Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

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 children/youth with behavioral health needs and children/youth in the foster care 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.

Pediatric BH 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	Implement the use of an integrated care plan	9/30/19
3	Screen members using SDOH and develop procedures for intervention	9/30/19
4	Develop communication protocols with MCO's and providers	9/30/19
5	Screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII)	9/30/19
6	Participate in the health information exchange with Health Current	9/30/19
7	Identify community-based resources	9/30/19
8	Develop protocols for Trauma-Informed Care	9/30/19
9	Develop communication protocols in agreement with ASD	9/30/19
10	Develop procedures to provide information to families with children/youth with ASD	9/30/19
11	Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers	9/30/19
12	Develop a protocol for obtaining records for those in the foster care system and medication needs.	9/30/19
13	Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy	9/30/19
14	Participate in relevant TI program-offered training	N/A

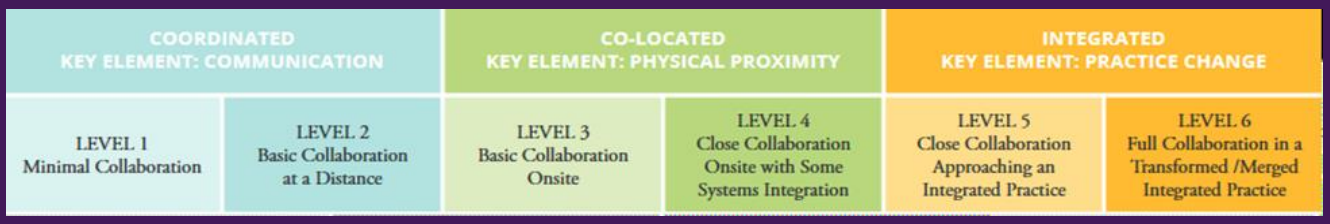
Provider Type: Behavioral Health Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

1.

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).



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 by 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**, 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 [1]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. *****Resources available on the last page of this document*****

[1] IPAT scores to be submitted via the TI attestation portal.

2.	**Implement the use of an integrated care plan[2] using established data elements[3].**	
	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 who had integrated treatment plans created, attest that the integrated treatment plan includes the established data elements and is documented in the electronic health record 70% 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).**	
	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 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 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. *****Resources available on the last page of this document*****

[2] 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

[3] 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.

4.

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 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 newly identified as having received or referred to primary care services: If the practice is co-located [including co-located via telehealth] attest that a warm hand-off [4] by a provider or care manager, or other licensed professional [5] to a licensed professional, consistent with the practice's protocol, occurred 85% of the time. Appointments scheduling may be conducted by whomever the practices determine. If the practice is not co-located attest that, 85% of the time referrals are made within 72 hours by a provider or the care manager, or other licensed professional to a licensed professional[5], the information specified in the practice's communication protocol is provided at the time of the referral, and that the member is outreached in person or telephone regarding the shared information and the referral status. Appointments scheduling may be conducted by whomever the practices determine. ***Resources available on the last page of this document***

[4] Warm handoff: The licensed behavioral health provider directly introduces the patient to the primary care provider at the time of the behavioral health visit.

[5] Behavioral Health Technicians (BHT) as defined by 9 A.A.C 10, whether licensed or not, may also perform the handoff. *"Behavioral health technician" means an individual who is not a behavioral health professional who provides, with clinical oversight by a behavioral health professional, the following services to a patient to address the patient's behavioral health issue: a. Services that, if provided in a setting other than a health care institution would be required to be provided by an individual licensed under A.R.S, Title 32, Chapter 33; or b. Health-related services.*

5.	**Routinely[6] screen children from ages 0–5 using the Early Childhood Service Intensity Instrument (ECSII) to assess what intensity of services are needed to assist them with their emotional, behavioral, and/or developmental needs and to inform service recommendations into the integrated care plan.** **The practice must develop procedures for interventions and treatment, including periodic reassessment.**	
	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, 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.	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. *****Resources available on the last page of this document*****

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 (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.[7] **AND** B. Implement policies and procedures that describe how 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 of 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**

[6] "Routinely" is defined as: 1) at Intake 2) Yearly, at minimum 3) Based on significant changes in child's life

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

	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[8] 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/TargetedInvestments/Downloads/PO_70708_Member_and_family_experience_survey-SP.docx
8.	**Develop protocols for utilizing the AHCCCS defined standardized suite of evidence-based practices and trauma-informed services.**	
	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 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, **AND** B. By September 30, 2018, demonstrate that all staff AHCCCS requires to be trained and have participated in an AHCCCS-identified Trauma-Informed Care training program or registered for the training by that date.	By September 30, 2019, attest to utilizing the evidence based practices and coinciding case management that have been established in Year 2 for trauma-informed care that encompass the SAMSHA 6 Guiding Principles for trauma-informed care[9].

[8] Survey questions can be added to existing survey if analysis can be segregated.
[9] See page 11 for the six guiding principles.

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 created by the ASD Advisory Committee.** **B. Develop communication protocols[10] 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**	**Milestone Measurement Period 2** (October 1, 2018-September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	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[11], 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[12] with which the primary care or behavioral health site has developed a communication protocol and referral agreement. *****Resources available on the last page of this document*****

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**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	By September 30, 2019, attest to the development and implementation of 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. *****Resources available on the last page of this document*****

[10] Communication may be facilitated with the use of telehealth.
[11] Members whose EPDST assessments or other applicable assessment indicate any developmental milestones that are not met should be screened on the M-CHAT, ASQ, or PEDS tools.
[12] Providers able to assess children/individuals and may provide a diagnosis on the autism spectrum disorder, as applicable. Additional resources available on the last page of this document.

11.	**Develop protocols[13] for teenagers/young adults with ASD to facilitate smooth care transitions from pediatric to adult providers.**	
	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, attest to the development and implementation of 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 and/or behavior health providers. *****Resources available on the last page of this document*****

12.	**A. Develop a protocol for obtaining records for children/youth in the foster care 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 foster care 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.[14]**	
	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, attest to the development and implementation of A. Protocols used for obtaining records for children/youth engaged in the foster care system, prior to and after the first visit, and for addressing their psychotropic medication needs, **AND** B. Protocols for addressing any medication needs of children/youth engaged in the foster care system, consistent with this Core Component.

[13] Protocol elements should include a) Continuum of services dependent on individual needs b) Degree of preparation for living independently and c) Hand-off process to adult providers including specialists-identify specific providers. Additional resources available on the last page of this document

[14] Recommendations about the use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems
www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf

13.	**A. Complete a comprehensive after-visit summary that is shared with the foster parents/guardians, the foster care 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: http://downloads.aap.org/DOCHW/HFCA/DischargeForm.docx** **B. 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.** **C. 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 foster care system.** [15,16]	
	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, attest to the development and implementation of A. Policies and procedures for developing and sharing comprehensive after-visit summaries with foster, parents/guardians that contain referrals and recommendations, **AND** B. Protocols for assessing risk and educating foster parents/guardians on the child's needs, **AND** C. Protocols that ensure confidentiality between the member and provider. *****Resources available on the last page of this document*****

[15] See "Consent & Confidentiality in Adolescent Health Care: A Guide for the Arizona Health Practitioner. http://www.azmed.org/resource/resmgr/Publications/2015_Adol_Consent_Conf_Bookl.pdf?hhSearchTerms=%22confidentiality%22

[16] For additional resources for teens, see the following DBHS Practice Tools: Youth Involvement in the Arizona Behavioral Health System (www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/YouthPracticeProtocol.pdf) and Transition to Adulthood (www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/tas.pdf)

14.	**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 Investment 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 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:

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 #9:

RBHA Resources:

https://www.mercymaricopa.org/providers/resources/providers-autism

https://www.azcompletehealth.com/find-a-doctor.html

https://www.stewardhealthchoiceaz.com/health-wellness/childrens-behavioral-health/

AHCCCS Resources:

Arizona established diagnostic and referral pathways:

https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/PCP_SYSTEM_PATHWAY_2-22-19.pdf

Back to Basics-Developmental Screening:

https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Downloads/ASD.pptx

Core Components #10 and #11:

https://www.azahcccs.gov/shared/asd.html

https://www.azahcccs.gov/shared/Downloads/ASD/EBPTool053117.pdf

Core Component # 13

Discharge Form