Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 1: Integration of Primary Care and Community Behavioral Health Services (primary care site)
Objective: To integrate behavioral health services (some of which are paid for by Regional Behavioral Health Authorities (RBHAs)) into the primary care site. This project would include seriously mentally ill (SMI) individuals enrolled in an integrated RBHA and non-SMI individuals receiving services from both the RBHA and the assigned acute care health plan.

		DY 1		DY 2		DY 3	
CC#	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Taking Steps Toward Integration						
1	Utilize a commonly accepted behavioral health integration practice self-assessment instrument. Self-assessment tools and behavioral health integration toolkits can be found through the SAMHSA-HRSA Center for Integrated Health Solutions (see www.integration.samhsa.gov/operations-administration/assessment-tools).	Identify the names of the self-assessment instruments the practice has employed and report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of an assessment; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.	N/A	N/A	N/A	N/A
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration. Self-assessment tools and behavioral health integration toolkits can be found through SAMHSA-HRSA Center for Integrated Health Solutions (see www.integration.samhsa.gov/operations-administration/assessment-tools).	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.	N/A	N/A	N/A	N/A

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	Management of High-Risk Patients						
3	Utilize care managers [1] at a maximum caseload of 1:100 (unless otherwise specified by AHCCCS) to, in part, help develop integrated care plans, work with families and facilitate linkages to community organizations, social service agencies and schools.	Identify the name of at least one care manager serving at the primary care site. Indicate the caseload level per care manager.	Percentage of practices that have identified a care manager for each practice site; Percentage of practices that have met the caseload level standards.	N/A	N/A	N/A	N/A
		Document that care managers have been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care managers that have received DSRIP entity care coordination training; Evidence of training agenda and training materials.	N/A	N/A	N/A	N/A
		Document that care managers have been trained to engage and educate patients who are frequent ED utilizers to utilize the behavioral health practice, instead of the ED, when appropriate.					
		Document that care managers have been trained in motivational interviewing for patient self-management support.					

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4	Track-members with high risk to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement.	Develop a) a registry of high-risk patients and b) processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have implemented processes for routinely screening for high-risk status indicators.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry.	N/A	N/A
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can and is incorporated into the high-risk registry.	Demonstrate the functionality to utilize the registry to communicate which patients are not responding to treatment as per the care plan.	Percentage of providers using a registry tool to communicate which patients are not responding to treatment as per the care plan.	N/A	N/A
6	Screen all patients to assess their complexity and what factors are affecting their health by using a tool that addresses common social determinants of health. (One such tool is the Patient Centered Assessment Method (PCAM) which can be found at www.pcamonline.org/about-pcam.html.)	(1) Identify what screening tool is used. (2) Confirm that the results of all screening tool assessments are contained in the electronic health record.	(1) Frequency distribution of SDOH screening tools (2) Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that 90% of patients are screened using the practice-identified screening tool.	Percentage of practices that meet the requirement to screen 90% of their patients using the practice-identified screening tool.	N/A	N/A

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7	Develop procedures for intervention or referral based on the result of the practice-identified SDOH screening tool.	Document policies and procedures for intervention or referral to resources / agencies as the result of the screening. Referrals to community-based organizations should be consistent with protocols established in the Core Component 13 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.	N/A	N/A	N/A	N/A
8	Implement the use of integrated care plans to be managed by a clinical care manager.	Demonstrate that all patients and identified as high-risk have been referred to a care manager for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. AHCCCS will conduct an audit of sample of practices to confirm that high-risk patients have care plans consistent with the required elements.	Demonstrate that the integrated care plan is in an integrated electronic medical record such that primary care providers and behavioral health providers both have access to it.	Percentage of practices that have integrated care plans documented in an integrated medical record.	N/A	N/A

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		Demonstrate that all patients identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and barriers to care, including results from the PCAM on social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient's goals, desired outcomes, and objectives and readiness to address any individual needs. Document that behavioral health care providers provide input into the integrated care plan when the primary care provider is the originator of the plan, consistent with Core Component 8.					

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9	Conduct a root cause analysis to determine why certain practice patients are frequent ED and / or inpatient service utilizers and identify the barriers to reducing the frequency of ED and inpatient use, including those that may be practice-based.	List the adopted practice strategies to address the barriers, and engage the patients with high ED and / or IP use to access the primary care practice or their principal behavioral health provider in lieu of an ED visit, when appropriate, and with measurable goals and timelines.	Percentage of practices that developed strategies for addressing high ED and / or inpatient use; Summary categorization of practice strategies and goals with frequency distribution.	Provide a progress report on the areas of focus and attainment to practice-identified goals.	Percentage of practices that provided a progress; Summary description of progress practices have made to reduce ED and IP utilization.		
10	Utilize the AZ Guidelines for Prescribing Opioids for Chronic Pain (excluding cancer, palliative, and end-of-life-care) available at: http://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opiod-prescribing-guidelines.pdf	Demonstrate that providers have been trained on the AZ guidelines for opioid prescribing	Percentage of providers in each practice that have been trained on the AZ guidelines	Demonstrate that AZ guidelines are accessible within the practice's electronic medical record.	Percentage of practices with AZ guidelines embedded within its electronic medical record.	N/A	N/A

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	Relationships with Community Behavioral Health Providers						
11	Develop referral agreements with mental health and substance use providers in the community and within the tribes to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation. Details should include the communication modality by which the primary care clinician can reach the behavioral health provider (e.g., telephone, pager, email, etc.); (b) protocols for referrals, crisis, information sharing, and obtaining consent; (c) protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers; (d) protocols for ongoing and collaborative-team-based care, including for behavioral health providers to provide input into an integrated care plan, and (e) protocols for ensuring same-day availability for a behavioral health visit on the day of a physical health visit.	Identify the names of the behavioral health practices with which the primary care site has developed a referral and care coordination agreement.	Percentage of practices with referral and care coordination agreements; A listing of mental health and substance use providers with which each practice has completed a referral and care coordination.	Identify the names of practices with which the primary care site has developed a referral and care coordination agreement in DY 2.	Percentage of practices with an increase in the number of referral and care coordination agreements.	N/A	N/A

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	Clinical Care within the Primary Care Office						
12	Routinely screen patients for depression, anxiety, drug and alcohol misuse using the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression, CAGE-AID for drug and alcohol use, GAD-7 for generalized anxiety disorder.	Confirm that the results of all screening tool assessments are contained in the electronic health record.	Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.	Percentage of practices that have documented that the results of the screening tool are being tracked over time and that treatment is being adjusted based on the results of the screening tool.	N/A	N/A
13	Develop procedures for intervention or referrals as the result of a positive screening.	Document policies and procedures for intervention or referrals as the result of a positive screening. Referrals to behavioral health providers should be consistent with protocols established in the Core Component 8 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.	Document that "warm hand-offs" are occurring, where a primary care provider directly introduces the patient to a behavioral health care provider at the time of a primary care appointment (when clinically appropriate) for any necessary follow-up care.	Percentage of practices that utilize "warm hand-offs" when clinically appropriate, and consistent with Core Component 11.	N/A	N/A
	Integrated clinical records						
14	Establish and implement integrated access to clinical information from BH providers in primary care records, as appropriate and permissible.	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	N/A	N/A

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15	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (i.e., both sending and receiving data).	Document a) a written agreement with AzHeC has been executed and b) that the practice is routinely receiving AzHeC ADT feeds.	Percentages of practices a) with a signed agreement with AzHeC, and b) routinely receiving AzHeC ADT feeds.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into clinical care planning and treatment.	Percentages of practices a) routinely supplying EHR data to AzHeC , and b) incorporating AzHeC data into clinical care planning and treatment.	N/A	N/A
16	Enhance electronic health record (EHR) capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication	N/A	N/A	N/A	N/A	Document whether the practice maintains a single primary care and behavioral health care plan (treatment plan) for all patients.	Percentages of practices with a) a single primary care and behavioral health care plan (treatment plan) for all patients.
	Community-based Supports						
17	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, and peer professionals by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	Percentage of practices that have community-based resources lists with contact information, a schedule for updating the resource and protocols for engaging the resources and/or referring patients.	N/A	N/A	N/A	N/A

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	E-Prescribing						
18	Consult Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as per established clinical protocols, before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.	Document the percentage of the practice's prescribers who are routinely using the CSPMP.	Percentage of practices that are routinely utilizing the CSPMP.	N/A	N/A
19	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.	Document the percentage of the practice's prescribers who are routinely e-prescribing Schedules 2, 3, 4 and 5 controlled substances; and barriers that prevent the routine use of e-prescribing.	Percentage of prescribers who are routinely e-prescribing for Schedules 2, 3, 4 and 5 controlled substances; A summary of barriers identified by practices for routine use of e-prescribing.	N/A	N/A
	Involvement with DSRIP Entity						
20	Participate in DSRIP entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	Percentage of practices that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 2: Integration of Primary Care and Behavioral Health Services (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care coordination of the preventive and chronic illness care for SMI individuals.

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	Taking Steps Toward Integration						
1	Utilize a commonly accepted behavioral health integration practice self-assessment instrument.	Identify the names of the self-assessment instruments the practice has employed and report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of an assessment; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.	N/A	N/A	N/A	N/A
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.	N/A	N/A	N/A	N/A

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	Management of High-Risk Patients						
3	Utilize care managers [1] at a maximum caseload of 1:100 (unless otherwise specified by AHCCCS) to, in part, help develop integrated care plans, work with families and facilitate linkages to community organizations, social service agencies and schools	Identify the name of at least one care manager serving at the primary care site. Indicate the caseload level per care manager.	Percentage of practices that have identified a care manager for each practice site; Percentage of practices that have met the caseload level standards.	N/A	N/A	N/A	N/A
		Demonstrate that the care manager(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care managers that have received DSRIP entity care coordination training; Evidence of training agenda and training materials.	N/A	N/A	N/A	N/A
		Demonstrate that care manager(s) have been trained to engage and educate patients who are frequent ED utilizers to utilize the behavioral health practice, instead of the ED, when appropriate.		N/A	N/A	N/A	N/A
		Document that care managers have been trained in motivational interviewing for patient self-management support.		N/A	N/A	N/A	N/A

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4	Track-members with high risk to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have defined and implemented processes for routinely screening for high-risk status indicators.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry.	N/A	N/A
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can be and is incorporated into the high-risk registry.	Demonstrate the functionality to utilize the registry to communicate which patients are not responding to treatment as per care plan.	Percentage of providers using a registry tool to communicate which patients are not responding to treatment as per care plan.	N/A	N/A
6	Implement the use of integrated care plans to be coordinated by a clinical care manager.	Demonstrate that all patients and identified as high risk have been referred to a clinical care manager for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. A sample audit of high-risk patients to identify whether their care plans consistent of the required elements may occur.	Demonstrate that the integrated care plan is documented in an integrated, and electronic medical record, in such a way that primary care providers and behavioral health providers both have access.	Percentage of practices that have integrated care plans documented in an integrated medical record.	N/A	N/A

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		Demonstrate that all patients identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient's goals, desired outcomes, and objectives and readiness to address any individual needs.				N/A	N/A
		Document that primary care providers provide input into the integrated care plan, when the behavioral health provider is the originator of the plan, consistent with Core Component 3.					
7	Screen all patients to assess their complexity and what factors are affecting their health by using a tool that addresses common social determinants of health. (One such tool is the Patient Centered Assessment Method (PCAM) which can be found at www.pcamonline.org/about-pcam.html.)	(1) Identify what screening tool is used. (2) Confirm that the results of all screening tool assessments are contained in the electronic health record.	(1) Frequency distribution of SDOH screening tools (2) Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that 90% of patients are screened using the practice-identified screening tool.	Percentage of practices that meet the requirement to screen 90% of their patients using the practice-identified screening tool.	N/A	N/A

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8	Develop procedures for intervention or referral based on the result of the practice-identified SDOH screening tool.	Document policies and procedures for intervention or referral to resources / agencies as the result of the screening. Referrals to community-based organizations should be consistent with protocols established in the Core Component 13 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.	N/A	N/A	N/A	N/A
	Relationships with Primary Care Providers and Hospitals						
9	Develop referral agreements with primary care providers in their community and within the tribes to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation. Details should include the communication modality by which the behavioral health provider can reach the primary care clinician (for example, telephone, pager, email, etc.). (b) protocols for referrals, crisis, information sharing, and obtaining consent. (c) protocols for incorporating a “warm hand-off” between primary care providers and behavioral health providers. (d) protocols for ongoing and collaborative-team-based care, including for primary care providers to provide input into an integrated care plan that originated with the behavioral health provider. (e) protocols for ensuring same-day availability for a physical health visit at the time of a behavioral health visit.	Identify the names of the primary care practices with which the community behavioral health care site has developed a referral and care coordination agreement.	Percentage of practices with referral and care coordination agreements; A listing of primary care providers with which each practice has completed a referral and care coordination.	Identify the names of practices with which the behavioral health care site has developed a referral and care coordination agreement in DY 2.	Percentage of practices with an increase in the number of referral and care coordination agreements.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 2: Integration of Primary Care and Behavioral Health Services (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care coordination of the preventive and chronic illness care for SMI individuals.

		DY 1		DY 2		DY 3	
CC#	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
10	Develop protocols with local hospitals to provide input into a patient's health history upon admission, 7 days per week.	Identify the hospitals with whom formal protocols have be established.	Percentage of behavioral health providers with protocols to provide meaningful input into their patient's health history upon admission, 7-days per week.	Identify the hospitals with which the behavioral health care site has developed protocols consistent with this Core Component in DY 2.	A sample audit from a list of patients who are attributed based on claims to a provider with whom a formal protocol has been established, to identify whether input is being provided into the patient's health history.	N/A	N/A
11	Develop protocols with local hospitals to improve the post-discharge coordination of care that cover communication, consultation, medical record sharing, medication reconciliation, for discharges 7 days per week.	Identify the hospitals with which formal protocols have been established.	Percentage of behavioral health providers with protocols to provide meaningful input into their patient's health history upon admission, 7 days per week.	N/A	N/A	N/A	N/A
	Clinical Care within the Behavioral Health Office						
12	Routinely screen patients receiving psychotropic medications for tobacco use, body mass index (BMI), metabolic syndrome, diabetes, and cardiovascular conditions, and document results in the medical record.	Confirm that the results of the screening tool assessments are contained in the electronic health record.	Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.	Percentage of practices that have documented that the results of the screening tool are being tracked over time and that treatment is being adjusted based on the results of the screening tool.	N/A	N/A
13	Develop procedures for intervention or referrals as the result of a positive screening, consistent with protocols established in Core Component 5.	Document policies and procedures for intervention or referrals as the result of a positive screening. Referrals to behavioral health providers should be consistent with protocols established in the Core Component 8 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.	Document that "warm hand-offs" are occurring, where a behavioral health provider directly introduces the patient to a primary care provider at the time of a behavioral health appointment (when clinically appropriate) for any necessary follow-up care.	Percentage of practices that utilize "warm hand-offs" when clinically appropriate, and consistent with Core Component 7.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 2: Integration of Primary Care and Behavioral Health Services (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care coordination of the preventive and chronic illness care for SMI individuals.

		DY 1		DY 2		DY 3	
CC#	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Integrated Clinical Records						
14	Establish and implement integrated access to clinical information from primary care providers in BH records, as appropriate and permissible.	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	Demonstrate that the primary care provider can access the chart notes of behavioral health providers, and that behavioral health providers can access the primary care records.	Percentage of providers who can access both the behavioral and medical records (either via same EHR or separate BH and medical EHRs)	N/A	N/A
15	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (i.e., both sending and receiving data).	Document a) a written agreement with AzHeC has been executed and b) that the practice is routinely receiving AzHeC ADT feeds.	Percentage of practices a) with a signed agreement with AzHeC, and b) routinely receiving AzHeC ADT feeds.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into clinical care planning and treatment.	Percentage of practices a) routinely supplying EHR data to AzHeC , and b) incorporating AzHeC data into clinical care planning and treatment.	N/A	N/A
16	Enhance electronic health record (EHR) capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	N/A	N/A	N/A	N/A	Document whether the practice maintains a single primary care and behavioral health care plan (treatment plan) for all patients.	Percentages of practices with a) a single primary care and behavioral health care plan (treatment plan) for all patients.
	E-Prescribing						
17	Consult Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as per established clinical protocols, before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.	Document the percentage of the practice's prescribers who are routinely using the CSPMP.	Percentage of practices that are routinely utilizing the CSPMP.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 2: Integration of Primary Care and Behavioral Health Services (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care coordination of the preventive and chronic illness care for SMI individuals.

		DY 1		DY 2		DY 3	
CC#	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
18	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.	Document the percentage of the practice's prescribers who are routinely e-prescribing Schedules 2, 3, 4 and 5 controlled substances; and barriers that prevent the routine use of e-prescribing.	Percentage of prescribers who are routinely e-prescribing for Schedules 2, 3, 4 and 5 controlled substances; A summary of barriers identified by practices for routine use of e-prescribing.	N/A	N/A
	Involvement with DSRIP entity						
19	Participate in DSRIP entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	Percentage of practices that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	N/A

Note:

[1] Tools include: the Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration (OATI), a Standard Framework for Level of Integrated Healthcare, the Integrated Practice Assessment Tool, the Behavioral Health Integration Capacity Assessment, the Maine Health Access Foundation Site Assessment (SSA), the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center Checklist, the Integrated Behavioral Health Project Tool, the Dual Diagnosis Capability in Health Care Settings, the Massachusetts Patient Centered Medical Home Behavioral Health Toolkit.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Taking Steps Toward Further Integration				
1	Utilize a commonly accepted behavioral health integration practice self-assessment instrument. [1]	Identify the names of the self-assessment instruments the practice has employed and report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of an assessment; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.	N/A	N/A
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Management of High-Risk Patients				
3	Utilize care managers [1] at a maximum caseload of 1:100 (unless otherwise specified by AHCCCS) to, in part, help develop integrated care plans, work with families and facilitate linkages to community organizations, social service agencies and schools	Identify the name of at least one care manager serving at the primary care site. Indicate the caseload level per care manager.	Percentage of practices that have identified a care manager for each practice site; Percentage of practices that have met the caseload level standards.	N/A	N/A
		Demonstrate that the care manager(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care managers that have received DSRIP entity care coordination training; Evidence of training agenda and training materials.	N/A	N/A
		Demonstrate that care manager(s) have been trained to engage and educate patients who are frequent ED utilizers to utilize the behavioral health practice, instead of the ED, when appropriate.		N/A	N/A
		Document that care managers have been trained in motivational interviewing for patient self-management support.			

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
4	Track-members with high risk to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have defined and implemented processes for routinely screening for high-risk status indicators.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry.
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can be and is incorporated into the high-risk registry.	Demonstrate the functionality to utilize the registry to communicate which patients are not responding to treatment as per care plan.	Percentage of providers using a registry tool to communicate which patients are not responding to treatment as per care plan.
6	Implement the use of integrated care plans to be managed by a clinical care manager.	Demonstrate that all patients and identified as high risk have been referred to a clinical care manager for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. A sample audit of high-risk patients to identify whether their care plans consistent of the required elements may occur.	Demonstrate that the integrated care plan is documented in an integrated, and electronic medical record, in such a way that primary care providers and behavioral health providers both have access.	Percentage of practices that have integrated care plans documented in an integrated medical record.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
		Demonstrate that all patients identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient's goals, desired outcomes, and objectives and readiness to address any individual needs.			
		Document that primary care providers provide input into the integrated care plan, when the behavioral health provider is the originator of the plan, consistent with Core Component 3.			

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
7	Conduct a root cause analysis to determine why certain practice patients are frequent ED and / or inpatient utilizers and identify the barriers to reducing the frequency of ED use, include those that may be practice based.	Develop strategies to address the barriers, and engage the patients with high ED and / or inpatient use to access the primary care practice or their principle behavioral health provider in lieu of an ED visit, when appropriate.	Percentage of practices that developed strategies for focus; Summary description of practice action plan areas of focus and goals.	Provide a progress report on the areas of focus and attainment to practice-identified goals.	Percentage of practices that provided a progress; Summary description of progress practices have made to reduce ED and/or inpatient utilization.
8	Screen all patients to assess their complexity and what factors are affecting their health by using a tool that addresses common social determinants of health. (One such tool is the Patient Centered Assessment Method (PCAM) which can be found at www.pcamonline.org/about-pcam.html.)	(1) Identify what screening tool is used. (2) Confirm that the results of all screening tool assessments are contained in the electronic health record.	(1) Frequency distribution of SDOH screening tools (2) Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.	Demonstrate that 90% of patients are screened using the practice-identified screening tool.	Percentage of practices that meet the requirement to screen 90% of their patients using the practice-identified screening tool.
9	Develop procedures for intervention or referral based on the result of the practice-identified SDOH screening tool.	Document policies and procedures for intervention or referral to resources / agencies as the result of the screening. Referrals to community-based organizations should be consistent with protocols established in the Core Component 13 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Integrated Clinical Functions				
10	Routinely screen patients for depression, anxiety, drug and alcohol misuse using the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression, CAGE-AID for drug and alcohol use, GAD-7 for generalized anxiety disorder.	Demonstrate the results of the screening tool are documented in the electronic health record, and that behavioral health providers and primary care providers are using the same screening tools.	Percentage of practices that have documented that the same screening tools are routinely used by all provider types, that they are documented in the electronic record.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.	Demonstrate that the practice is tracking patient progress through the use of the screening tools and making adjustments to treatment based on the results of the screening tool.
11	Develop procedures for warm hand-offs with behavioral health providers when the results of a positive screening warrant intervention or referrals to the behavioral health provider.	Demonstrate that there are procedures and protocols in place for a warm hand-off.	Percentage of practices that conduct warm hand-offs.	Demonstrate that warm hand-offs occur consistent with procedures and protocols.	A sample audit of medical records may occur to identify whether patients who have positive screens had appropriate interventions or referrals documented in the medical record.
12	Integrate chart notes for primary care providers and behavioral health providers, as appropriate and permissible.	Document that the behavioral health service provider chart notes (related to clinical information relevant to the assessment and treatment of the patient) are placed in the same location as the PCP chart notes. (Psychotherapy / personal notes should be kept separately).	The percentage of practices that can demonstrate the use of an integrated chart.	Document whether the practice maintains a) a single primary care and behavioral health care plan (treatment plan) for all patients and b) behavioral health and primary care clinician access to that care plan via the same EHR.	Percentage of providers with a single care plan (treatment plan) for all patients and whose care team members (behavioral health and primary care) have access to that care plan (either via the same EHR or separate BH and medical EHRs).

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
13	Ensure same-day availability for a behavioral health visit at the time of a physical health visit, and a physical health visit at the time of a behavioral health visit.	Document that the practice has the ability to provide same-day behavioral health care when the need arises during a primary care visit, and that a primary care visit can occur when the need arises during a behavioral health care visit.	Percentage of practices that demonstrate that immediate behavioral health needs, or physical health needs, can be accessed at the point of care.	Document that there is one system for making both primary care and behavioral health appointments.	Percentage of practices that have one system for making both primary care and behavioral health appointments.
14	Integrate physical space in the practice site.	N/A	N/A	Document that behavioral health providers and primary care providers have treatment space located in the same exam room area of the practice and provide service there.	Percentage of providers that physically integrate behavioral health and primary care providers.
15	Develop protocols with local hospitals to provide appropriate post-discharge follow-up care for empaneled patients.	Identify the hospitals with which the practices have developed protocols to assist the hospital in discharge planning, to receive the hospital discharge summary, and to provide appointments for patients within 7 days of discharge.	Percentage of practices with documented protocols.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
16	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (i.e., both sending and receiving data).	Document a) a written agreement with AzHeC has been executed and b) that the practice is routinely receiving AzHeC ADT feeds.	Percentage of practices a) with a signed agreement with AzHeC, and b) routinely receiving AzHeC ADT feeds.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into clinical care planning and treatment.	Percentage of practices a) routinely supplying EHR data to AzHeC , and b) incorporating AzHeC data into clinical care planning and treatment.
	E-Prescribing				
17	Consult Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), as per established clinical protocols, before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.	Document the percentage of the practice's prescribers who are routinely using the CSPMP.	Percentage of practices that are routinely utilizing the CSPMP.
18	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.	Document the percentage of the practice's prescribers who are routinely e-prescribing Schedules 2, 3, 4 and 5 controlled substances; and barriers that prevent the routine use of e-prescribing.	Percentage of prescribers who are routinely e-prescribing for Schedules 2, 3, 4 and 5 controlled substances; A summary of barriers identified by practices for routine use of e-prescribing.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)
Objective: To achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

		DY 1		DY 2	
CC #	Core Component	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Practice Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Involvement with DSRIP Entity				
19	Participate in DSRIP entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	Percentage of practices that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.

Footnotes

[1] Tools include: the Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration (OATI), a Standard Framework for Level of Integrated Healthcare, the Integrated Practice Assessment Tool, the Behavioral Health Integration Capacity Assessment, the Maine Health Access Foundation Site Assessment (SSA), the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center Checklist, the Integrated Behavioral Health Project Tool, the Dual Diagnosis Capability in Health Care Settings, the Massachusetts Patient Centered Medical Home Behavioral Health Toolkit.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Health Stay (Hospital)

Objective: To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient health stay.

		DY1		DY2	
CC #	Core Component	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Care Coordination with Outpatient Behavioral Health and Primary Care Providers Upon Admission				
1	Develop protocols with high-volume community behavioral health providers and primary care providers to solicit their input into their patient's health history upon admission, 7-days per week, including for their input on whether a patient is on a long-term injectable, when the last injection was, and when the next injection is due.	Identify the names of the behavioral health providers and primary care providers with whom formal protocols have be established.	Percentage of hospitals with documented protocols, allowing behavioral health providers and primary care providers to provide meaningful input into their patient's health history upon admission, 7 days per week.	N/A	N/A
	Medication Management				
	Provide direct medication management support and education to patients prior to discharge by:				
2	(a) conducting a health literacy assessment to determine whether the patient has the capacity to obtain, process, and understand basic health information and services needed to follow the prescribed medication regime, and develop protocols for when the patient does not pass the literacy assessment. Utilize one of the screeners available at http://healthliteracy.bu.edu/all;	N/A	N/A	Document policies and procedures for conducting a health literacy assessment with one of the endorsed screeners. Document policies and procedures for providing medication management support and education to patients who do not pass the literacy assessment.	Percentage of hospitals with documented procedures for a) conducting on health literacy assessments, and b) providing medication management support and education to patients who do not pass the literacy assessment.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Health Stay (Hospital)

Objective: To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient health stay.

		DY1		DY2	
CC #	Core Component	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
3	(b) providing (either through a hospital-based outpatient pharmacy, or through collaboration with a local outpatient pharmacy) medication required for post-discharge care in amounts at least sufficient to cover the patient until their first scheduled outpatient follow-up appointment;	Document policies and procedures for discharging patients with medication required for post-discharge through a hospital-based pharmacy or local outpatient pharmacy.	Percentage of hospitals with the specified policies and procedures in place for medication provision.	N/A	N/A
4	(c) reconciling medications received in the hospital to what may be taken (or available) at home using any means necessary, including the HIE.	Document that a medication reconciliation took place immediately prior to discharge, and document that the HIE was consulted as part of medication reconciliation.	Percentage of hospitals with documented policies and procedures for performing medication reconciliation consistent with this Core Component.	N/A	N/A
5	(d) educating on how and when to take the medications.	Document that the patient received education on all medications.	Percentage of hospitals with documented policies and procedures for performing medication education.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Health Stay (Hospital)

Objective: To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient health stay.

		DY1		DY2	
CC #	Core Component	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
	Care Coordination with Outpatient Behavioral Health and Primary Care Providers Upon Discharge				
6	Develop protocols with high-volume **community behavioral health providers** to improve post-discharge coordination of care. The protocols cover communication, consultation, medical record sharing, and medication reconciliation for discharges 7 days per week. If a patient is discharged on multiple antipsychotics, protocols for communicating plans to transition the patient to monotherapy.	Identify the names of the behavioral health providers with whom formal protocols have be established.	Percentage of hospitals with documented protocols, containing all of the required elements.	The percentage of patients discharged from an inpatient psychiatric setting on two or more antipsychotic medications.	From the population of patients who are reported in **NQF Measure 0552: HBIPS -4 Patients discharged on multiple antipsychotic medications,** (http://tinyurl.com/harj9nk) a sample audit of medical records to be used to identify whether communication regarding use of antipsychotic medications between hospital and community behavioral health provider was documented.
7	Develop protocols with high-volume **community primary care providers** to improve the post-discharge coordination of care. The protocols cover communication, consultation, medical record sharing, and medication reconciliation for discharges 7 days per week.	Identify the names of the primary care providers with whom formal protocols have be established.	Percentage of hospitals with documented protocols, containing all of the required elements.	N/A	N/A

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Health Stay (Hospital)

Objective: To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient health stay.

		DY1		DY2	
CC #	**Core Component**	**Hospital Reporting Requirement to DSRIP Entity**	**DSRIP Entity Reporting Requirement to AHCCCS**	**Hospital Reporting Requirement to DSRIP Entity**	**DSRIP Entity Reporting Requirement to AHCCCS**
8	Provide a discharge summary to the **community primary care provider** and **community behavioral health provider** within 24 hours of discharge which includes reason for hospitalization, principle discharge diagnosis, discharge medications and next level of care recommendations.	Document the policies and procedures by which discharge summaries are shared with primary care providers and community behavioral health providers in the required timeframe, and with the required elements.	**NQF Measure 0557: HBIPS-6 Post-discharge continuing care plan created.** Psychiatric inpatients for whom the post-discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations. Report hospital rates using The Joint Commission HBIPS-6 measure specifications. (http://tinyurl.com/j8hsyjy)	N/A	**NQF Measure 0558: HBIPS-7 Post-discharge continuing care plan transmitted to next level of care provider upon discharge.** Psychiatric inpatients for whom the post-discharge continuing care plan was transmitted to the next level of care. Report hospital rates using The Joint Commission HBIPS-7 measure specifications. (http://tinyurl.com/j3ajpzv)

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Health Stay (Hospital)

Objective: To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient health stay.

		DY1		DY2	
CC #	Core Component	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
9	With input from the patient, schedule follow-up appointments with a community behavioral health provider(s).	Document the policies and procedures that govern the process for setting up post-discharge follow-up appointments with the patient's input.	**RBHA will report on the following measure and DSRIP entity will be held accountable. NQF Measure 0576: Follow-Up After Hospitalization for Mental Illness.** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.	N/A	**RBHA will report on the following measure and DSRIP entity will be held accountable. NQF Measure 0576: Follow-Up After Hospitalization for Mental Illness.** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT
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		DY1		DY2	
CC #	Core Component	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS	Hospital Reporting Requirement to DSRIP Entity	DSRIP Entity Reporting Requirement to AHCCCS
10	Follow-up with the patient within forty-eight hours of discharge for medication reconciliation and to help with any questions or problems related to transitioning care for his/her condition to the community.	Document the policies and procedures that govern the process for following-up with the patient within forty-eight hours of discharge.	Percentage of hospitals with documented policies and procedures.	N/A	A sample audit of medical records to identify the percentage of patients who had a follow-up contact with the hospital, including medication reconciliation, within forty-eight hours of discharge.
	Care Coordination with RBHAs				
11	Develop protocols with RBHAs to communicate identified member-specific social and economic determinants of health (e.g., housing) that will be important to address to support the member upon transition to a community setting and prevent or delay the need for a readmission.	Document a protocol for contacting the RBHA prior to patient discharge in the event that the hospital has identified a social determinant of health that the RBHA may be able to address in order to support community tenure post-discharge.	Percentage of hospitals with a protocol for communicating member-specific social determinants pre-discharge in order to facilitate transition to the community.	N/A	N/A
	Involvement with DSRIP Entity				
12	Participate in DSRIP entity-offered training and education.	N/A	Percentage of hospitals that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.	N/A	Percentage of hospitals that participated in a) all, and b) each DSRIP-entity provided training during the DY; Evidence of training agenda and training materials.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

The DSRIP entity and individual practices participating in this strategic focus area will be held accountable for reporting their performance on a specified number of measures, to be defined by AHCCCS, beginning in DY2, and for improving their performance beginning in DY3. The measure list below includes measures under consideration for use at the DSRIP entity and/or practice level.

NQF #	Measures
0557	HBIPS-6 Post-discharge Continuing Care Plan Created
0558	HBIPS-7 Post-discharge Continuing Care Plan Transmitted to Next Level of Care Provider upon Discharge
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
2606	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
2602	Controlling High Blood Pressure for People with Serious Mental Illness
2599	Alcohol Screening and Follow-up for People with Serious Mental Illness
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
1401	Maternal Depression Screening
0105	Antidepressant Medication Management
0576	Follow-Up After Hospitalization for Mental Illness (FUH)
0710	Depression Remission at 12 months
1884	Depression Response at 6 months
0018	Controlling High Blood Pressure
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)
0055	Comprehensive Diabetes Care: Eye Exam
0059	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
0575	Comprehensive Diabetes Care: Hemoglobin A1c Control (<8.0%)
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy
1799	Medication Management for People with Asthma
0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
NCQA/ 0421	Adult BMI Assessment *or* Adult Weight (BMI) Screening and Follow-up
0028	Tobacco Use: Screening and Cessation Intervention
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

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NQF #	Measures
2372	Breast Cancer Screening
HEDIS	Inpatient Visits/1000
HEDIS	ED Visits per 1000
	Medication adherence upon discharge for BH+PH providers
	Falls risk and other measures related to seniors