Project: Ambulatory

Area of Concentration: Children/Youth with Behavioral Health Needs

Provider Type: Pediatric 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 and children/youth with behavioral health needs and children/youth in the child welfare 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."

<table>
<thead>
<tr>
<th>Core Component</th>
<th>Milestone</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare</td>
<td>5/31/18</td>
</tr>
<tr>
<td>2</td>
<td>Implement the use of an integrated care plan</td>
<td>9/30/18</td>
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<tr>
<td>3</td>
<td>Screen members using SDOH and develop procedures for intervention</td>
<td>9/30/18</td>
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<tr>
<td>4</td>
<td>Develop communication protocols with MCO’s and providers</td>
<td>9/30/18</td>
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<tr>
<td>5</td>
<td>Screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII)</td>
<td>9/30/18</td>
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<tr>
<td>6</td>
<td>Participate in the health information exchange with Health Current</td>
<td>9/30/18</td>
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<tr>
<td>7</td>
<td>Identify community-based resources</td>
<td>9/30/18</td>
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<tr>
<td>8</td>
<td>Develop protocols for Trauma-Informed Care</td>
<td>9/30/18</td>
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<tr>
<td>9</td>
<td>Develop communication protocols in agreement with ASD</td>
<td>9/30/19</td>
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<tr>
<td>10</td>
<td>Develop procedures to provide information to families with children/youth with ASD</td>
<td>9/30/19</td>
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<tr>
<td>11</td>
<td>Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers</td>
<td>9/30/19</td>
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<tr>
<td>12</td>
<td>Develop a protocol for obtaining records for those in child welfare system and medication needs.</td>
<td>9/30/19</td>
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<td>13</td>
<td>Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy</td>
<td>9/30/19</td>
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<tr>
<td>14</td>
<td>Participate in relevant TI program-offered training</td>
<td>N/A</td>
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</table>
A. 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 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.

B. 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).

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some Systems Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

**Milestone Measurement Period 1**
(October 1, 2017–September 30, 2018**)

**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 by submitting your IPAT results here.

**Milestone Measurement Period 2**
(October 1, 2018–September 30, 2019**)

**Practice Reporting Requirement to State**

- 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, **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.

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. Implement the use of an integrated care plan\(^1\) using established data elements\(^2\).

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<tr>
<td>(October 1, 2017–September 30, 2018**)</td>
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**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 primary care 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.

3. 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).

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**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 7, 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 applicable intervention(s) or referral(s).

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\(^1\) 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.
### Milestone Period Measurement Period 1
(October 1, 2017–September 30, 2018**)

#### 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

### Milestone Period Measurement Period 2
(October 1, 2018–September 30, 2019**)

#### Practice Reporting Requirement to State

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 primary care services during the past 12 months, attest that a warm hand-off, consistent with the practice’s protocol, occurred 85% of the time.

### Milestone Period Measurement Period 1
(October 1, 2017–September 30, 2018**)

#### Practice Reporting Requirement to State

- **A.** By September 30, 2018, document the practice’s policies and procedures for use of the ECSII, **AND**

- **B.** By September 30, 2018, attest that the results of the ECSII are in the electronic medical record.

### Milestone Period Measurement Period 2
(October 1, 2018–September 30, 2019**)

#### Practice Reporting Requirement to State

By September 30, 2019, based on a practice record review of a random sample of at least 20 members’ ages 0–5, attest that the practice performed the ECSII 85% of the time and incorporated service intensity recommendations into the integrated treatment plan.

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3 “Routinely” is defined as: 1.) at Intake  2.) Yearly, at minimum  3.) Based on significant changes in child’s life
**Provider Type:** Behavioral Health Provider  
**Area of Concentration:** Children/Youth with Behavioral Health Needs

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**Practice Reporting Requirement to State**

6. **Participate in bidirectional exchange of data with Health Current, the health information exchange (for example, both sending and receiving data), which includes transmitting data on core data set for all members to Health Current.**

- **Milestone Period Measurement Period 1**
  - 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.

- **Milestone Period Measurement Period 2**
  - By September 30, 2019,
    - A. Attest that the practice is transmitting data on a core data set for all members to Health Current.
    - B. Attest that longitudinal data received from Health Current are routinely accessed and used to inform care management of high-risk members.

7. **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**
  - 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.

- **Milestone Period Measurement Period 2**
  - 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.

8. **Develop protocols for utilizing the AHCCCS defined standardized suite of evidence-based practices and trauma-informed services.**

- **Milestone Period Measurement Period 1**
  - **Practice Reporting Requirement to State**

- **Milestone Period Measurement Period 2**
  - **Practice Reporting Requirement to State**

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4 A core data set will include a patient care summary with defined data elements.
### Provider Type: Behavioral Health Provider  
**Area of Concentration: Children/Youth with Behavioral Health Needs**

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#### Practice Reporting Requirement to State

| A. | By Sept 30, 2018, identify the developmentally appropriate evidence based practices and coinciding case management that have established approaches for trauma-informed care and encompass the [SAMSHA 6 Guiding Principles for trauma-informed care](https://www.samhsa.gov), AND | By September 30, 2019, document the protocols for utilizing the AHCCS-defined evidence-based practices that were identified in Year 2. |
| B. | By September 30, 2018, demonstrate that all staff AHCCS requires to be trained and have participated in an AHCCCS-identified Trauma-Informed Care training program or registered for the training by that date. | |

#### 9. A. Follow Arizona-established diagnostic and referral pathways for any member that screens positive on the Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R), Ages & Stages Questionnaires® (ASQ) or Parents’ Evaluation of Developmental Status (PEDS) tool.  
B. Develop communication protocols and referral agreements with autism spectrum disorder (ASD) Specialized Diagnosing Providers to facilitate referral and diagnosis for members who have screened positively on the M-CHAT-R, PEDS or ASQ.  

#### Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)  
**Practice Reporting Requirement to State**  
N/A

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

- By September 30, 2019, based on a practice record review of a random sample of at least 20 members screened as positive on the M-CHAT, ASQ or PEDS tool, attest that 85% were referred to the appropriate providers, consistent with the Arizona established diagnostic and referral pathways, AND
- By September 30, 2019, Identify the name(s) of the ASD Specialized Diagnosing Providers with which the primary care or behavioral health site has developed a communication protocol and referral agreement.

#### 10. Develop procedures to provide information regarding parent support and other resources for families and other caregivers of children/youth with ASD, which include practice use of available resource lists.  

#### Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)  
**Practice Reporting Requirement to State**  
N/A

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

- By September 30, 2019, Document the policies and procedures that guide the practice in providing information regarding parent support and other resources for families and other caregivers of children/youth with ASD.

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5 Communication may be facilitated with the use of telehealth.
11. **Develop protocols for teenagers/young adults with ASD to facilitate smooth care transitions from pediatric to adult providers.**

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**Practice Reporting Requirement to State**

| N/A | By September 30, 2019, document the policies and procedures that guide the practice in facilitating the transition of care for teenagers and young adults with ASD, who will be aging out of pediatrics and seeking care from adult primary care providers. |

12. **A. Develop a protocol for obtaining records for children/youth in the child welfare system prior to and after the first visit, which specifically prioritizes identifying the psychotropic medication history of the member. The protocol should include:**

   1. Obtaining the proper consent for accessing behavioral health and substance use records, and
   2. Utilization of multiple resources to identify past medical and behavioral health providers, including the HIE, information obtained from the Arizona Department of Child Safety (DCS) case worker, and the Comprehensive Medical and Dental Program (CMDP).

   **B. Develop a protocol for addressing medication needs of children/youth in the child welfare system during the first visit, which includes how the practice will:**

   1. Make efforts to consult with the most recent prescriber of psychotropic medication, to understand the child’s baseline, response to treatment, side effects and ongoing plan of care, and
   2. Follow the American Academy of Child and Adolescent Psychiatry (AACAP) recommendation about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems.  

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**Practice Reporting Requirement to State**

| N/A | By September 30, 2019, document protocols used for obtaining records for children/youth engaged in foster care, prior to and after the first visit, and for addressing their psychotropic medication needs, **AND** document protocols for addressing any medication needs of children/youth engaged in the child welfare system, consistent with this Core Component. |

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### 13. Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)

**Practice Reporting Requirement to State**

<table>
<thead>
<tr>
<th>A.</th>
<th>Complete a comprehensive after-visit summary that is shared with the foster parents/guardians, the child welfare case worker and the Child and Family Team, as appropriate, to assist foster parents/guardians and case workers in following-up on referrals and recommendations. An example of a visit discharge and referral summary for families can be found here: <a href="http://downloads.aap.org/DOCHW/HFCA/DischargeForm.docx">http://downloads.aap.org/DOCHW/HFCA/DischargeForm.docx</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>The comprehensive after-visit summary should include recommendations for foster parents/guardians to assess safety risk and monitor the child’s medical or behavioral health issues at home. Parenting support should include education about the child’s physical and emotional needs at the time of the initial visit, and as required in follow-up visits, to assist the child and family in understanding the care plan.</td>
</tr>
<tr>
<td>C.</td>
<td>Develop and implement a policy that the comprehensive after-visit summary should not divulge confidential information between the member and provider, particularly for teens engaged in the child welfare system.⁷,⁸</td>
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</tbody>
</table>

**Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)

**Practice Reporting Requirement to State**

<table>
<thead>
<tr>
<th>By September 30, 2019</th>
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</thead>
<tbody>
<tr>
<td>A.</td>
</tr>
<tr>
<td>B.</td>
</tr>
<tr>
<td>C.</td>
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### 14. Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**)

**Practice Reporting Requirement to State**

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

**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.

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⁸ For additional resources for teens, see the following DBHS Practice Tools: [Youth Involvement in the Arizona Behavioral Health System](http://www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/YouthPracticeProtocol.pdf) and [Transition to Adulthood](http://www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/tas.pdf)
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 #3:
- 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 #4:
- Riverside Protocol Example
- Riverside Protocol Example (Word Version)

Core Component #5:
- Early Childhood Service Intensity Instrument (ECSII)

Core Component # 13
- Discharge Form