-related problems found on the review (including opioid use) must be communicated to the member's primary care and/or behavioral health provider.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Hospital Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Hospital Reporting Requirement to State**
	A. By September 30, 2018, document the criteria used to identify individuals who would most benefit from in-person medication reviews and those who could be supported with a telephonic or telehealth-enabled review, **AND** B. By September 30, 2018, document the protocol that governs the process for conducting the medication review within 48 hours of discharge to the community, including how the hospital ensures the primary care and/or behavioral health provider are contacted when a medication problem arises.	By September 30, 2019, based on a hospital record review of a random sample of at least 20 discharged members who fit the hospital's medication review criteria attest that, 85% of the time, the hospital assisted in these reviews with the member, within 48 hours of discharge to the community, and communicated any medication-related problems to the PCP and/or behavioral health provider.

5.	**The hospital provides priority medications (including opioid addiction-treatment drugs prescribed for any reason and naloxone, as per Arizona Opioid Prescribing Guidelines) in amounts sufficient to meet patient needs until his or her first scheduled outpatient follow-up appointment.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Hospital Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Hospital Reporting Requirement to State**
	A. By September 30, 2018, document which medications the hospital has prioritized for this Core Component, **AND** B. By September 30, 2018, document policies and procedures for discharging members with prioritized medications in amounts sufficient to cover member needs until his or her first scheduled outpatient follow-up appointment and attest to their implementation.	By September 30, 2019, based on a hospital record review of a random sample of at least 20 discharged members with a primary discharge diagnosis of behavioral health and persons with serious mental illness designation, attest that, 85% of the time, the hospital dispensed the priority medication in an amount sufficient to cover the member until the first scheduled outpatient follow-up appointment.

6.	**Participate in any Targeted Investment program offered learning collaborative, training and education, relevant to this project. In addition, utilize any resources developed or recommendations made during the Targeted Investment period by AHCCCS to assist in the treatment of AHCCCS-enrolled members.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018*) **Hospital Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019*) **Hospital 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.

Resource Links

Core Component #5

Arizona Opioid Prescribing Guidelines