

Provider Type: Justice
Area of Concentration: Adults Transitioning from Criminal Justice System

Project: Ambulatory

Area of Concentration: Adults Transitioning from the Criminal Justice System

Provider Type: Regional Behavioral Health Authority (RBHA) Selected Providers

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 transitioning from the Criminal Justice System.

***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.**

***Note:** Selected providers are also required to participate in the Adults with Behavioral Health Needs – Area of Concentration or Primary Care Provider Area of Concentration.

Justice 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	Develop high-risk registry and develop criteria used to identify high-risk members	9/30/19
3	Use practice care managers for members included in the high-risk registry Demonstrate care manager is trained in integrated care	1/1/19 5/31/19 9/30/19
4	Implement integrated care plan	9/30/19
5	Screen members using SDOH and procedures for intervention	9/30/19
6	Develop communication protocols with MCO's and providers	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 individuals in the high-risk registry	9/30/19
12	Establish contracts with MCOs for reimbursement	3/31/19
13	Establish integrated care in probation/parole office	3/31/19
14	Develop outreach plan	3/31/19 9/30/19
15	Include practice care managers in care plan	3/31/19 9/30/19
16	Create Access to MAT	3/31/19 9/30/19
17	Create peer/family support plan	3/31/19 6/30/19 9/30/19
18	Participate in relevant TI program-offered training	N/A

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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(PCMH) and the 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).

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

<p>Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)</p> <p>◄————►</p> <p>Practice Reporting Requirement to State</p> <p>By June 30, 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</p> <p>By June 30, 2018, report the practice site's level of integration using the results of the IPAT level of integration tool, by Site Participant Number [SPN] to AHCCCS and submitting your IPAT results here.</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p> <p>◄————► ◄————►</p> <p>Practice Reporting Requirement to State</p> <p>By December 31, 2018, attest 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</p> <p>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</p> <p>Complete and submit an updated IPAT score ¹between 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.</p> <p>**Resources available on the last page of this document**</p>
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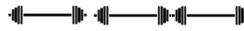
¹ IPAT scores to be submitted via the TI attestation portal.

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2.	<p>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.²</p> <p>The registry may be maintained inside or outside of the EHR.</p> <p>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 and c) are at medium to high criminogenic risk as determined by probation/parole and the appropriate criminogenic screening tools listed below:</p> <ol style="list-style-type: none"> 1) Offender Screening Tool (OST); 2) Field Reassessment Offender Screening Tool (FROST); 3) Criminal Thinking Scales; 4) Arizona Community Assessment Tool (ACAT); 5) Risk, Need, and Responsivity(RNR); 6) Women’s Risk Need Assessment (WRNA); and 7) Sex Offender Treatment Intervention and Progress Scale (SOTIPS). 						
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A.	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top; padding: 5px;"> By September 30, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members. </td> <td style="width: 50%; border: none; vertical-align: top; padding: 5px;"> By September 30, 2019, attest 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, AND By September 30, 2019, attest 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> </tr> </table>	By September 30, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk members.	By September 30, 2019, attest 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, AND By September 30, 2019, attest 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.				
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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.

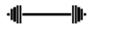
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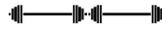
<p>3. Utilize practice care managers³ for members included in the high-risk registry, with a case load not to exceed a ratio of 1:100. Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system) or contracted by the practice from external sources. Practice-level care management functions should include:</p> <ol style="list-style-type: none"> 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. 	
<p>Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)</p>  <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p>  <p>Practice Reporting Requirement to State</p>
<p>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</p> <p>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</p>	<p>A. By January 1, 2019, attest that the care manager(s) has been trained in:</p> <ul style="list-style-type: none"> • Comprehensive assessment of member needs and goals; • Use of integrated care plans; • Member and family education; and <p>Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10, AND</p> <p>B. By May 31, 2019, document that care managers have been trained in motivational interviewing⁴, are conducting motivational interviewing with high risk members including member activation and self-management support, AND</p> <p>C. 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 completed all required documentation including: a) completing a comprehensive assessment, b) educating members, c) appropriately facilitating linkages to community-based organizations, and d) whether the member already received integrated care/case management from other practices and/or MCOs, at least 85% of the time.</p> <p>**Resources available on the last page of this document**</p>

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 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 CM motivational interviewing training requirement: 6 CEUs by May 31, 2019; or 6 CEUs within the past 24 months; or motivational interviewing certificate within the past 24 months. Please see example trainings last page of this document.

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4.	Implement the use of an integrated care plan⁵, using established data elements⁶, for members identified as part of Core Component 2.	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018 ^{**}) 	Milestone Measurement Period 2 (October 1, 2018–September 30, 2019 ^{**}) 
	Practice Reporting Requirement to State	Practice Reporting Requirement to State
	By September 30, 2018, demonstrate that the practice has designed and is able to implement an integrated care plan.	By September 30, 2019, based on a practice record review of a random sample of at least 20 members in the high risk registry, 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 medical record 70% of the time ⁷ .

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 <u>Patient–Centered Assessment Method (PCAM)</u> , the <u>Health Leads Screening Toolkit</u> , the <u>Hennepin County Medical Center Life Style Overview</u> and the <u>Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE)</u>.	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018 ^{**}) 	Milestone Measurement Period 2 (October 1, 2018–September 30, 2019 ^{**}) 
	Practice Reporting Requirement to State	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 85% of members were screened using the identified tool and that the care manager/case manager connected the member to the appropriate community resource and documented the intervention/referral in the care plan for those who scored positively on the screening tool. <i>**Resources available on the last page of this document**</i>

⁵ 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 the care plan in consultation with all members of the clinical team, the patient, the family and when appropriate, the Child and Family Team. Can include scanned documents

⁶ Established data elements may include: problem identification, risk drivers, barriers to care, medical history, medication history, etc.

⁷ Integrated care plans may be effectively shared via secure email-consult Health Current with questions

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7.	<p>Routinely screen all members at the age-appropriate time 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, developmental delays in infancy and early childhood, and suicide risk, using age-appropriate and standardized tools, such as, but not limited to:</p> <ol style="list-style-type: none"> 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 AHCCCS approved screening tools. <p>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.</p>	
	<p>Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**)</p> <p style="text-align: center;">◄───►</p> <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p> <p style="text-align: center;">◄───►</p> <p>Practice Reporting Requirement to State</p>
	<p>A. By September 30, 2018, identify the practice's policies and procedures for use of standardized screening tools to identify:</p> <ol style="list-style-type: none"> 1) Depression, 2) Drug and alcohol misuse, 3) Anxiety, 4) Suicide risk. <p>The policies must include which standardized tools will be used, AND</p> <p>B. By September 30, 2018, identify the practice's procedures for interventions or referrals, as the result of a positive screening, AND</p> <p>C. By September 30, 2018, attest that the results of all practice's specified screening tool assessments are documented in the electronic health record.</p>	<p>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.</p>

8.	<p>Utilize the <u>Arizona Opioid Prescribing Guidelines for acute and chronic pain</u> for acute and chronic pain (excluding cancer, palliative and end-of-life-care)</p>	
	<p>Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**)</p> <p style="text-align: center;">◄───►</p> <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p> <p style="text-align: center;">◄───►</p> <p>Practice Reporting Requirement to State</p>
	<p>By September 30, 2018, demonstrate that all providers in the practice have been trained on the AZ guidelines for opioid prescribing.</p>	<p>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.</p> <p>**Resources available on the last page of this document**</p>

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9.	Participate in <u>bidirectional exchange of data</u> 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**)	Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)
		
	Practice Reporting Requirement to State	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.	A. By September 30, 2019, attest that the practice is transmitting data on a core data set for all members to Health Current. ¹⁰ AND B. By September 30, 2019, implement policies and procedures that require longitudinal data received from Health Current to be routinely accessed and used to inform care management of high-risk members.

10	Identify community-based resources, at a minimum, through use of lists maintained by the MCO. 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: <ol style="list-style-type: none"> 1) Community-based social service agencies. 2) Self-help referral connections. 3) Substance misuse treatment support services. 	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**)	Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)
		
	Practice Reporting Requirement to State	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, attest that the A. Practice has implemented the AHCCCS defined member and family experience survey questions ¹¹ geared toward evaluating the success of referral relationships, and B. Document that the information obtained from the surveys is used to improve the referral relationships with an action plan summarizing the survey results including addressing response trends that indicate a need for process improvement. English Version: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/Member and family experience survey.docx Spanish Version: https://www.azahcccs.gov/PlansProviders/TargetedInvestment

¹⁰ A core data set will include a patient care summary with defined data elements.

¹¹ Survey questions can be added to existing survey if analysis can be segregated.

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11.	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 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.								
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N/A	By September 30, 2019, attest to the development and implementation of the protocols used to prioritize access to members listed in the high-risk registry.								
12.	Establish contracts with MCOs¹² to be reimbursed for integrated services, ideally located within select county probation offices or Department of Corrections (DOC) parole offices, or in close proximity, which may include probation/parole offices relocating to health care facilities.								
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13.	Establish an integrated health care setting(s) co-located with select county probation offices and/or DOC parole offices, the number to be determined by the MCOs and AHCCCS. If the MCOs and provider agree, and AHCCCS approves, a provider using a mobile unit in near proximity to the offices, or a permanent location in close proximity to the probation office and/or DOC parole offices, will be acceptable.								
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¹² MCOs include acute plans and RBHAs.

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		<p>15th, 2019.</p> <ul style="list-style-type: none"> • An ongoing, collaborative relationship with probation/parole the TI provider co-locates with including, but not limited to: <ul style="list-style-type: none"> ○ Cross-training between healthcare and probation/parole (e.g. criminogenic risk, trauma-informed care), ○ Shared case management of members when appropriate (e.g. probation officer shares with the healthcare provider the member's progress/challenges towards achieving criminogenic goals and the healthcare provider shares with probation officer the member's progress/challenges toward achieving improved health outcomes).
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14.	<p>Develop an outreach plan that is updated regularly, in cooperation with the probation and parole offices to encourage individuals pre- and post-release to utilize the established integrated clinic. This plan should include:</p> <ol style="list-style-type: none"> 1) Targeted efforts to provide pre-release care coordination and schedule appointments in the integrated clinic for individuals with medium to high criminogenic risk screening. 2) Targeted efforts to provide eligibility and enrollment support to individuals transitioning to probation who are not already identified as Medicaid enrolled and to schedule appointments in the integrated clinic upon release. 	
	<p>Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)</p> <p style="text-align: center;">◄───►</p> <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p> <p style="text-align: center;">◄───►</p> <p>Practice Reporting Requirement to State</p>
	<p>Wave 1:</p> <ol style="list-style-type: none"> A. By September 30, 2018, document that the practice has developed and implemented an outreach plan in cooperation with the probation and/or DOC parole office(s) that specifically targets individuals with medium to high criminogenic risk, AND B. By September 30, 2018, document the practice procedures for identifying and providing eligibility and enrollment support to individuals transitioning to probation and/or DOC parole offices. 	<p>Wave 2 (March 31, 2019): Attest that the practice has developed and implemented an outreach plan in cooperation with the probation and/or DOC parole office(s) that specifically targets individuals with medium to high criminogenic risk.</p> <p>Waves 1 and 2 (September 30, 2019):</p> <ol style="list-style-type: none"> A. Attest to the development and implementation of practice procedures for identifying and providing eligibility and enrollment support to individuals transitioning to probation and/or DOC parole offices, AND B. Attest that the practice has a means for obtaining and analyzing, at least semi-annually, the member experience of those members who have visited the clinic, and those who have not, yet still visit the associated probation/parole office, AND C. Attest that the practice has developed and implemented changes in its outreach plan in response to member experience, to attain higher utilization of practice services among those on probation/parole who travel to the probation or parole office per the terms of their release.

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15.	<p>For the Justice involved population who are listed in the high-risk registry, practice care managers must include in the integrated care plan: a) health care services recommended as part of the probation/parole-specific community supervision plan, and when applicable, b) the critical elements from the care plan developed as a result of "reach-in" activities conducted by the MCOs and/or c) mandated health care services as outlined in the member's Comprehensive Mental Health Court agreement.</p> <p>The practice care manager must also collaborate with parole/probation officer to align, to the extent possible, follow-up appointments with probation/parole office visits.</p>				
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16.	<p>Practices must have reliable and consistent access within the practice setting (via in-person or telemedicine-enabled means) to medication-assisted treatment (MAT), and must develop or adopt protocols to provide MAT of opioids using evidence-based guidelines. Such guidelines can be found at: Medication Assisted Treatment of Opioid Use Disorder Pocket Guide</p>				
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		<p>**Resources available on the last page of this document**</p>
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17.	<p>Create a peer and family support plan using evidence-based approaches that incorporates AHCCCS identified & approved training & credentialing for peer and family support specialists. Peer and family support specialists will have lived experience in the public behavioral health system and Criminal Justice System and be available to the co-located staff to assist formerly incarcerated individuals and their families with, including but not limited to:</p> <ol style="list-style-type: none"> 1) Eligibility and enrollment applications; 2) Health care education/system navigation; 3) Finding transportation; and 4) Information on other support resources, including health literacy and financial literacy training. 	
	<p>Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)</p>  <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p>  <p>Practice Reporting Requirement to State</p>
	<p>Wave 1: By September 30, 2018, document that the practice has created a peer and family support plan, which incorporates peer and family specialists as part of the co-located staff and specifically articulates their role. Attest that peers and family support specialists have been trained using AHCCCS identified & approved Forensic Peer and Family Training Section 1.</p>	<p>Wave 2 (By March 31, 2019): Attest that the practice has created a peer and family support plan, which incorporates peer and family specialists as part of the co-located staff and specifically articulates their role, AND</p> <p>Wave 2 (By March 31, 2019): Attest that peers and family support specialists have been trained using AHCCCS identified & approved Forensic Peer and Family Training Section 1, AND</p> <p>Waves 1 and 2 (By June 30, 2019): Attest that peers and family support specialists have been trained using AHCCCS identified & approved Forensic Peer and Family Training Section 2, AND</p> <p>Waves 1 and 2 (By June 30, 2019): Attest and demonstrate that all members served are provided comprehensive information that enables their choice of services from:</p> <ol style="list-style-type: none"> A. An AHCCCS recognized Forensic Peer & Family Run organization, AND B. A Forensic Peer & Family specialist on staff at the TI Justice provider clinic who is eligible and trained using AHCCCS identified & approved Forensic Peer and Family Training, AND <p>Waves 1 and 2 (By September 30, 2019): Attest that peers and family support specialists have been trained using AHCCCS identified & approved Forensic Peer and Family Training Section 3.</p>

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18.	Participate in any Targeted Investments 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 Investment period by AHCCCS to assist in the treatment of AHCCCS-enrolled individuals.	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**)	Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)
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	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.

Resource Links

Core Component #1:

- [Organizational Assessment Toolkit \(OATI\)](#)
- [Massachusetts Behavioral Health Integration Toolkit \(PCMH\)](#)
- [PCBH Implementation Kit](#)
- [Integrated Practice Assessment Tool \(IPAT\)](#)

Core component #3:

Motivational Interviewing Training Examples

- <https://cabhp.asu.edu/content/motivational-interviewing>
- <https://reliasacademy.com/browse/productDetailSingleSku.jsp?productId=c61576>
- <https://ce.pharmacy.purdue.edu/mi/introduction>
- <https://cne.nursing.arizona.edu/oltpublish/site/program.do?dispatch=showProgramSession&id=87836c34-5903-11e7-a6ac-0cc47a352510&inner=false>

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:

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[Riverside Protocol Example](#)

[Riverside Protocol Example \(Word Version\)](#)

Core Component #8:

[Arizona Opioid Prescribing Guidelines for acute and chronic pain](#)

[Riverside Protocol Example \(Word Version\)](#)

Core Component #16

[Medication Assisted Treatment of Opioid Use Disorder Pocket Guide](#)